WIPA & Community Partner Work Incentives Counseling National Training Curriculum:

Promoting Employment and Financial Stability of Social Security Beneficiaries with Disabilities

2024 Edition

National Training and Data Center at Virginia Commonwealth University

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Introduction - Understanding the WIPA Program and Your Role as a Community Work Incentives Coordinator (CWIC)
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Introduction - Understanding the WIPA Program and Your Role as a Community Work Incentives Coordinator (CWIC)

Learning Objectives

After you have read this chapter and completed the associated lectures and activities during the WIPA Initial Training, you should be able to:

1. Describe the relationship between poverty and disability, and how low rates of employment among adults with disabilities contributes to this problem.

2. Identify the goals of the WIPA program.

3. Identify and describe the six service components of the WIPA program.

4. Describe the five requirements Community Work Incentives Coordinators (CWICs) must meet to provide WIPA services.

5. Describe the essential job functions of CWICs.

6. Describe the differences between CWICs and Community Partner Work Incentives Coordinators (CPWICs)

7. Describe the purpose of the WIPA initial training manual and the limits to using this manual to provide comprehensive and accurate work incentives counseling.

8. Identify sources of information CWICs use to research questions about benefits and work.

List of Acronyms

- BS&A – Benefits Summary and Analysis
- CCCs – Continuing Certification Credits
- CWIC – Community Work Incentives Coordinator
- CPWIC – Community Partner Work Incentives Coordinator
Understanding the Problem – The Relationship between Poverty and Disability

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

- In the United States in 2019, the poverty rate of working-age people with disabilities was 25.1 percent (American Community Survey - Poverty - 2019 - 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 inability 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.

- Individuals with disabilities are also nearly twice as likely to lack even modest savings in case of an unexpected expense or other financial shock. Seventy percent of individuals with disabilities responded that they “certainly” or “probably” could not come up with $2,000 to meet an unexpected expense, compared to 37
percent of individuals without disabilities (See Disability Is a Cause and Consequence of Poverty 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 pronounced. Consider these facts from Social Security’s Monthly Statistical Snapshot for September 2021 (https://www.ssa.gov/policy/docs/quickfacts/stat_snapshot/):

- Approximately six million beneficiaries - more than 70 percent of Supplemental Security Income (SSI) beneficiaries and 30 percent of Social Security Disability Insurance (SSDI) beneficiaries - are currently living below the federal poverty level.

- The average SSI benefit of $586 per month (September 2021) was only 55.1 percent of the 2021 federal poverty level for a family of one. The maximum federal monthly SSI payment of $794 (in 2021) was 74.7 percent of the 2021 federal poverty limit for a family of one.

- The average SSDI monthly benefit of $1,152 (September 2021) was only 83.7 percent of the 2021 federal poverty level for a family of one.

A major cause of poverty and material hardship among Social Security disability beneficiaries continues to be the low rates of employment within the population. According to the U.S, Bureau of Labor Statistics, in 2021, only 19.1 percent of persons with a disability were employed while 63.7 percent of persons without disabilities were employed during the same period. In addition, working disabled individuals worked fewer hours. Among workers with a disability, 29 percent usually worked part time in 2021, compared with 16 percent of those without a disability (Persons with a Disability - Labor Force Characteristics Summary February 24, 2022; https://www.bls.gov/news.release/disabl.nr0.htm.).
Breaking the Connection between Poverty and Disability – Work Incentives Planning and Assistance (WIPA) as Part of the Solution

Social Security beneficiaries with disabilities are often economically vulnerable, and often receive essential support from a web of benefit providers and means-tested economic support programs. These benefit programs and support service systems have entitlement requirements sensitive to earned income. Beneficiaries often do not fully understand how paid employment will affect their benefits. This lack of understanding leads beneficiaries to fear that employment will cause the loss of critical cash benefits and health insurance.

In 1999, Congress passed the Ticket to Work and Work Incentives Improvement Act to address this barrier to employment. The Ticket to Work and Work Incentives Improvement Act authorized the Work Incentives Planning and Assistance (WIPA) program. The WIPA program has a national cadre of highly trained professionals who provide in-depth counseling to Social Security disability beneficiaries about how paid employment affects benefits. The goals of the national WIPA program are to:

- 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.
- Support beneficiaries in successfully maintaining employment (or self-employment) over time. Success means not just getting a job, but instead, improving long-term economic security through employment.

The Ticket to Work and Work Incentives Improvement Act authorized Social Security to award cooperative agreements to community-based organizations to provide WIPA services to its disability beneficiaries. Social Security currently funds and oversees 74 cooperative agreements throughout every state, the District of Columbia, and the U.S. territories of American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the Virgin Islands. WIPA programs provide disability beneficiaries with accurate, comprehensive information about how employment impacts...
Social Security disability benefits, associated health insurance (Medicare and Medicaid), as well as other federal, state, or local benefits programs.

**WIPA Service Components**

The WIPA program includes the following service components:

1. **Screening Requests for Services to Establish Program Eligibility and Determine Priority for WIPA Services**

   WIPA services are available to individuals who are between age 14 and full retirement age who are eligible for Social Security disability benefits. Not everyone who contacts a WIPA program seeking services meets the eligibility requirements. WIPA personnel must screen all requests to ensure that they provide services to eligible individuals.

   Once WIPA staff establishes eligibility, they may need to establish the priority for services. To ensure beneficiaries at highest risk receive services quickly. The priority categories follow:

   - Beneficiaries who are working full-time, are self-employed full-time or are about to start full-time work.

   - Beneficiaries who are working part-time, are self-employed part-time or about to start part-time work.

   - Beneficiaries who have had a job interview within the 30 days prior to their first contact with the WIPA project or Help Line, or who have a job interview within the two weeks following contact with the Help Line or initial contact with the WIPA project.

   - Beneficiaries seriously considering employment, who are currently receiving services from a State Vocational Rehabilitation (VR) agency, or who have assigned their Ticket to an EN or other vocational program, or who indicate serious intent to work.

   - Other beneficiaries seeking work incentives counseling if the project has capacity to serve them. (2023 Terms and Conditions).

Not everyone who is eligible for WIPA services will have priority for the most in-depth individualized services WIPA programs provide. Social
Security requires WIPA staff to determine which beneficiaries have the greatest and most urgent need for individualized work incentives counseling. We provide you with specific information about managing initial requests for WIPA services in Chapter 10 of Part II of this manual.

2. Providing Information and Referral (I&R) Services:

Beneficiaries contact WIPA programs because they have questions about benefits and work, but they also pose questions about many other issues. WIPA programs work with each eligible beneficiary to determine their presenting needs and then provide the specific information and/or necessary service referrals to meet those needs. Information and referral 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 for persons with disabilities, as well as a large number of other income support and community service programs (housing, transportation, advocacy, financial services, etc.). We provide you with information about providing I&R services in Chapter 11 of Part II in this manual.

3. Gathering Information and Verifying Benefits

Social Security requires WIPA programs to gather comprehensive information from beneficiaries before providing work incentives counseling. This information includes contact information, basic demographics, benefits received, plans or goals regarding employment, past work since entitlement, and a variety of other data based on the unique needs and circumstances of the individual. WIPA programs must also verify benefits to ensure that information is correct and complete. The information gathering and verification process drives all subsequent work incentives counseling. We provide information about gathering information and verifying benefits in Chapter 12 of Part II in this manual.

4. Providing Individualized Work Incentives Planning and Assistance Services

This is the cornerstone of the WIPA program 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, using, and managing work incentives;

• Assistance with resolving problems related to benefits;

• Assistance with identifying and resolving barriers to obtaining or maintaining employment including referral to other services that may help;

• Coordination with members of the beneficiary’s employment support team; and

• Training and support on effective records maintenance and reporting techniques.

We provide information about individualized WIPA services in Chapter 13 of Part II of this manual.

5. Supporting Beneficiaries to Manage Benefits

Social Security disability beneficiaries often need training and technical assistance from WIPA programs to understand their public benefits. WIPA programs help beneficiaries understand the basic eligibility requirements of the benefits they receive. Armed with accurate information, beneficiaries will be less likely to do things that accidentally cause loss of essential cash payments and health insurance. WIPA programs also teach beneficiaries about the effect of earned income on the benefits and the work incentives built into the various programs. When beneficiaries understand how wages will affect benefits, they can plan ahead and prepare for these changes.

WIPA programs also help beneficiaries understand what reports government agencies require. Unfortunately, even with accurate reporting, some benefit problems will occur. WIPA programs also help resolve these problems. We provide specific information about how WIPA programs support beneficiaries to manage their benefits successfully in Chapter 14 of Part II in this manual.
6. Ongoing Proactive Follow-Up Services

Many beneficiaries require ongoing contact from WIPA personnel. Each beneficiary’s need for follow-up services is unique. Some individuals may require intense assistance for a short period while others may need lower levels of support spread out over months or years. Some beneficiaries may require long-term work incentives management on a scheduled, continuous basis. We provide specific information about providing WIPA follow-up services in Chapter 15 of Part II in this manual.

Understanding the Role of Community Work Incentives Coordinator (CWICs)

Social Security funded WIPA programs are staffed by personnel known as Community Work Incentives Coordinators (CWICs). CWICs provide WIPA services directly to disability beneficiaries. Social Security has several important requirements for individuals hired to be CWICs in WIPA programs.

1. CWICs must dedicate at least 40% of a full-time schedule (no fewer than 16 hours per week for a 40-hour work week) to WIPA work incentives counseling services with WIPA eligible beneficiaries. CWICs working less than a Full-Time Equivalent (FTE) position must still meet the minimum hour requirement of 16 hours per week providing WIPA services under WIPA project funding.

2. To do their jobs, CWICs must access personal information about the beneficiaries they serve. Social Security requires any WIPA personnel who have access to beneficiary Personally Identifiable Information (PII) to successfully complete a moderate risk (Tier 2) suitability determination prior to working with beneficiaries.

3. CWICs must attend required WIPA Initial Training and successfully earn provisional certification prior to serving beneficiaries. Social Security only accepts the Virginia Commonwealth University National Training and Data Center (VCU NTDC) certification to provide WIPA services. The certification has two parts, both of which Social Security and the VCU NTDC designed to build the necessary technical expertise to serve beneficiaries effectively at
a beginning level. Part I includes initial training and testing to achieve provisional certification. Part II includes training on federal benefits beyond the ones Social Security administers, as well as opportunities to receive feedback on benefits analyses written for current clients. Prospective CWICs must submit and pass the review of three analyses prior to achieving full certification.

4. Fully certified CWICs must earn a minimum of 18 Continuing Certification Credits (CCCs) annually to enhance their skills. CWICs earn CCCs through approved supplemental training sessions. Certified staff must meet this requirement during each cooperative agreement award year to retain certification. Certified CWICs must also submit a Benefits Summary and Analysis (BS&A) report for review on a periodic basis. CCCs represent the minimum level of continuing education. Social Security expects CWICs to continue to be active learners and researchers.

5. VCU NTDC training and technical support provides training on federal programs and work incentives that affect beneficiaries. CWICs must work to learn the state and local benefits within their service area to provide effective work incentives counseling. In addition to the CCC requirements for state and local benefit training, WIPA Program Directors must provide training opportunities and technical assistance for all CWICs on applicable state and local programs. Training should focus on eligibility requirements and the effect that employment has on these programs.

**CWIC Job Duties**

CWICs counsel beneficiaries about how employment will affect their current benefits, public and private health insurance, and other federal, state, and/or local benefits. The essential job functions of a CWIC include:

- Respond to referrals for WIPA services provided by the Ticket to Work Help Line using prescribed protocols.
- Conduct initial interviews with beneficiaries that gather all information necessary to provide comprehensive individualized benefits counseling.
• Verify all federal, state, and local benefits that could be affected by paid employment.

• Provide in-depth individualized benefits analysis covering all federal, state, and local benefits.

• Provide customized counseling about the effect of an individual’s employment or earnings goal on all federal, state, and local benefits.

• Develop individualized BS&A reports using the required BSADocs report writing software.

• Assist beneficiaries with identifying, developing, utilizing, and managing work incentives.

• Assist beneficiaries with resolving problems related to benefits.

• Support beneficiaries to identify barriers to obtaining or maintaining employment and make referrals for employment or other services based on the beneficiary’s needs.

• Coordinate WIPA services with members of the beneficiary’s employment support team.

• Provide training and support to beneficiaries on effective reporting procedures and benefits management techniques.

• Provide ongoing proactive follow-up services to employed beneficiaries as needed.

• Maintain communication with the Social Security Administration and state and local agency personnel as needed to provide effective WIPA services.

• Collect, record, enter, and submit service data as required by the WIPA Program Terms and Conditions.

• Protect the confidentiality and security of all beneficiaries’ Personally Identifiable Information (PII).
Community Partner Work Incentives Counselors (CPWICs)

Social Security has a limited amount of funding to support the WIPA program. The demand for WIPA services exceeds the capacity of the current WIPA program.

To support work incentives counseling capacity, Social Security allows PABSS program staff, Employment Network (EN) staff, State Vocational Rehabilitation (VR) staff, and VR sponsored vendors to attend initial WIPA training and pursue full certification. Once certified, we call these individuals Community Partner Work Incentives Counselors or CPWICs. Since CPWICs do not work for WIPA programs that Social Security funds, there are some differences in their requirements. Here are the requirements for CPWICs:

1. Because CPWICs will work with beneficiary Personally Identifiable Information (PII), Social Security requires them to have a favorable suitability determination from Social Security prior to registration for WIPA Initial Training. WIPA staff may attend initial training while their suitability determination is in process but may not work with beneficiaries until Social Security gives them a favorable suitability clearance.

2. Prior to registering for the initial training, CPWICs must complete the Introduction to Social Security Disability Benefits, Work Incentives, and Employment Support Programs Web Course; we also call this the Introductory Web Course. CWICs do not have this requirement, though Social Security encourages them to complete the course if they have the ability to do so before training.

3. Prospective CPWIC training participants must commit to delivering individualized work incentive counseling services to Social Security disability beneficiaries at least 16 hours per week. This means working directly with beneficiaries providing WIPA services to beneficiaries. Since Social Security does not directly oversee CPWIC services, the agency can only recommend that CPWICs provide services at least 16 hours per week in order to retain their knowledge base.
4. Like CWICs, CPWICs are required to complete the WIPA Initial Training and achieve full certification. There is no difference in this process for CPWICs and CWICs.

5. CPWICs are required to complete the 18 Continuing Certification Credits each year to maintain their certification as CWICs, but CPWICs are not required to include in these credits any specific training in state/local benefits. CPWICs also are not currently required to submit BS&A reports for review and grading in order to maintain their WIPA certification.

**Note:** CWICs work for WIPA-funded programs. CPWICs work under other funding. Social Security does not permit people providing services under WIPA to follow only the CPWIC requirements.

**Using the WIPA Training Manual and Accessing Additional Resources**

The WIPA Initial Training Manual does not represent everything you need to master to become a fully certified CWIC/CPWIC. The information presented in this manual content is limited to what you are expected to master during initial training through Part I of the CWIC certification process (provisional certification). CWICs require additional training and technical assistance to provide accurate and complete individualized WIPA services during Part II of the certification process (full certification) and beyond. Provisionally certified CWICs/CPWICs have just enough information and expertise to begin serving beneficiaries. There is much more you need to do to develop true expertise.

An important part of a CWIC/CPWIC’s job is recognizing what you do not know as you begin to serve beneficiaries. As you work with individuals who have complex benefits situations, there will be times when the manual will not provide the depth of information you need. To build competence, CWICs/CPWICs must conduct independent research and seek out additional training and technical assistance.

When conducting independent research into benefits issues, you must access trusted sources of information. Here are some resources we recommend for WIPA program personnel:
► Social Security’s Website

Social Security has an accessible website with resources, tools, and general information that may help CWICs understand complex situations or may provide simple explanations for CWICs to offer beneficiaries when they have questions.

► Social Security Publications and Forms

Social Security maintains a repository of publications written in plain language covering a wide range of topics. These publications make excellent handouts to give to beneficiaries, but they are also useful for CWICs as they conduct research. You will find Social Security's publications online (https://www.ssa.gov/pubs/).

There are also times when CWICs need to locate certain Social Security forms. You will find Social Security’s forms on their website (https://www.ssa.gov/forms/).

► Social Security’s Program Operations Manual System (POMS)

The POMS is a primary source of information used by Social Security employees to process claims for Social Security benefits. Social Security maintains the public POMS as a searchable online database on Social Security’s website (https://secure.ssa.gov/apps10/). The public version of POMS is identical to the version used by Social Security employees except that it does not include internal data entry and sensitive instructions.

The POMS contains instructions for Social Security employees and is written in technical terms. Because of this, CWICs sometimes struggle with using the POMS to conduct research. You can get an overview of how to use the POMS by reviewing an archived supplemental training session entitled "Navigating the POMS" found on the NTDC website (https://vcu-ntdc.org/training.supplemental/archives.cfm).

► Approved Resources Developed by VCU’s NTDC

Social Security contracts with the VCU NTDC to provide training and technical support to WIPA programs. You will find the NTDC resources webpage online at https://vcu-ntdc.org/resources/resources.cfm.
Social Security also contracts with the NTDC to develop and deliver supplemental training sessions for CWICs/CPWICs. You will find a list of upcoming training sessions on the NTDC website (https://vcu-ntdc.org/training-supplemental/upcoming.cfm). The VCU NTDC archives all live supplemental training sessions on the NTDC website so you can access them at any time. The NTDC also develops on-demand training sessions. You will find a complete listing of these archived training sessions on the NTDC website (https://vcu-ntdc.org/training-supplemental/archives.cfm).

▶ Technical Support Provided by NTDC Technical Assistance (TA) Liaisons

As soon as you complete initial training, we will provide you with information on your assigned NTDC TA Liaison for ongoing support. This person is available to you by phone or email to provide any assistance you might need as you begin serving beneficiaries. Your TA Liaison can also help with reviewing Benefits Summary and Analysis (BS&A) reports to provide feedback and conducting case reviews to make sure you have covered all the bases in your counseling. You can find a Listing of the NTDC TA Liaisons with contact information on the NTDC website (https://vcu-ntdc.org/aboutus/liaisons.cfm).

Next Steps

This chapter gives a basic understanding of the WIPA program, the WIPA service components, and your job as a CWIC/CPWIC. During initial training, your instructors will also cover what to expect during the course as well as provide more detail about the CWIC certification process.

The rest of this manual is divided into two parts. Part I covers all of the technical information you need to understand how Social Security Disability benefits work and how paid employment affects them. Part II describes how to provide effective WIPA services to beneficiaries.

Providing work incentives counseling is both challenging and rewarding. You will be the person with the right answer who can help beneficiaries improve their quality of life. Remember that what you do can and will make a difference. Happy learning!
Part I Chapter 1 – Understanding Social Security Disability Benefits
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Chapter 1 – Understanding Social Security Disability Benefits

Learning Objectives

After you have read this chapter and completed the associated lectures and activities during the WIPA Initial Training, you should be able to:

1. Identify the basic eligibility requirements of the three Social Security disability benefit programs.

2. Identify and describe key factors Social Security considers during Substantial Gainful Activity (SGA) determinations.

3. Describe work incentives that can be applied to reduce countable earned income during SGA determinations – Impairment Related Work Expenses (IRWE) and Subsidy/Special Conditions.

4. Describe work incentives that allow beneficiaries to test their ability to work without losing cash payments – Trial Work Period (TWP) and Grace Period.

5. Describe work incentives that allow beneficiaries to get benefits back if work stops – Extended Period of Eligibility (EPE) and Expedited Reinstatement (EXR).

List of Acronyms

- CDB – Childhood Disability Benefits
- COLA – Cost of Living Adjustment
- CS – Claims Specialist
- CWIC – Community Work Incentives Coordinator
- DAC – Disabled Adult Child Benefits
- DWB – Disabled Widow(ers) Benefits
- EPE – Extended Period of Eligibility
- EXR – Expedited Reinstatement
Overview of Social Security Disability Benefits

Title II of the Social Security Act authorizes the Old-Age, Survivors, and Disability Insurance (OASDI) program of the Social Security Administration (SSA). The original Social Security retirement and survivor’s benefit program that began in 1935 did not contain provisions for disability insurance. Congress added the "D" in OASDI more than 20 years later, on August 1, 1956. This is the date that President Dwight D. Eisenhower signed into law the 1956 Amendments to the Social Security Act establishing the Social Security Disability Insurance (SSDI) program.

Over the years, the program has grown. Social Security’s current disability program provides monthly benefits to the following groups:
1. Former workers with a recent work history (SSDI) (may also include benefits for dependent family members such as minor children);

2. Disabled children (aged 18 or older) of retired, deceased, or disabled workers (Childhood Disability Benefits or CDB); and

3. Disabled widows or widowers aged 50 or older (Disabled Widow(ers) Benefits or DWB).

There is another disability program Social Security administers called Supplemental Security Income or SSI. The SSI program targets eligible persons who have limited income and resources and who are disabled, blind, or aged 65 or older. Blind or disabled children, as well as adults, are also eligible to receive SSI benefits. Monthly SSI benefits assist with the costs of food and shelter. Unlike Social Security OASDI benefits, SSI benefits are not based on prior work. Instead, Congress funded the SSI program from income taxes. This chapter focuses exclusively on the Social Security disability benefits authorized by Title II of the Social Security Act. We cover the SSI program, which was authorized by Title XVI of the Social Security Act, in Chapter 3.

**Earning Entitlement to Social Security Benefits**

Workers earn Social Security benefits by paying taxes on wages or on the net-profit from a trade or business. You may recognize this tax as a payroll deduction called “FICA” which stands for the Federal Insurance Contributions Act. Social Security calls having enough work to become entitled to benefits “Insured Status”. To determine a worker's insured status, Social Security looks at the amount of the worker's earnings on which the worker paid Social Security taxes. Workers earn “credits”, also called Quarters of Coverage (QC), for those earnings. Workers can earn a maximum of four QC per calendar year. The amount of earnings required for a QC adjusts automatically each year in proportion to increases in the average wage level. Social Security determines insured status based on a minimum number of credits during certain periods of a person’s working life. The requirements for insured status differ depending on the type of Social Security benefit involved.
You can learn more about **Quarters of Coverage** by referring to Social Security’s website (https://www.ssa.gov/oact/cola/QC.html).

**Fully Insured Status**

Eligibility for most types of Social Security benefits requires that the worker is “fully insured”. Social Security considers someone to be fully insured if they earn 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. A person can earn these credits any time during their work history. Regardless of 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 that work record. The number of credits required for insured status will never exceed 40, or the cumulative equivalent of ten years of covered earnings.

**Disability Insured Status**

There is another type of insured status required for people to receive disability benefits based on their own work history, called “disability insured” status. Disability insured status means that the individual meets the fully insured status test discussed above, and also meets a 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. However, at least 6 credits are required even if the claimant is younger than age 31.

Social Security provides an explanation of insured status accessible by visiting **The Redbook – A Guide to Employment Supports (Publication No.64-030)** (www.ssa.gov/redbook). Since Community Work Incentives Coordinator (CWICs) who provide Work Incentives Planning and Assistance (WIPA) services work exclusively with individuals who are already receiving disability benefits, they do not need to have expertise in insured status. CWICs do need to have a general understanding of the concept since some beneficiaries may establish eligibility for additional types of Social Security benefits after services begin or may ask questions about how they earned the benefit.
Types of Social Security Disability Benefits and Eligibility Requirements

An individual may establish entitlement to a Social Security benefit in many ways, the majority of which have nothing to do with disability. Remember, Social Security benefits authorized by Title II of the Social Security Act include retirement benefits, survivor’s benefits and benefits to dependent family members of insured former workers. In this chapter, we focus on the benefits based on disability since eligibility for WIPA services is limited to these individuals. Title II of the Social Security Act authorizes three distinct types of disability benefits:

1. Social Security Disability Insurance (SSDI) is a wage replacement benefit paid to insured former workers who are no longer able to support themselves by working due to disability. To qualify for SSDI, an individual must:
   a. Be fully insured and meet the requirements for disability insured status;
   b. Be disabled per Social Security’s standards;
   c. File an application with the Social Security Administration; and
   d. Serve a waiting period consisting of five full calendar months before SSDI cash payment will begin.

Social Security can pay SSDI cash benefits retroactively – meaning before the date of application. Payments may be paid back to the date of disability onset (the date Social Security determines an individual first met the disability standard), up to a maximum of 12 months before the month the person filed the application.

2. Childhood Disability Benefits (CDB), previously called Disabled Adult Child’s benefits (DAC), are payable to the adult child of an insured worker who has died, or who is entitled to a
retirement or disability benefit. To qualify for CDB, an individual must:

a. Be the child of an insured former worker who is deceased or collecting Social Security benefits based on his or her work;

b. Have a disabling condition based on Social Security’s standards that began prior to the time the child attained age 22;

c. Be at least 18 years old;

d. File an application with the Social Security Administration; and

e. Not be married (with some exceptions).

Individuals who are eligible for CDB do not have to serve a five-month waiting period before monthly payments begin. Social Security does not pay Childhood Disability Benefits before the month the individual turns 18. **(Note: Prior to age 18, children of a deceased or entitled worker, even if the child has a disability, may receive benefits based on age and relationship, called “child’s benefits.”)**

3. Disabled Widow(er)’s Benefits (DWB) are payable to the widow, widower, or surviving divorced spouse of an insured former worker. To qualify for DWB, an individual must:

a. Be at least age 50 years of age;

b. Provide proof of the marriage with the deceased worker and meet other requirements regarding the length of time between that worker’s death and the disability onset, reaching age 50, and the application for benefits;

c. Be unmarried (with some exceptions);

d. File an application with the Social Security Administration; and

e. Serve a waiting period consisting of five full calendar months before DWB cash payment will begin.

The definition of disability and the disability determination process are the same for all three disability benefit groups. We discuss Social Security’s disability standard and the disability determination process at length in Chapter 7.
How Social Security Determines Monthly Benefit Payments

Once Social Security determines that a former worker has sufficient QCs to permit entitlement to benefits, they determine the Primary Insurance Amount (PIA). The PIA is the result of a complex benefit calculation that Social Security performs to determine the amount of monthly payments. Social Security calculates all benefits it pays on the worker’s record from the PIA. This includes benefits paid to the worker as well as any benefits paid to dependent family members or survivors. There are many different calculations depending on the type of Social Security benefits available on a worker’s record. Social Security chooses the appropriate calculation based on a worker’s date of birth and the date the disability began, the date a worker died, or the date a worker became entitled to a retirement benefit. Social Security calculates the PIA and determines monthly benefit payment amounts when someone first applies for benefits. After initial application, the payment amount may change due to annual cost-of-living adjustments (COLAs) or periodic re-computations that occur when an individual has additional earnings that positively affect the benefit.

When more than one person is entitled to a benefit based on a worker’s record, Social Security limits the total amount of benefits paid each month based on the “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 up to the FMAX. 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.
Effect of Work on Title II Disability Benefits

**NOTE:** The information in this chapter relates to Title II disability beneficiaries who are engaging in wage employment rather than self-employment. Social Security treats self-employment and wage employment very differently. You will need to complete additional training to be able to provide effective WIPA services to disability beneficiaries who are engaging in self-employment or planning to become self-employed. You can find detailed information about the effect of self-employment on Title II disability benefits by reading a resource document entitled *Self-employment and Social Security Disability Benefits* available on the NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=35).

Congress created Social Security disability benefits to serve as a partial wage replacement program for individuals who are unable to support themselves by working due to disability. Social Security measures a person’s ability to support themselves through working by comparing what a person earns or can be expected to earn with a special monthly wage figure they call “Substantial Gainful Activity” or SGA. Social Security makes SGA determinations when individuals first apply for disability benefits and during periodic reviews that continue as long as individuals receive benefits. An individual who Social Security determines is engaging in SGA or is able to engage in SGA is not considered to be “disabled” by definition and thus is not eligible for disability benefits. The concept of SGA is critically important in Social Security’s disability benefit program.

**Introduction to Substantial Gainful Activity (SGA)**

During an SGA determination, Social Security determines the value of an individual’s work activity as compared to a specific dollar figure known as the SGA guideline. The SGA guideline is a monthly earned income figure. Once Social Security applies all work appropriate deductions and work incentives, they compare the “countable” monthly earned income to the applicable monthly SGA guideline for the calendar year — different years have different SGA guideline amounts. If
countable earned 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 to be SGA. Beneficiaries who are not working at a substantial level continue to receive full monthly benefit payments. Individuals who work at a substantial level may eventually have benefits suspended or terminated.

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 blindness and another SGA guideline applies to all other individuals with disabilities. You can find the SGA guidelines for the current year and all past years in Social Security’s Program Operations Manual System (POMS) at POMS DI 10501.015 Tables of SGA Earnings Guidelines and Effective Dates Based on Year of Work Activity (https://secure.ssa.gov/apps10/poms.nsf/lnx/0410501015).

Social Security Claims Specialists (CS) within the local Social Security field office (FO) typically make SGA decisions, but other Social Security personnel may make these determinations under certain circumstances. Social Security personnel make SGA determinations when they conduct a work Continuing Disability Review (CDR). A work CDR occurs when a beneficiary reports having earnings from employment or self-employment or when Social Security discovers that a beneficiary has earned income that could affect entitlement or use of work incentives.

**Earnings Evaluation during SGA Determinations — Important Concepts to Understand**

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 eligibility for benefits ends. SGA determinations involve the interpretation of complex regulations as they apply to an individual beneficiary given that person’s unique situation. This flexibility is necessary, but can be challenging to understand.

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. Let’s look at some important concepts that apply whenever Social Security evaluates an individual’s earned income to determine if the work represents SGA.

**Pay for Work Activity**

Social Security bases SGA determinations on earned income. This means income individuals receive in exchange for work. Social Security does not consider unearned income during SGA determinations. In addition, Social Security makes SGA determinations based on a beneficiary’s GROSS earnings – this means earnings before any deductions such as federal or state taxes, FICA deductions or withholding for health insurance premiums. Social Security also considers “in-kind” payments as well as cash. The value of anything beneficiaries receive in exchange for work they perform may count as earned income during an SGA determination. Payments in-kind would include items such as room and board in exchange for performing work.

When determining how much in wages to count during SGA determinations, federal regulations require that Social Security personnel disregard certain types of pay. For example, Social Security only counts wages that represent the beneficiary’s actual work effort. Because of this policy, if an individual receives sick or vacation pay in a particular month, Social Security will not consider that pay as countable income for that month. In addition, payments beneficiaries may receive such as reimbursements for travel expenses generally do not count during an SGA determination since this is not pay based on work activity.

You will find detailed information on how Social Security defines wages in the POMS at [RS 01401.000 Wages](https://secure.ssa.gov/apps10/poms.nsf/lnx/0301401000).

**Earned Income Counts in the Month when Earned, Not When Paid**

In the Title II disability program, Social Security evaluates earnings on a calendar month-by-month basis. Social Security generally counts earned income in the month when the beneficiary earned it, not in the month the beneficiary was PAID. This may seem like a minor distinction, but it can have an effect upon SGA determinations. For example, beneficiaries may be concerned about losing entitlement
because they received an extra paycheck in a month. This happens when individuals are paid every week or every other week due to the way pay dates fall within a calendar month. Since Social Security counts wages when they are earned, not when they are paid, the two months each year that involve an extra paycheck should not cause benefit termination. Another example would include teachers who may elect to be paid on a 12-month basis, even though they only teach for 9-10 months out of the year. These teachers 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.

Current regulations require that Social Security personnel evaluate any readily available earnings verification sources to determine when the beneficiary earned wages. However, in some cases, it is hard to determine when wages were actually earned. 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.

**Social Security Disability Program Work Incentives**

Social Security considers many different things when they are evaluating a beneficiary’s work to see if that person is engaging in SGA. In addition to the concepts described above, there are work incentives that apply in the Title II program to help ease the transition from dependence on benefits to self-support through employment. Some of these work incentives apply to all Title II disability beneficiaries who work, while others only apply under a set of prescribed circumstances. There are lots of different work incentives, and they can be sorted into three main categories:
1. Work incentives that allow beneficiaries to earn above SGA and not lose benefits right away;

2. Work incentives that reduce how much earned income counts during an SGA determination; and

3. Work incentives that help individuals get benefits back again if needed after Social Security suspends or terminates benefits due to earned income.

Let’s take a look at each of these categories and the different work incentive provisions that may apply in the Title II program.

Work Incentives that Allow Beneficiaries to Earn Above SGA and Not Lose Benefits Right Away

The Trial Work Period

By far the most important work incentive in this category is something Social Security calls the Trial Work Period or TWP. The TWP offers beneficiaries a limited period of time to test their ability to work while maintaining full benefit payments, no matter how much the beneficiary earns. As long as a beneficiary remains in their TWP, Social Security will not stop their benefits due to SGA. When an individual has used up all available TWP months, the TWP ends and Social Security will evaluate that person’s wages to see if they are able to engage in SGA level work. During SGA determinations that Social Security performs after the TWP ends, Social Security may consider the wages earned during the TWP. SGA level work performed during the TWP may cause benefits to stop AFTER the TWP ends. The TWP does not mean that Social Security ignores all of the work performed during that period of time. The TWP simply protects benefit continuation during the months in which this work incentive applies. Suspension due to SGA cannot occur until after the TWP ends.

Each year, Social Security sets a monthly amount of gross wages as a guideline for determining use of TWP months. When an individual earns more than the applicable TWP guideline in a calendar month, they use up one TWP month. The TWP guidelines change every calendar year.
You can find the **current and past TWP guidelines** in the POMS (https://secure.ssa.gov/apps10/poms.nsf/lnx/0413010060).

The TWP ends when a beneficiary performs nine months of work over the TWP guideline within a rolling period of 60 consecutive months. The TWP months within the 60-month period do not have to be consecutive for Social Security to count them. When a beneficiary reports that they are working, Social Security looks at the wages on a month-by-month basis and marks all of the possible months with wages over the applicable TWP guideline. Social Security counts forward until they identify nine TWP months, then counts back 60 consecutive months to see if the beneficiary completed all nine TWP 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 that a beneficiary uses a TWP 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. The 60-month timeframe does not mean that a person receives a new TWP every five years. Instead, it means that Social Security may ignore months of TWP level work that happened a long time before the current work effort. If a beneficiary works sporadically, TWP months can be spread out over a long period of time. Some beneficiaries have more than nine months of TWP level work, but the TWP does not end because the months are so spread out they do not have nine months that fall within a 60-month period. It will take some practice for you to be able to count TWP months correctly. Your instructors will provide you with lots of TWP examples during initial training.

Once the TWP ends, the TWP protections end. Beneficiaries have only one TWP during a period of entitlement. The person does not get another TWP based on the same Social Security record unless Social Security terminates the person’s benefits, and the person subsequently
becomes entitled again. Let’s look more closely at several key aspects of the TWP:

- TWP months are only used if an individual earns pre-tax (gross) wages of more than the current monthly TWP guideline. If the gross monthly wages are under the TWP guideline, Social security will not count that as a TWP month.

- Unlike the SGA guideline, there is no special TWP guideline for individuals who receive benefits based on blindness. The same TWP guideline applies to all Title II disability beneficiaries regardless of disability across all three of the Social Security disability benefit programs (SSDI, CDB and DWB).

- During the TWP, Social Security is only concerned with income paid for work usually performed for pay 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 pay (e.g., therapy, training, or self-care) will not use a TWP month.

- To use 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 reviewing a person’s medical condition.

- 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. The TWP may not begin before the date a person applies for disability benefits. The TWP may not occur before the first month a beneficiary becomes entitled, or re-entitled, to benefit payments.

- There are no deductions that apply to gross wages during the TWP. Social Security will determine the gross wages a beneficiary earned in a month and compare those monthly wages to the current TWP guideline. If the gross wages are
over the current TWP guideline, the beneficiary will have used a TWP month.

**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 demonstrates the ability to perform SGA level work after the TWP, Social Security considers the disability has “ceased”. Social Security allows beneficiaries to receive a payment in this month, called the cessation month, and the two succeeding months, called the “Grace Period”. This results in a three-month period during which benefit payments continue even though Social Security has determined the beneficiary engaged in SGA. Even though we refer to cessation month and grace period separately, Social Security always applies them together as one three-month block. Benefits do not stop until after the grace period. Social Security calls the first time a person performs SGA after the TWP “cessation” because when a person is able to engage in SGA level work, they are no longer considered to be disabled per the agency’s standards. You will learn more about Social Security’s disability standard and how SGA is considered during disability determinations in Chapter 7.

The cessation and grace months, like the TWP, are only available once during a period of disability. Social Security gives beneficiaries another Cessation Month/Grace Period only if they become re-entitled to benefits. The Grace Period remains available to protect a beneficiary’s cash payments for three months if or when the beneficiary ever engages in SGA after the TWP ends. The Grace Period may fall immediately after the TWP ends, at some other point in the future if the beneficiary engages in SGA later than the end of the Trial Work Period. If the beneficiary never performs SGA, Cessation may not occur at all, even if the TWP ends.

**Income Averaging**

Title II disability beneficiaries often fear that a single month in which their earnings exceed the current SGA guideline will result in benefit termination. Fortunately, this is seldom the case due to two very important tools Social Security applies during SGA determinations: Income Averaging and Unsuccessful Work Attempts (UWA).
Fluctuations in wages may 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. The rules governing when Social Security can apply averaging and which months of wages can be averaged together are complex. The important thing to remember is that in most cases, beneficiaries who have increased earnings in a single month are unlikely to lose entitlement to their benefits due to SGA level work. You can learn more about income averaging by completing a short archived training session available on the NTDC website (https://vcuntdc.org/resources/viewContent.cfm?contentID=200).

**Unsuccessful Work Attempts**

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 does not want to needlessly stop payments to a beneficiary who tries to perform substantial work, only to find that they cannot sustain that effort over time because of the disability. Because SGA is really a pattern of work behavior, it makes sense that Social Security would excuse a work effort of short duration under certain circumstances. Social Security refers to this as an Unsuccessful Work Attempt or UWA.

Just as with averaging, there are only certain circumstances in which Social Security can apply the UWA provisions when evaluating a beneficiary’s work. When UWA applies, Social Security will consider SGA level work of six months or less to be an UWA if the beneficiary stopped working or reduced work and earnings below the SGA earnings level because of an impairment or because of the removal of special conditions that accommodated the beneficiary’s impairment and permitted the beneficiary to work. Social Security cannot disregard SGA-level work lasting more than six months as UWA regardless of why it ended or why wages were reduced to the non-SGA level. 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.
You can learn more about UWA by reading a resource document entitled *Understanding Unsuccessful Work Attempts* available on the NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=250). You can learn more about how Social Security decides when a period of SGA level work is unsuccessful by completing a short online archived training session available on the NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=198).

**Work Incentives that Reduce How Much Earned Income Counts during an SGA Determination**

**Impairment Related Work Expenses (IRWE)**

Social Security recognizes that some beneficiaries incur additional expenses when they work because they are disabled that a non-disabled person would not have to pay. Because of this, Social Security allows disability beneficiaries to subtract the cost of certain disability related items and services they need to work when determining how much of the person’s earned income is “countable” during SGA determinations. Social Security calls these special costs Impairment Related Work Expenses or IRWEs. The purpose of the IRWE work incentive is to take work costs associated with a disability into account when assessing the value of a beneficiary’s earnings.

For Social Security to approve an IRWE deduction, the expense must meet five criteria:

1. 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 they 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. The expense has to relate to a medically determinable impairment for which the beneficiary is receiving treatment from a health care provider, rather than being a cost that anyone would incur by working. This means that Social Security will not count things like FICA deductions or health insurance premiums as IRWEs.

3. The individual must pay the expense out of pocket and not be reimbursed from another source. Social Security requires beneficiaries to submit documentation to prove payment of IRWEs.

4. In most cases, the individual must pay for the expense in a month during which the individual was working. 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. In some cases, beneficiaries may also subtract expenses they incurred in a month of work, but paid for after work stopped.

5. The expense must be “reasonable.” An expense is within reasonable limits if it is no more than the prevailing charge for the item or service in the local area. Prevailing charges fall within a range 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 costs 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 necessary and reasonable, considering the person’s impairment(s) and circumstances. There is no definitive all-inclusive list of acceptable IRWEs, but to find a list of common IRWEs, read The Redbook – A Guide to Employment Supports (Publication No.64-030) (www.ssa.gov/redbook).
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 is 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 deduct the expense as an IRWE all in one month or pro-rate the expense over a period of 12 months, depending on which is better for the beneficiary.

The IRWE work incentive includes many complex rules about what expenses Social Security may count and how they may apply the deduction for various expenses. You can learn more about IRWEs by completing an online archived training entitled **Understanding Impairment Related Work Expenses** available on the NTDC website (https://vcu-ntdc.org/training/supplemental/archives.cfm). You can also read detailed information about **IRWEs in the POMS** at (https://secure.ssa.gov/apps10/poms.nsf/lnx/0410520000).

**Subsidy and Special Conditions**

When Social Security conducts SGA determinations, they are interested in the “value” of an individual’s work. Social Security rules recognize that what a person actually receives in pay may or may not be the same as the value of that person’s work when compared to a non-disabled peer. Social Security considers the value of work because it is a better indicator of an individual’s ability to support themselves by working over time.

Social Security uses a work incentive called Subsidy/Special Conditions when there is evidence a person is being paid more than the value of the work performed as compared to non-disabled peers. Subsidy is support a beneficiary receives on the job that could result in a beneficiary receiving more pay than the value of the person’s work. Social Security recognizes that sometimes a person’s disability results in the need for extra assistance, a reduced production rate, frequent breaks, fewer job duties than co-workers in a similar job, or other special treatment. When that happens, the individual’s wages represent not only pay for their own work product or effort, but also direct help from someone else, like a supervisor, a co-worker, or a job coach. Subsidy could also occur when an employer pays the same wage to a worker with a disability who may work more slowly or produce lower
quality work than other employees. In simplest terms, Subsidy means that in some cases, a beneficiary may receive more pay than the reasonable value of their work when compared to other non-disabled employees performing the same tasks.

When performing SGA determinations, Social Security is only interested in evaluating earnings that they can attribute to the beneficiary. Social Security adjusts the value of the pay a beneficiary receives by deducting the value of extra help or special accommodations that a beneficiary gets. Applying “subsidy” during SGA determinations is the process of performing this adjustment.

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. An example of this would be if an employer hired a reader to assist an employee who was blind. The actual cost of the readers’ salary would be a specific subsidy. Employers also provide non-specific subsidies that are a little bit more difficult to quantify in terms of value. Non-specific subsidy would include things like providing a disabled employee more time to complete a task, or changing someone’s job duties to accommodate a disability. To determine the value of a non-specific employer subsidy, the employer must estimate the proportional value of the work according to the prevailing wage for such work paid to a non-disabled employee.

Another type of subsidy is called “special conditions.” Special conditions exist when a beneficiary 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 Vocational Rehabilitation (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. 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.
Social Security will investigate the possibility of subsidy or special conditions 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 their employer, and possibly from any disability services agencies involved in providing job supports. Beneficiaries provide this information by completing a special form called a Work Activity Report (form SSA-821). This form asks a series of questions about the beneficiary’s work performance and special accommodations the beneficiary receives to be successful at work. You can view a copy of the Work Activity Report by going to Social Security’s website (https://www.ssa.gov/forms/ssa-821.pdf).

If Social Security finds a subsidy, they will determine the value of the subsidy and subtract this amount from monthly gross wages to determine the actual value of the countable earned income. Social Security will consider the countable earned income rather than the actual dollar amount the individual received in wages when making the SGA determination.

You can find detailed information about subsidy in Social Security’s POMS (https://secure.ssa.gov/apps10/poms.nsf/lnx/0410505010). You can also learn more by completing an archived training session on Subsidy and Special Conditions entitled Title II Disability Benefits Work Incentives Series: Subsidy/Special Conditions found on the NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=199).

Work Incentives that Help Individuals get Benefits Back Again if Needed After Benefits Are Suspended or Terminated Due to Earned Income

Extended Period of Eligibility (EPE)

The 1980 amendments to the Social Security Act created a special reinstatement period called the Extended Period of Eligibility (EPE) for Title II disability beneficiaries who complete the Trial Work Period and continue to have a disabling impairment. This provision allows a
beneficiary whose benefit payments stopped due to SGA to be re-entitled to benefits any time during a 36-month, re-entitlement period, if their countable income falls below the SGA level.

An important benefit of the EPE is that entitlement to benefits does not terminate due to work during the re-entitlement period. Instead, Social Security suspends payments. Beneficiaries who become unemployed or whose monthly wages fall below SGA during the EPE can return to cash payment status by simply contacting Social Security. Beneficiaries with benefits suspended during the EPE do not need to re-apply for benefits to get them back if they are again unable to perform SGA. The EPE reinstatement period begins with the month immediately following the last month of the TWP and ends 36 consecutive months later. Here are some important things to know about the EPE:

- The EPE is a work incentive protection. A beneficiary must continue to have a disabling impairment to benefit from the EPE.

- The EPE always begins the month after the TWP ends, regardless of whether or not the beneficiary continues to work beyond the TWP. Once the EPE begins, it does not stop until 36 months have passed.

- If the beneficiary performs SGA at any time during the EPE, Social Security suspends rather than terminates benefits. The earliest benefit termination may occur due to work is the first month of SGA after the 36-month EPE re-entitlement period ends. If the beneficiary did not perform SGA during the EPE, but 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 period of entitlement has officially ended.

- If Social Security reinstates benefits 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 a beneficiary is not
performing SGA at the time the 36-month re-entitlement period ends, benefits may continue indefinitely.

- Cessation and Grace months may, or may not, occur during the EPE. Cessation happens the first time after the TWP that a person performs SGA. That could be the first month after the TWP, it could be years later, or it might never happen. The Cessation Month/Grace Period is a completely separate work incentive from the EPE.

- The beneficiary will need to supply evidence that work has ended or that countable earnings have decreased below the SGA guideline for benefits to start again after cessation during the EPE.

You can read detailed information about the EPE by going to POMS citation DI 28055.000 Extended Period of Eligibility (EPE) Cases (https://secure.ssa.gov/apps10/poms.nsf/lnx/0428055000).

**Expedited Reinstatement (EXR)**

The Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999 created an important work incentive for disability beneficiaries called Expedited Reinstatement (EXR). Expedited Reinstatement gives eligible individuals a quick way to re-establish entitlement for Social Security disability benefits after the agency terminated those benefits due to SGA. An important advantage of EXR is that it allows an individual to receive up to six months of provisional 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.

EXR is available to former Social Security disability beneficiaries (SSDI, CDB, DWB) who meet the following requirements:
• The individual must not be able to perform SGA in the month of the EXR request.

• To request EXR, a beneficiary needs to have fully terminated from benefits. Beneficiaries who are still in their EPE do not need to request EXR, since benefits are only suspended.

• Social Security must have terminated the individual’s prior entitlement due to SGA, NOT medical recovery or any other reason.

• The individual must be unable to perform SGA due to the same disability (or a related disability) that entitled the beneficiary to payments previously.

• To receive EXR benefits the beneficiary must request reinstatement within 60 months of when Social Security terminated the prior benefit, unless Social Security can establish good cause. If a person’s disability causes the reduction or cessation of work more than five years after Social Security terminates the record, EXR will not be available, and the beneficiary must file a new application for benefits.

Social Security will pay provisional benefits and reinstate Medicare (if applicable) beginning with the month the individual files the request for reinstatement if the individual does not perform SGA in that month. If the individual’s wages are above the SGA guideline that month, provisional benefits will begin the following month. Social Security bases the provisional payment amount on the applicable percentage of the worker’s Primary Insurance Amount (the worker’s highest benefit), and the payment 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. A person may receive up to six months of provisional payments while Social Security reviews the applicant’s medical records to see if the person still meets the disability standard. If Social Security determines that the beneficiary has medically improved and denies reinstatement, Social Security normally doesn’t reclaim provisional payments, meaning there is usually no overpayment.
An important aspect of EXR is that it allows individuals to get another TWP and EPE, but not immediately. Individuals must receive 24 months of EXR payments before Social Security entitles them 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 they stop performing SGA and Social Security entitles them to another EXR payment. Once the individual has received 24 months of EXR payments, they receive a new TWP and EPE, and all of the other work incentives Social Security gives initial disability applicants.

Social Security regulations prohibit individuals from requesting EXR and reapplying for disability benefits under a new period of entitlement at the same time. There are certain advantages and disadvantages to either option, but in most cases, requesting EXR will offer the best pathway to getting benefits back. You can learn more about this issue and other details about EXR provisions by reading a resource document entitled **Understanding Expedited Reinstatement** available on the NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=39).

**Next Steps**

We covered a great deal of complex information in this chapter – especially about how work affects Title II disability benefits. The information we provided on this topic is enough to give you a basic understanding about how Social Security makes SGA determinations and applies work incentives, but there is still much you will not master without additional training and technical support. Here are some things you can do to develop more competency while you work to achieve full CWIC certification:

1. Start by reviewing the [NTDC resource documents](https://vcu-ntdc.org/resources/resourceDetail_search.cfm?id=2) that cover various topics related to how work affects Title II disability benefits. You will find all of those documents posted on the NTDC website (https://vcu-ntdc.org/resources/resourceDetail_search.cfm?id=2).

2. There are several helpful [supplemental training sessions about work and the Title II disability benefits](https://vcu-ntdc.org/resources/resourceDetail_search.cfm?id=2) archived on the NTDC website (https://vcu-ntdc.org/resources/resourceDetail_search.cfm?id=2).
ntdc.org/training/supplemental/archives.cfm). The best sessions to start with are the ones marked as the Social Security Disability Benefits Work Incentives series.

3. As you work with beneficiaries who are going through an SGA determination, rely on your assigned NTDC Technical Assistance (TA) Liaison for help. Your TA Liaison can answer any questions you have about how Social Security applies work incentives in the Title II disability program.
Part I Chapter 2 – Understanding Medicare
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Chapter 2 – Understanding Medicare

Learning Objectives

After you have read this chapter and completed the associated lectures and activities during WIPA Initial Training, you should be able to:

1. Describe the basic operations of the federal Medicare program including Medicare Parts A (Hospital), B (Medical), C (Medicare Advantage Plans), and D (prescription drug coverage).

2. Describe the eligibility requirements for Medicare for persons with disabilities and the Medicare Qualifying Period (MQP).

3. Describe the options for enrolling in the various parts of Medicare, options for declining coverage, and the premium penalties for delaying enrollment.

4. Identify and describe programs that help Medicare beneficiaries pay for out-of-pocket costs, including Medigap plans, Medicare Savings Programs (MSPs), and the Part D Low-Income Subsidy (LIS).

5. Describe the interaction of Medicare with other public and private health insurance.

6. Describe the effect of work on Medicare coverage and two work incentives that allow individuals to retain Medicare coverage after cash payments ceases; the Extended Period of Medicare Coverage (EPMC) and Premium Hospital Insurance (HI) for the Working Disabled.

Acronyms

- ACEP - Annual Coordinated Election Period
- CMS – Centers for Medicare and Medicaid Services
- EPMC - Extended Period of Medicare Coverage
- EXR – Expedited Reinstatement
- FPL – Federal Poverty Level
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 does not cover all medical expenses or the cost of most long-term care. Along with Federal Insurance Contributions Act (FICA) taxes that workers and their employers pay, workers pay a Medicare tax. This tax and monthly premiums finance the Medicare program. The Centers for Medicare and Medicaid Services (CMS) is the federal agency in charge of the Medicare program, but Social Security determines who is eligible for Medicare, enrolls people in the program, and provides 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 health care program designed primarily to help those with low income and few resources. Medicare is an entitlement earned by someone who has paid into the Medicare trust fund through taxes on earned income; it is not needs based. The federal government helps pay for Medicaid and sets broad program guidelines states must follow, but each state has its own rules about who is eligible and what services the programs cover. In contrast, original Medicare is a federal 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 coverage. CMS refers to these people as “dual eligible.” We will provide detailed information about Medicaid programs available to individuals with disabilities in Chapter 5.

Medicare Parts

There are three core parts to Medicare coverage: 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.” Medicare Part D is prescription drug coverage. It was added to the Medicare program in 2006. Part C Medicare Advantage (MA) Plans are another health plan choice available to individuals who are eligible for Medicare. Part C Medicare Advantage Plans are offered by private companies approved by Medicare.

Medicare Part A

- When Title II disability beneficiaries first become eligible for Medicare, they are automatically enrolled in Medicare Part A Hospital Insurance (HI). Part A covers inpatient care in a hospital or limited time at a skilled nursing facility (following a
hospital stay). It also pays for some home health care and hospice care.

- Social Security beneficiaries who are eligible for Medicare Part A do not have the option of declining this coverage.
- 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. Medicare processes claims and payments to cover what Medicare rules allow.

**Medicare Part B**

- Anyone who is eligible for premium-free Medicare Part A can also enroll in Medicare Part B Supplemental Medical Insurance (SMI). Part B pays for services from doctors and other health care providers, outpatient care, home health care, durable medical equipment, and some preventive services.
- When Title II disability beneficiaries become eligible for Medicare, they are automatically enrolled in Part B, unless they tell Social Security that they want to decline this coverage. It is possible to enroll in Part A, but decline Part B.
- Under the original Medicare model, using Part B works the same as using Part A. The beneficiary locates a medical provider that accepts Medicare and receives medical services from that provider; then, the provider bills Medicare.

**Medicare Part D**

- Medicare Part D helps pay the costs of prescription drugs for Medicare beneficiaries in the United States.
- Anyone who is enrolled in Medicare Part A or Part B can also enroll in Part D. Enrollment in Part D is optional for everyone except those who are also eligible for Medicaid. States automatically enroll beneficiaries who are eligible for Medicaid into a Part D plan when Medicare begins, unless they choose a plan themselves.
- Unlike with Parts A and B, Social Security does not 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 below). Private insurance companies that contract with CMS to participate in the Medicare Part D program develop and operate the prescription drug plans.

**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. To join a Medicare Advantage Plan, individuals must have both Medicare Part A and Part B.

- 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 vary widely. Individuals who join one of these plans generally get all of their Medicare-covered health care through that plan. Depending on the plan the beneficiary purchases, MA may include prescription drug coverage. Medicare Advantage plans often offer extra benefits that people enrolled in the Original Medicare Plan do not receive.

- 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.

**Medicare Eligibility for Individuals with Disabilities**

Social Security disability beneficiaries (SSDI, CDB or DWB) are eligible to enroll in all parts of Medicare after they serve a 24-month 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 disability benefit payment. Medicare coverage begins the first day of the 25th month of Title II disability benefit entitlement, with a few exceptions.
The Medicare Qualifying Period (MQP)

CWICs need to understand how the Medicare Qualifying Period (MQP) works so they can answer questions beneficiaries may pose about when Medicare coverage will begin. Here are some important facts about the MQP:

- In some cases, Social Security approves a beneficiary’s disability benefit many months or even years after that person applied. When that happens, it is possible that an individual may have met all or part of the MQP by the time cash benefit payments begin. The 24 months start with the month in which disability benefits were first payable – even if that is in the past.

- Most individuals who qualify for SSDI and DWB have to serve a five-month waiting period before benefit payments begin. For these beneficiaries, the MQP begins after the five-month waiting period ends.

- Childhood Disability Beneficiaries (CDBs) do not have to serve a five-month waiting period before entitlement, but entitlement cannot begin prior to age 18. Because of this, CDBs will not meet the MQP before their 20th birthday.

- The MQP does not have to be served consecutively within one period of entitlement. If Social Security terminates an individual’s entitlement to cash benefits and re-entitles them 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 is possible that the time period for re-entitlement without a new qualifying period could be indefinite.

- Beneficiaries continue to serve the MQP even when they are not in cash payment status due to Substantial Gainful Activity (SGA) level earnings during the Extended Period of Eligibility (EPE). Even though a cash benefit may not be payable for a particular month, all months of disability
Benefit entitlement are counted in determining when the person meets the MQP requirement.

Most disability beneficiaries have to serve the MQP before they can enroll in Medicare, but there are some specific exceptions to this general rule. This is particularly the case for people who were on disability benefits at some point in the past and subsequently became re-entitled to benefits. These complicated exceptions are not usually part of a CWIC’s counseling. To learn more about these exceptions, you may refer to POMS HI 00801.152 - Counting Months in Reentitlement Cases (https://secure.ssa.gov/apps10/poms.nsf/lnx/0600801152).

Enrolling in Medicare

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 living in the U.S. (except Puerto Rico) in Medicare Parts A and B when they first become eligible for Medicare.

Initial Enrollment Period (IEP)

The initial enrollment period is the first opportunity a person has to enroll in Medicare based on disability benefits. It is 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, they need only keep the card and Medicare Parts A and B coverage will begin automatically. If a person does not want Medicare Part B, the individual returns the signed card to the sender. Returning the card indicates refusal of Part B coverage. If entitled, beneficiaries cannot decline Part A. Beneficiaries can also choose to enroll in a Medicare Advantage Plan (Part C) or a Prescription Drug Plan (Part D) during the IEP.
General Enrollment Period (GEP) or Open Enrollment Period

Each calendar year eligible individuals who do not 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 the month following the month they enroll. For Medicare Parts C and D, the annual Open Enrollment Period occurs October 15 through December 7.

Special Enrollment Period (SEP)

Once a beneficiary’s IEP ends, they may have the chance to sign up for Medicare during a Special Enrollment Period (SEP). These SEPs allows certain individuals to sign up for Part A and/or Part B at any time as long as they meet certain criteria.

There are several circumstances that can trigger SEPs. One of the most common SEPs used by working (or formerly working) beneficiaries covers individuals enrolled in a group health plan. To be eligible for this SEP, the individual must be currently or previously enrolled in a group health plan (GHP) or large group health plan (LGHP). The coverage must be based on either the individual’s employment or the employment of a spouse. This SEP allows the individual to sign up for Part B during any month that they are still covered by the GHP or LGHP and continues for an eight-month period 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.

The SEP for Part C and D involves a different set of circumstances. The list of circumstances is available in the CMS Publication Understanding Medicare Part C and D Enrollment Periods (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. The ACEP lasts from October 15 through December 7.

**Opting out of Medicare Parts B or D**

Social Security beneficiaries who are eligible for Medicare Part A do not have the option of declining this coverage. All eligible individuals are enrolled in Part A. Medicare Parts B and D are optional. When a person is first enrolled in Medicare, the packet of information they receive in the mail includes instructions on how to decline Part B coverage. Basically, individuals simply return the signed Medicare card to the sender. Returning the card indicates refusal of Part B coverage. Medicare Part C (Medicare Advantage) plans are optional, but they require a beneficiary to be enrolled in Parts A and B. To find out more about how to enroll in a Medicare Advantage Plan refer to the Medicare website (https://www.medicare.gov/sign-up-change-plans/joining-a-health-or-drug-plan).

Enrollment in Part D is not automatic in most cases as there are many different plans from which to choose. Beneficiaries select a plan that meets their needs and then complete the enrollment paperwork. If someone does not want Part D prescription drug coverage, they simply need to not enroll in a Part D plan. For more information about enrolling in a Part D plan go to the Medicare website (https://www.medicare.gov/drug-coverage-part-d/how-to-get-prescription-drug-coverage).

Beneficiaries who decline Part B or Part D when they first become eligible to enroll may have to pay a higher monthly premium if they decide to enroll later. CMS refers to this as the premium penalty or premium surcharge. The monthly Part B premium increases 10 percent for each full 12-month period the beneficiary could have had Part B but did not sign up for it. Because of the Special Enrollment Period provisions, beneficiaries are protected from that penalty for any month the beneficiary had employer-sponsored health insurance (through their own employer or their spouse’s employer). To learn more about the Part B premium penalty, refer to the Medicare website.
Beneficiaries who elect to enroll in Part D late, and who do not have other creditable coverage, may also experience an increased premium. To find out more about the Part D late enrollment penalty, go to the Medicare website (https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/part-d-late-enrollment-penalty).

Medicare and Other Forms of Insurance

When beneficiaries have Medicare and other health insurance (like from a group health plan, retiree coverage, or Medicaid), each type of coverage is called a "payer." When there is more than one payer, "coordination of benefits" rules decide who pays first. The "primary payer" pays what it owes on medical bills first, and then sends the rest to the "secondary payer" (supplemental payer) to pay. 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 process medical bills correctly. Beneficiaries also need to let Medicare know if they have any other forms of insurance to make sure benefits are coordinated between the payers.

It is important to understand how Medicare interacts with other forms of insurance because it may affect decisions beneficiaries make about enrolling in the various parts of Medicare. Beneficiaries may ask questions about these issues, and CWICs need to be prepared to provide answers or referrals to reliable sources of information. The most common forms of insurance you are likely to encounter include Medicaid, Veterans Administration (VA) Healthcare, TRICARE, and employer group health insurance or other group insurance. When you encounter a beneficiary who has other forms of health insurance, be sure to research how that form of insurance may interact with Medicare. An excellent source of information about this topic is Medicare and Other Benefits: Your Guide to Who Pays First (https://www.medicare.gov/sites/default/files/2021-10/02179-Medicare-and-other-health-benefits-your-guide-to-who-pays-first.pdf).
Medicare Out-of-Pocket Costs

Like most forms of health insurance, Medicare involves certain out-of-pocket costs. These consist of premiums, co-insurance, co-payments, and deductibles.

- **Premiums:** In the Medicare program, Part A is premium-free in most cases. Medicare Parts B, D, and C all require payment of a monthly premium. Monthly premium amounts vary and they typically change at the beginning of each calendar year. You can find details about the Medicare premiums for the various parts of Medicare (https://www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance).

Social Security automatically deducts Part B premiums for beneficiaries who receive a Social Security disability payment. Beneficiaries may also elect to have Part C and D premiums withheld from the monthly Social Security payment, but that is not automatic. Eligible individuals who no longer get a monthly payment will receive a bill for their Medicare premiums. You can learn more about paying Medicare bills (https://www.medicare.gov/basics/costs/pay-premiums).

- **Co-insurance and Co-payments:** Co-insurance is the percentage of a medical bill that the individual pays. A co-payment is a fixed fee that subscribers to a health plan pay for their use of specific medical services. All parts of Medicare require these types of out-of-pocket costs and these costs vary by part. You can find detailed information about Medicare co-insurance and co-payments for the current year by referring to the Medicare website (https://www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance).

- **Deductibles:** A deductible is the amount of money an individual is responsible for paying before the health plan will start helping to pay for covered items or services. You can find detailed information about Medicare deductibles for the current year by referring to the Medicare website.
Medicare Supplements or Medigap Plans

Because Medicare involves deductibles and coinsurance payments, some people end up with many out-of-pocket expenses. Medicare supplemental insurance policies, also called “Medigap Plans,” 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 must 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 must sell “standardized” Medigap policies, so that individuals can compare them easily. 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 the Medicare Plan Finder Tool (https://www.medicare.gov/medigap-supplemental-insurance-plans/#/m?lang=en&year=2024) to find interactive electronic tools that compare various Medicare and Medigap plans. For additional information on Medigap policies, including how to decide if a Medigap policy makes sense, and what Medigap policies cover, you can refer to the publication titled Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare (https://www.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf).

Getting Help Paying Medicare Out-of-Pocket Costs

While Medigap plans are a valuable resource for Medicare beneficiaries, some beneficiaries will find this form of supplemental insurance unaffordable. Fortunately, there are several additional options for helping low-income Medicare beneficiaries get help paying Medicare out-of-pocket expenses.
Option 1: Establishing Eligibility for Medicaid

Medicare enrollees who are also eligible for Medicaid have an effective way to cover out-of-pocket costs without enrolling in a Medigap plan. 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, within the limits of the items and services included in the State Medicaid Plan. Medicaid will cover most costs associated with copayments, coinsurance or deductibles. Depending on the state Medicaid plan, Medicaid may also pay the Medicare Part B premium. We provide detailed information about Medicaid in Chapter 4.

Option 2: Medicare Savings Programs

Medicare Savings Programs (MSPs) are Medicaid-administered programs for people on Medicare who have limited income and resources. These programs help certain qualified individuals to afford Medicare coverage by paying some or all of the Medicare Part A and B out-of-pocket expenses (premiums, copayments, co-insurance or deductibles). MSPs do help with Part D costs.

At the federal level, CMS provides regulatory oversight of the MSPs (e.g., guidance and policy interpretation). A designated state agency, usually the agency administering Medicaid, is responsible for operating the MSPs at the local level. These agencies accept applications for MSPs, determine who is eligible, and conduct eligibility redeterminations. In some states, this program may not be called the Medicare Savings Program but may instead go by a different name.

Since MSPs are intended to help people who have low income and few, if any, assets, eligibility determinations involve means tests. To be eligible for MSPs, beneficiaries must have countable income and resources below limits set by the state Medicaid agency. The term “countable income” refers to the income left after all applicable deductions and exclusions have been applied. The laws enacting the Medicare Savings Program established specific percentages of the Federal Poverty Level (FPL) as the income limits for the MSPs, but some states have opted to use higher amounts. In addition, some states have opted to use higher or no resource limits.
Note about the FPLs: The U.S. Department of 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. 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. More information about the FPLs is available at the DHHS web site (https://aspe.hhs.gov/poverty-guidelines).

The Medicare Savings Program includes four separate programs. Each program has different income and resource limits. Not all MSP programs cover the same Medicare expenses. We will cover three MSPs in this section as they are the ones CWICs will encounter the most. The fourth MSP is covered in the section in the chapter about Medicare and work.

Qualified Medicare Beneficiary (QMB)
Of the four Medicare Savings Programs, QMB (sometimes referred to as "quimby") provides the most financial costs support. If a Title II disability beneficiary is eligible for QMB, the state Medicaid agency will pay their Part B premium as well as any Part A and B deductibles and co-insurance. To be eligible, a beneficiary must have Medicare Part A, have countable income up to 100 percent of the current FPL (or a higher limit set by the state), have countable resources below certain prescribed limits and meet the general nonfinancial requirements or conditions of eligibility for Medicaid in his or her state (e.g., citizenship, residency).

Specified Low-Income Medicare Beneficiaries (SLMB)
Individuals eligible under SLMB (also referred to as “slimby”) will get help paying their Part B premium. SLMB does not cover other Medicare expenses such as co-payments, co-insurance, or deductibles. To be eligible for SLMB, beneficiaries must have Medicare Part A, have countable income that exceeds 100 percent but is less than 120 percent
of the current FPL (or a higher limit set by the state), have countable resources below certain prescribed limits, and meet the general nonfinancial requirements or conditions of eligibility for Medicaid in their state (e.g., citizenship, residency).

**Qualified Individual (QI)**

Individuals eligible under QI will get help paying their Part B premium. Like SLMB, QI does not cover other Medicare expenses such as co-payments, co-insurance, or deductibles. To be eligible, beneficiaries must have Medicare Part A, have countable income that is at least 120 percent but below 135 percent of the current FPL (or a higher limit set by the state), have countable resources below certain prescribed limits, meet the general nonfinancial requirements or conditions of eligibility for Medicaid in their state (e.g., citizenship, residency), and be ineligible for Medicaid.

Many CWICs wonder what the difference is between SLMB and QI, aside from the income limit, since both programs only pay Part B premiums. From the beneficiary’s perspective, there is one key difference. A person who has Medicaid can use SLMB but cannot 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.

We will provide you with more detailed information about how state Medicaid agencies determine countable income for MSP eligibility determinations in Chapter 5. For more information about the Medicare Savings Programs and their current eligibility requirements, refer to Medicare’s MSP web page (https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/medicare-savings-programs). You can also read detailed information about the MSPs by referring to a resource document on the NTDC website entitled Understanding Medicare Savings Programs (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=133).

**Option 3: Part D Low-Income Subsidy**

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 CMS and Social Security also
call this program “Extra Help.” Unlike the MSPs, LIS is not a state-administered program. CMS administers the LIS while Social Security has primary responsibility for taking LIS applications and making determinations on those applications.

With LIS, beneficiaries generally do not have to pay a monthly Part D premium. 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. LIS eligible individuals who choose to participate in a more expensive plan are responsible for the difference. Those eligible for LIS also do not have co-payments and do not have to meet an annual deductible. To be eligible for the LIS, an individual must:

- Be entitled to benefits under Medicare Part A or entitled to Medicare Part B or both; and
- Reside in one of the 50 states or the District of Columbia; and
- Have countable income up to 150 percent of the FPL and resources at or below certain prescribed limits; or
- Be “deemed eligible”. The following groups are deemed LIS eligible: Medicaid recipients, SSI beneficiaries, QMBs, SLMBs, or QIs. Individuals who are deemed eligible do not have to apply for LIS; instead, CMS automatically enrolls them.

Individuals who are not deemed eligible may apply for LIS by submitting an online application on Social Security’s website; calling 1-800-772-1213 to apply over the phone; or applying in person at a local Social Security office. Once Social Security receives the application, the agency determines if the countable income is at or below the applicable percentage of the FPL and if countable resources are below the applicable limits.

Part D coverage and eligibility rules can be complex. To learn more about Part D and the LIS, refer to a resource document on the NTDC website Medicare Part D and the Low-Income Subsidy (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=132). There is also helpful information about Part D and the LIS on Social Security’s website (https://www.ssa.gov/benefits/medicare/prescriptionhelp.html). Finally, refer to the Part D Extra Help webpage on CMS’s website
We will provide you with more detailed information about how Social Security determines countable income for LIS eligibility determinations in Chapter 5.

Medicare and Work

Beneficiaries remain eligible for all parts of Medicare as long as they remain eligible for cash payments. This means that beneficiaries who are working, but still eligible for disability benefits, will experience no interruption in their Medicare coverage. Beneficiaries of the Title II disability programs often believe that Medicare entitlement stops when cash payments stop due to SGA level work. 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 entitlement to Title II disability 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, until at least 93 months after the end of the Trial Work Period (TWP). In many cases, the period will be longer.

Once beneficiaries exhaust the EPMC, they may continue Medicare coverage through the second work incentive called 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. Under the EPMC provision, when an
individual’s entitlement to disability benefits ends because they engaged in, or demonstrated the ability to engage in SGA after the 36 months following the end of the Trial Work Period (TWP), Medicare entitlement continues until the earlier of the following:

- The last day of the 78th month following the first month of SGA 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.

While this might sound complicated, in practice it is actually fairly straightforward. The EPMC involves several key time periods:

- The end of the TWP;
- The first 16 months of the Extended Period of Eligibility (EPE);
- The cessation month; and
- The 78 months of the EPMC.

The EPMC provides at least 93 months of coverage after the end of the TWP. It is not coincidental that the 15 months plus the 78 months listed above equals 93. Historically, Medicare coverage only extended to 15 months of the EPE. Congress extended this original 15-month rule several times over the years. Social Security has to use this original limit when counting months for EPMC purposes. Because of this, under the current EPMC rules, the EPMC counting period will never begin earlier than the 16th month of the EPE.

Ninety-three months is the least amount of time beneficiaries will have Medicare if their cash benefit stops due to work and they continue 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:
● If SGA also occurs in the 16th month of the EPE, EPMC will end at least 93 months after the TWP. The beneficiary must continue to have a disability throughout this period.

● If the beneficiary does not perform SGA in the 16th month of the EPE, the EPMC will end 78 months from the first time the beneficiary performs SGA 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, the EPMC will end 78 months after the Grace Period. The beneficiary must continue to have a disability throughout this period.

Predicting the exact end of the EPMC is impossible unless three events have occurred:

- The TWP has ended;
- Cessation has occurred; and
- The person is past the 16th month of the EPE.

It is impossible to know exactly when a beneficiary’s EPMC time period would end if the beneficiary has not yet engaged in SGA. The EPMC months do not begin to count until the TWP is over, SGA work has occurred, and Social Security has established the cessation month.

The EPMC is a work incentive for Title II disability beneficiaries. It is NOT a way to keep Medicare when beneficiaries lose benefits due to medical recovery. Individuals using the EPMC as the basis for their continued eligibility for Medicare must continue to meet the Social Security disability requirement, even though their entitlement to Title II disability benefit payments has ended.

**Discussing EPMC with Beneficiaries**

The EPMC can be very complex. When advising beneficiaries about this work incentive, remember that Social Security is the only place to find out how long the coverage will last. The EPMC depends on when the TWP ended, whether cessation occurred, or even if work caused benefit termination. Some beneficiaries’ EPMC time period may have partially or completely passed without the beneficiary even realizing it. A CWIC
may not have enough information about the person’s work history to determine the exact end of the EPMC. In addition, a CWIC cannot predict the future. Will the person again become entitled to cash benefits and thus regular Medicare? Will Social Security decide the beneficiary has medically improved? 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 entitlement to Title II disability benefits.

**Premium-HI for the Working Disabled**

At the end of the EPMC, if a person is still not receiving Title II cash benefits because of SGA level work, it is possible for former beneficiaries who still have a disability to continue Medicare coverage by “buying into” the Medicare program. This provision is referred to as “Premium-HI for the Working Disabled.”

Essentially, this work incentive allows disabled and 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 disabiling 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 Part A premium for the Working Disabled is not 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 surcharge rules. If an individual were paying an increased Part B premium during the last month of premium-free Part A, but enrolls in Part B under the Working Disabled provision during his or her Initial Enrollment Period, the Part B premium reverts to the standard rate, and the surcharge stops.

Premium-HI for the Working Disabled continues until the earliest of the following points in time:

● The end of the month following the month Social Security notifies the individual that they no longer have a disabiling impairment;

● The end of the month following the month the individual files a request for termination of Premium-HI;

● The end of the month before the month the individual becomes re-entitled to premium-free HI, such as when the beneficiary becomes entitled to Medicare Part A due to age or becomes entitled to Title II disability benefits again without a requirement to serve another qualifying period. 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.);

- The end of the grace period for non-payment of premiums; or
- Date of death.

**Paying Medicare Premiums during Premium HI for the Working Disabled**

Individuals who buy into Medicare through premium HI are billed for their Part A and B premiums on a quarterly basis. A special feature of the Premium HI program is that certain individuals are eligible for reduced Part A premiums if they have sufficient work history. In addition, states are required to pay Part A (but not Part B) premiums for certain people under a special type of Medicare Savings Program called Qualified Disabled and Working Individuals (QDWI). QDWI is a benefit designed for individuals who are under age 65, disabled, and no longer entitled to free Medicare Hospital Insurance Part A solely because they successfully returned to work. To be eligible for this help, an individual must:

- Continue to have a disabling impairment;
- Sign up for Premium Hospital Insurance (Part A);
- Have countable income up to 200 percent of the current Federal Poverty Level (FPL);
- Have countable resources worth less than a prescribed amount; and
- Not already be eligible for Medicaid.


More information about the **QDWI eligibility requirements** is available on Medicare’s website (https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/medicare-savings-programs).
Effect of Work on Medicare Savings Programs and the Low-Income Subsidy

Because the MSPs and the LIS are financial needs-based programs, when a person begins working, the increased income could cause their eligibility to change from one level to another or end altogether. In some cases, going to work may actually allow a beneficiary to establish eligibility for MSP or LIS coverage if the wages are high enough to cause the Title II disability payment to stop. To evaluate the effect of work on MSPs and the LIS, CWICs use special calculation sheets to determine total countable income (including the actual wages or earnings goal) and then compare that figure to applicable FPL levels. Calculating countable income for MSP and LIS determinations is complicated and is based on methods we introduce later in the chapter on the Supplemental Security Income (SSI) program. We will cover the MSP and LIS income calculation processes in detail in Chapter 6, after you have learned about the SSI income determination methodologies.

When Medicare Ends

Medicare coverage ends under the following circumstances:

1. Medicare coverage will stop if Social Security decides the person no longer meets the disability standard. Medicare coverage will stop the month after the month the person receives the notice that Social Security has terminated their disability benefits. There is no retroactivity to the Medicare termination.

2. Medicare eligibility will also cease after the EPMC ends for individuals who work their way off cash benefits unless the person purchases Premium HI for the Working Disabled.

3. To retain Parts B and D Medicare coverage (and Part A under Premium HI for the Working Disabled), beneficiaries must pay applicable premiums. Failure to pay Medicare premiums may result in termination of the applicable Part of Medicare.
4. When Title II disability beneficiaries turn 65 years of age, Medicare entitlement based on disability ends and Medicare eligibility based on age begins. There is no break in coverage, and beneficiaries do not 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 Referrals**

Medicare beneficiaries have to make many choices that will determine how they receive their Medicare. They may choose 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 may require the CWIC to 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.shiphelp.org).

**Next Steps**

This chapter provides a basic overview of the Medicare concepts CWICs encounter in their day-to-day work. It does not provide sufficient information for you to provide in-depth and comprehensive counseling to beneficiaries about complex Medicare issues – particularly issues
related to the effect of work on Medicare coverage and programs that help pay Medicare out-of-pocket expenses.

To develop greater expertise in Medicare, you will need to complete additional training, conduct research, and consult with your VCU Technical Assistance (TA) Liaison. To deepen your understanding of the Medicare program and improve the quality of the counseling you provide, we recommend that you take the following next steps:

1. VCU’s NTDC offers a wide range of **resource materials about Medicare** on their website (https://vcu-ntdc.org/resources/resourceDetail_search.cfm?id=5#Medicare). In particular, there are detailed documents that cover some of the more complex topics introduced in this chapter.

2. VCU offers a four-week web course on the Medicare program several times each year. We recommend that all CWICs complete this web course within the first year of employment to reinforce the concepts they learned during initial training and strengthen their understanding of how paid employment affects Medicare coverage and programs that help pay Medicare out-of-pocket expenses. Once you achieve provisional CWIC certification, you will start receiving email notices when registration for NTDC web courses opens.

3. The VCU NTDC website contains numerous archived training sessions that cover various Medicare concepts. You can find a listing of **archived supplemental training sessions** on the NTDC website (https://vcu-ntdc.org/training/supplemental/archives.cfm).

4. This chapter contains links to excellent resources for more information about Medicare. You should keep these in mind when you need to learn more.
Part I Chapter 3 – Understanding Supplemental Security Income (SSI)
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Chapter 3 – Understanding Supplemental Security Income (SSI)

Learning Objectives

After you have read this chapter and completed the associated lectures and activities during WIPA Initial Training, you should be able to:

1. Identify the factors that affect SSI eligibility and monthly benefit payment amounts;

2. Describe how Social Security defines earned and unearned income and identify common income exclusions;

3. Describe the basic effect of earned income on SSI cash payments and the steps involved in using the SSI calculation sheet to determine adjusted SSI payment amounts;

4. Describe deeming and in-kind support and maintenance (ISM) and how these special forms of income affect SSI eligibility and benefit payments;

5. Describe the effect of resources on SSI eligibility and identify common resource exclusions;

6. Describe the redetermination process and 12-month suspension provisions; and

7. Identify and describe the SSI work incentives that can be applied to reduce countable earned income – the Student Earned Income Exclusion (SEIE), Impairment Related Work Expenses (IRWE), and Blind Work Expenses (BWE).
Overview of Supplemental Security Income (SSI) Program

Social Security pays Supplemental Security Income (SSI) benefits to eligible individuals who are disabled, blind, or age 65 and older who have few resources and low income, and who meet certain citizenship or residency requirements. Unlike the Title II disability benefits we discussed in Chapter 1, SSI benefits do not come from the Social Security Trust Fund; instead, Social Security pays SSI benefits out of
general federal tax dollars. In most cases, individuals who are eligible for SSI benefits are also eligible for Medicaid coverage.

Congress created the SSI program to provide a uniform minimum income level for persons aged 65 and older, blind or disabled adults, and blind or disabled children. SSI supplements a beneficiary’s other income to meet their basic food and shelter needs.

**SSI as a Means-tested Program**

SSI is a means-tested benefit program that includes income and resource limits. Social Security determines SSI eligibility and payment amount based on an individual’s “countable” income and resources. The term “countable” refers to income and/or resources after Social Security has subtracted all applicable deductions or exclusions. If an individual’s countable income and/or resources exceed applicable limits, the individual will not be eligible for SSI. In addition, unlike the Title II disability benefits, Social Security reduces monthly SSI payments if an SSI eligible individual has countable income. The more countable income an eligible individual has, the lower the monthly SSI cash payment will be. Individuals with countable income or resources above allowable limits are not due a payment. 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.

**The Federal Benefit Rate (FBR)**

The SSI program provides each eligible person a monthly cash payment based on a statutory federal benefit rate (FBR) that changes in January of each calendar year. The FBR is the maximum amount of federal SSI that eligible individuals may receive in a month. Individuals either receive the full FBR, or less than the FBR based on their countable income.

You can find a listing of [current and past SSI Federal Benefit Rates](https://secure.ssa.gov/apps10/poms.nsf/lnx/0502001020) in Social Security’s Program Operations Manual System (POMS) found online.
**State Supplemental Payments (SSPs)**

Some states choose to pay optional state supplements (SSPs) to SSI eligible individuals.

Some states that provide SSPs have elected to administer the payments themselves. In these states, the state agency that administers welfare programs and Medicaid typically makes decisions about SSP 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, the agency 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 payment amount.

**Monthly Payments Based on Retrospective Monthly Accounting**

Social Security makes SSI payments on the first of each month, and bases payment amounts on the income in a prior month. The term for this is “Retrospective Monthly Accounting” (RMA). Social Security staff first determines if an individual is eligible, based on that person’s income and resources at the beginning of the month, and then determines the individual’s countable income to calculate payments. The amount of the monthly payment is usually based upon how much countable income that person had two months before the month a payment is due.

Some situations require an exception to the two-month lag between income and its effect on payments. For now, though, the important thing to remember about RMA is that there is a lag between income and the payment that reflects that income. You can find out more about **Retrospective Monthly Accounting** by reading the resource document on the NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=257).

**Eligibility for SSI Benefits**

To qualify for SSI benefits, an individual must:
● Be age 65 or older, blind, or disabled;
● Reside in one of the 50 states, the District of Columbia, or the Northern Mariana Islands (with some exceptions);
● Be a U.S. citizen or legal resident meeting certain requirements;
● Have countable income and resources within specified limits;
● File for any other benefits for which they are potentially eligible; and
● Have filed an application.


Social Security cannot make SSI payments until the first full month following the date of application. For example, if a person applies for SSI on the 16th day of November and Social Security finds them eligible for SSI, Social Security will pay the first SSI benefit on the first day of the NEXT month, which would be December. Unlike the Title II disability program, the SSI program does not include a waiting period.

Understanding the Role of Income in the SSI Program

Social Security determines SSI eligibility and monthly benefit payment amount on a month-by-month basis. The benefit payment can change each month depending on a variety of factors, but the most common reason is the amount of countable income an individual received.

How Income is Defined in the SSI Program

The SSI program considers income to be anything individuals receive in cash or in-kind that they can use to meet the basic needs of food or
In-kind income is not cash, but food or shelter provided to eligible individuals by someone else. Under this definition, income includes the receipt of anything that a person can use, either directly or by sale or conversion, to meet their basic food or shelter needs. This means that some gifts that can be easily converted to cash may count as income when Social Security determines SSI eligibility and payment amount. Social Security statutes exclude some types of cash or in-kind items.

Social Security classifies any cash or in-kind item that meets the SSI definition of income as either earned income or unearned income. Social Security treats earned income and unearned income very differently in the SSI program, so it is important to understand the difference.

Earned income is any cash or in-kind item that a beneficiary receives in exchange for work. Earned income includes the following types of payments:

- **Wages**: An individual receives these payments for working as an 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.

- **In-kind Earned Income**: This includes 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 pay an individual receives for live-in employment.

- **Net Earnings from Self-Employment (NESE)**: This applies to individuals who are self-employed. Social Security follows IRS rules for deciding how much NESE a person has. This is usually what the business brings in, minus allowable deductions. Social Security counts net earnings from self-employment (NESE) on a taxable year basis, and divides NESE by 12, regardless of when in the calendar year the person did the work.
The definition of unearned income is very simple. Social Security describes unearned income as any cash or in-kind item a person receives that does not meet the definition of earned income. Common forms of unearned income include:

- Social Security benefits
- Veteran’s benefits
- Railroad Retirement benefits
- Unemployment Compensation

Social Security determines an individual’s total countable income after applying all allowable deductions or exclusions. Social Security allows certain exclusions for each of the two types of income (earned and unearned), some of which will be explained later in this chapter.

**What Is NOT Counted as 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 cannot use them to obtain food or shelter. The most common items that do not meet the SSI definition of income include:

- Medical and social services
- Receipts from the sale, exchange, or replacement of a resource
- Income tax refunds
- Proceeds of a bona fide loan
- Payment of an individual’s bills other than food and shelter
- Clothing

Social Security’s Program Operations Manual System (POMS) includes many sections that explain how Social Security makes income determinations in the SSI program. These sections start with the POMS Income Chapter Table of Contents (https://secure.ssa.gov/apps10/poms.nsf/subchapterlist!openview&restricttocategory=05008).

**Special Types of Income in the SSI Program – Deemed Income and In-Kind Support and Maintenance**

Under certain circumstances, Social Security may count the income of another person when determining SSI eligibility and payment amount for an SSI eligible individual. This is called “deeming” because Social Security considers that certain income from someone like a parent or a spouse is “deemed” available to meet the food and shelter needs of the SSI recipient. In addition, if an SSI recipient is given food or shelter by another person, Social Security will consider these gifts to be a type of unearned income called “in-kind support and maintenance” (ISM). The following sections provide a brief overview of these special forms of income.

**Deemed Income**

“Deeming” is the term Social Security uses to describe the process of considering another person’s income and/or resources to be available for meeting an SSI recipient’s basic need for food and shelter. Social Security law bases the deeming concept on the expectation that those who have a responsibility for others share their income and resources for the benefit of those persons. Deeming relationships include:

- The parental relationship to a minor child,
- A spouse-to-spouse relationship, and
- The relationship between a sponsor and a legal alien.

When deeming applies, Social Security determines that a certain amount of the responsible party’s income and/or resources are “deemed” available for the needs of the SSI recipient. Social Security considers deemed income and/or resources when making SSI eligibility determinations and when calculating the SSI payment amount. Social Security does not count all income and resources of the ineligible
parent(s), spouse, or sponsor when calculating the amount of deemed income. There are special exclusions for some types of resources and income that apply to deeming. Social Security counts the deemed income as unearned income for the SSI recipient.

Deeming computations are very complex and generally are beyond the scope of a CWIC’s work. However, it is important for CWICs to understand that income and/or resources belonging to a spouse, a parent, or an alien sponsor may affect entitlement or payment amount for an SSI recipient who is a minor child, spouse, or sponsored alien.

For more information, you can refer to several VCU NTDC resource documents on deeming available on the NTDC website (https://vcu-ntdc.org/resources/resourceDetail.cfm?id=1).

There are three briefing papers about deeming posted on this website. You can also refer to a helpful Social Security publication entitled SSI Spotlight on Deeming Parental Income and Resources (https://www.ssa.gov/ssi/spotlights/spot-deeming.htm).

**In-kind Support and Maintenance (ISM)**

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 may be provided by someone who lives in the same household as the recipient (such as a parent), or by someone outside of the household. 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).

Social Security will only apply one of these rules to an SSI recipient’s benefit calculation at a time. Social Security personnel follow specific policies about the SSI recipient’s living arrangement when deciding which ISM rule to apply. Basically, Social Security applies the Value of the One-Third Reduction (VTR) rule 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. You can learn more about the one-third reduction by

Social Security applies the Presumed Maximum Value (PMV) rule when an eligible individual receives ISM and the VTR rule does not apply, meaning that the eligible individual does not live in the household of another person or does not 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 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 share of expenses. Social Security counts the difference as ISM up to a “presumed maximum value” of one third of the current FBR plus $20. If the actual value of ISM is LESS than the presumed maximum value, Social Security personnel will count that lower figure as a form of unearned income when they calculate the SSI benefit amount.

ISM determinations can be very complex and inexperienced CWICs often misunderstand them. You can read more about living arrangements and ISM in a Social Security publication entitled **Understanding SSI - Living Arrangements and ISM** (https://www.ssa.gov/ssi/text-living-ussi.htm).

For more detailed information on this subject, refer to the VCU NTDC resource document entitled **Understanding In-kind Support and Maintenance** (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=19).

### SSI and Resources

**Social Security defines resources** as cash and any other personal property, including any real property, that an individual (or deemor, if any):

- Owns;
- Has the right, authority, or power to convert to cash (if not already cash); and
c. Is not legally restricted from using for his or her support and maintenance.

Social Security makes resource determinations as of the first day of each calendar month and they are applicable for the entire month. Because of this rule, subsequent changes in resources within the month have no effect until the following month’s resource determination. If countable resources are over the allowable limit, an individual will not be eligible for an SSI payment.

The limit for countable resources has not changed since 1987, when it became $2,000 for an individual and $3,000 for an “eligible couple”. An eligible couple exists when two SSI recipients are married and living in the same household. We describe eligible couples in more detail further on in this chapter. When deeming applies, the resources another person has might also make an individual ineligible for SSI. Refer back to the previous section about deeming for links to resource documents that describe this concept in more detail.

**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
This is not a comprehensive list and the rules governing some resource exclusions are complex.

You can read a helpful summary of the SSI resource rules in a Social Security publication entitled [Understanding SSI - Resources](https://www.ssa.gov/ssi/text-resources-ussi.htm). To learn more about resource determinations, you can refer to a detailed resource document entitled [How Resources Affect SSI Eligibility](https://vcu-ntdc.org/resources/viewContent.cfm?contentID=6). You can also find the POMS citation listing resources exclusions at [SI 01110.210 Excluded Resources](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501110210).

Social Security defines an eligible couple as two SSI-eligible individuals who are legally married and living together under the laws of the state where they have a permanent home. This includes same-sex couples. In some cases, Social Security may consider two SSI recipients who are not legally married to be an eligible couple. The Social Security Act provides that two people, who are not legally married, yet who live in the same household are in a “marital relationship” for SSI purposes if they hold themselves out as spouses to the community in which they live. Social Security refers to this provision as “holding out”.

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.

Social Security considers individuals to be no longer married for SSI purposes as of the date that:

- Either individual dies;
- An annulment or divorce is finalized;
- Either member of the couple begins living with another person as that person’s spouse;
- They no longer hold themselves out as married; or
- They are no longer married for Title II purposes.
Even when married, spouses are no longer an eligible couple when they cease to live together.

**Determinations for Members of an Eligible Couple**

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. First, Social Security applies a separate FBR to eligible couples that is higher than the FBR for individuals. When Social Security calculates the benefit amount for each member of the couple they consider the couple’s combined earned and unearned income. 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 also applies different resource limits to eligible couples and eligible individuals when determining SSI eligibility. Currently, the countable resource limit for an eligible couple is $3,000. 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. For the most part, Social Security applies resource exclusions to eligible couples in the same way they apply to individuals. In certain situations, Social Security treats an eligible couple as if they were one person. For example, Social Security excludes only one home and one vehicle for an eligible couple.

For detailed information on this subject, you may refer to the VCU NTDC resource document entitled [Eligible Couples](https://vcu-ntdc.org/resources/viewContent.cfm?contentID=21).

**SSI Redetermination Process**

Social Security conducts periodic redeterminations for all SSI recipients. A redetermination is a review of a beneficiary’s or couple’s living and financial situations to make sure they are still eligible for benefits and receiving the correct SSI payment. Generally, Social Security conducts a redetermination for SSI recipients at least once per calendar year.
During the redetermination, Social Security staff examine income available to the SSI eligible individual or couple on a month-by-month basis since the last redetermination. The information Social Security gathers during the redetermination determines eligibility and how much the person or couple should have received. During redeterminations, Social Security also examines resources available to the SSI recipient at the beginning of each month in the period. If the countable resources are too high in a month, no SSI payment is due for that month. During redeterminations, Social Security sometimes discovers that an individual has been overpaid or underpaid and the agency will then take steps to settle these differences.

You can learn more about the SSI redetermination process by reading a Social Security publication entitled Understanding SSI - Redeterminations (https://www.ssa.gov/ssi/text-redets-ussi.htm). You can find more detailed information about redeterminations by going to the POMS citation SI 02305.000 Redeterminations of Eligibility and/or Payment Amount (https://secure.ssa.gov/apps10/poms.nsf/lnx/0502305000).

**Twelve-month Suspension Period**

Sometimes SSI recipients have excess resources or unearned income that make them ineligible for SSI payments and associated Medicaid benefits. Ineligibility begins the first day of the month in which income or resources exceeds statutory limits. In the SSI program, this results in a suspended benefit, rather than termination. This is an important distinction. Termination means Social Security has completely closed a person’s record. A person in suspension status is not getting a cash benefit, but is still active in the Social Security system. This suspension can last up to 12 consecutive months.

The 12-month suspension period is a critically important safety net for SSI recipients. As long as the person still has a disability, the 12-month suspension period allows Social Security to begin SSI payments again without the person having to reapply when unearned income or resources fall below the statutory limits. Before Social Security can reinstate benefits during a 12-month suspension period, the individual must notify the agency that unearned income or resources are again
below allowable limits. There is no limit to the number of times an SSI recipient may move into and out of suspension status. Social Security will automatically terminate certain SSI records after 12 consecutive suspension months.

In a later section, we will discuss a different protection that occurs if earnings, instead of unearned income or resources, cause SSI payments to stop. That protection is called 1619(b) Continuation of Medicaid. The 12-month suspension period provision only applies to individuals who lose SSI payments due to excess resources or unearned income.

You can read more information about the 12-month suspension period at POMS SI 02301.205 - Suspension and Reestablishing Eligibility (https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301205).

**Effects of Work on SSI Benefits**

**NOTE:** The information in this chapter relates to SSI recipients who are engaging in wage employment rather than self-employment. Social Security treats self-employment and wage employment very differently. You will need to complete additional training to be able to provide effective WIPA services to SSI recipients who are engaging in self-employment or planning to become self-employed. You can find detailed information about the effect of self-employment on SSI benefits by reading a resource document entitled **Self-employment and SSI** on the VCU NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=11).

As stated earlier in this chapter, any countable income an SSI recipient receives will cause the SSI cash payment to decrease. Social Security applies a set of standard calculations to determine how much of an individual’s income is countable. We provide CWICs special SSI Calculation Sheets that help you understand and perform the steps necessary to determine an SSI recipient’s countable income so that you can estimate how much that person’s adjusted SSI cash payment will be. This is especially helpful for SSI recipients who are working or
planning to work. We provide the **SSI Calculation Sheet** as a blank template in this chapter and you will have opportunities to practice using it during initial training. You also will find **SSI Calculation Sheets for individuals and eligible couples** on the NTDC website ([https://vcu-ntdc.org/resources/resourceDetail_search.cfm?id=1](https://vcu-ntdc.org/resources/resourceDetail_search.cfm?id=1)).

**Understanding the SSI Calculation Sheet**

Before we go over the steps included in the SSI Calculation Sheet, let’s review a few general points about how Social Security counts income and then uses countable income to adjust monthly SSI payments.

1. Social Security starts by deciding how much of the income an individual received in the month is unearned and how much is earned. Some of the assistance a person received may not be counted in either category because it does not meet Social Security’s definition of income or it is a form of income that Social Security disregards by federal statute. You will see when you use the SSI Calculation Sheet that unearned and earned income are treated very differently. You must be clear about how much is in each category of income to estimate a payment correctly.

2. Income is counted in the month it is received or the month in which the SSI recipient has access to it. Remember, Social Security makes income determinations on a month-by-month basis and the SSI cash payment may fluctuate each month depending on countable income.

3. Social Security begins with GROSS income when determining countable income. For wages, that means before any deductions are taken out such as federal or state taxes or FICA. For unearned income like Social Security benefits, that means before deductions are taken out, such as deductions for Medicare premiums or overpayment recovery.
4. Social Security determines countable earned income after the agency applies all applicable work incentive deductions that allow working SSI recipients to keep more of their SSI cash payment when they work. We will cover each SSI work incentive in detail a bit later in the chapter. The work incentives listed in this section are in the order they appear in the SSI calculation sheet. Federal regulation determines this order. Here is a brief description of the earned income exclusions applicable to SSI benefits:

- **General Income Exclusion (GIE):** $20 exclusion of any kind of income, earned or unearned. If the beneficiary has unearned income, the GIE is applied to that first. If the 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 earned income.

- **Student Earned Income Exclusion (SEIE):** Special exclusion of income for individuals who are under age 22 and regularly attending school.

- **Earned Income Exclusion (EIE):** Social Security excludes the first $65 of earnings after subtracting 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. These are expenses an individual incurs because they are disabled and because they are 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 deducting the exclusions listed above. It is because of this work incentive that SSI beneficiaries are almost always better off financially when they choose to work.
• **Blind Work Expenses (BWE):** If the SSI recipient meets the definition of statutory blindness, they may deduct any expense they incur by working. These expenses do not have to be related to a person’s blindness or any impairment, although Social Security would deduct IRWEs here for a person who meets the definition of statutory blindness. BWEs only occurs in the SSI program.

• **Plan to Achieve Self-Support (PASS):** A PASS permits individuals to set aside countable income, or resources to pay for goods or services necessary to achieve a vocational goal. With a PASS, Social Security will exclude that income or resources when Social Security determines the payment amount. We will cover PASS in greater detail in Chapter 4.

5. Once Social Security has calculated the countable unearned income and the countable earned income, they add those two figures together to arrive at TOTAL countable income. Social Security subtracts that total figure from the FBR that applies to the individual or eligible couple.

6. After Social Security deducts the total countable income from the FBR, 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.

Now let’s take a look at the SSI Calculation Sheet so you can see how to apply the deductions listed above:

<table>
<thead>
<tr>
<th>Step</th>
<th>Calculations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unearned Income</td>
<td></td>
</tr>
<tr>
<td>2. General Income Exclusion (GIE) $20</td>
<td>_</td>
</tr>
<tr>
<td>3. Countable Unearned Income</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>Step</td>
<td>Calculations</td>
</tr>
<tr>
<td>------------</td>
<td>--------------</td>
</tr>
<tr>
<td>6. Remainder</td>
<td></td>
</tr>
<tr>
<td>7. GIE (if not used above) $20</td>
<td>–</td>
</tr>
<tr>
<td>8. Remainder</td>
<td></td>
</tr>
<tr>
<td>10. Remainder</td>
<td></td>
</tr>
<tr>
<td>11. Impairment Related Work Expenses (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. SSI Federal Benefit 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>
<tr>
<td>23. Adjusted SSI Payment</td>
<td></td>
</tr>
<tr>
<td>24. Gross Unearned Income Received</td>
<td>+</td>
</tr>
</tbody>
</table>
The following are step-by-step instructions for completing the SSI Calculation Sheet. Do not be concerned if these steps seem confusing. We will go over this in detail during initial training and your instructors will provide you with lots of examples and opportunities to practice performing the calculations.

**Step 1: Calculate Countable Unearned Income**

a. Add together unearned income an individual or members of an eligible couple receives and place that figure on the “unearned income” line on the calculation sheet. Forms of unearned income include:

   - Title II or other benefits (other than SSI);
   - In-kind Support and Maintenance (ISM) valued under the Presumed Maximum Value (PMV) rule; and
   - Any other unearned income that is not excluded under federal statute.


c. The result is Countable Unearned Income (CUI). Write result on Countable Unearned Income line on 3rd line of calculation sheet, and also on Countable Unearned Income line that appears on line 16 of the calculation sheet.

**Step 2: Calculate Countable Earned Income**

a. 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 for work; and
• Net Earnings from Self-Employment (NESE) for the year divided by 12.

b. Place the total gross monthly earnings on the Earned Income line (Line 4 of calculation sheet).

c. If the individual or either member of an eligible couple is a student under age 22, subtract the applicable Student Earned Income Exclusion (SEIE).

d. Subtract any remaining General Income Exclusion after considering unearned income.

e. Subtract the $65 Earned Income Exclusion. Eligible couples only receive one $65 Earned Income Exclusion.

f. Subtract the value of any applicable Impairment Related Work Expenses (IRWEs) for an individual or member of an eligible couple who is working. Do NOT deduct work expenses for blind individuals on this line.

g. Divide the remainder by 2.

h. If the individual or member of an eligible couple meets the definition of statutory blindness, subtract any applicable Blind Work Expenses (BWEs).

i. The remainder is Countable Earned Income (CEI). Write countable earned income in lines 15 and 17.

**Step 3: Determine Total Countable Income**

a. Add Countable Unearned Income to Countable Earned Income.

b. Subtract applicable PASS deductions from this combined total to determine Total Countable Income (CI).

c. Write total countable income figure on lines 19 and 21 of the calculation sheet.

**Step 4: Determine SSI Payment**

a. Enter applicable FBR for the SSI recipient or eligible couple (Individuals or couples who receives ISM valued under the VTR rule will have a reduced FBR).
b. Subtract the Total Countable Income.

c. The result is the estimated SSI payment.

**Step 5: Determine the Total Financial Outcome from Working**

The last few lines of the SSI Calculation Sheet are used to show the beneficiary the total financial outcome that they will achieve by working.

a. Add together all of the forms of income including the adjusted SSI cash payment, gross unearned income and gross earned income.

b. Subtract any of the work incentives deductions listed on the calculation sheet.

c. The end result will be the total amount of money the beneficiary will have available.

**Common SSI Calculation Errors to Avoid and Counseling Points with Beneficiaries**

1. When estimating an SSI payment, never show it on the SSI calculation sheet as a negative number as this may confuse beneficiaries. If the countable income is more than the individual’s FBR, simply indicate zero for the cash payment amount. The zero may alarm beneficiaries, as they sometimes believe that if they no longer get a cash payment, they will lose their Medicaid. As we will show you in the next chapter, that is rarely the case due to a work incentive called 1619(b) Medicaid While Working.

2. Remember that the only deduction allowed for unearned income is the $20 GIE.

3. The $20 GIE and $65 EIE 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.

4. Never enter the person’s current SSI payment on the “Unearned Income” line.
5. 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.

6. Do not 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.

7. Whenever calculating payments, make sure the person knows that Social Security has the final say in any calculation, or in the application of any exclusion. You are only providing an estimate.

8. When an SSI recipient has some of the SSI cash payment withheld to recover an overpayment, Social Security uses the gross SSI FBR when determining the adjusted SSI cash payment. The over payment recovery is applied to the adjusted SSI cash payment after completing the SSI calculation sheet.

9. Finally, remember that in most cases, there is a two-month delay between a person’s income and the adjusted SSI payment that is affected by that income.

**SSI State Supplementation**

Get to know the rules in the states in your service area regarding state supplementation. If Social Security administers the supplement, use the FBR plus the supplement when estimating payments. In states that administer their own supplement, the supplement may disappear with the last dollar of SSI. Seek support from experienced CWICs within your WIPA program or from your assigned VCU Technical Assistance Liaison if you have questions about how to apply the supplement in a specific state. For the state-by-state rules, go to [SSA - POMS: SI 01400.000 - State Supplementary Payments - Table of Contents - 12/22/2021](https://secure.ssa.gov/apps10/poms.nsf/lnx/0501400000).
SSI Work Incentives

As you can see from the SSI calculation sheet, there are special work incentives that Social Security can use to permit SSI recipients to reduce countable earned income and retain more SSI. These work incentives are:

1. The Student Earned Income Exclusion (SEIE);
2. The Earned Income Exclusion (EIE);
3. Impairment Related Work Expenses (IRWE)
4. Blind Work Expenses (BWE); and
5. Plans to Achieve Self Support (PASS).

Let’s take a closer look at some of these work incentives to understand who is eligible to use them and how they apply in the SSI program. We cover the SSI work incentives in the order that they apply in the calculation sheet and you will have many opportunities to practice performing calculations during initial training. The PASS work incentive is the most complicated, so we will cover those rules separately in the next chapter.

The 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; and
- Working.
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 them for a paying job for at least 15 hours per week if the course involves shop practice, or 12 hours per week if it does not 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.

In addition to the general requirements above, some SSI recipients may qualify to use the SEIE when they are homeschooled or participating in an online educational program. You can read more about SEIE eligibility requirements by referring to POMS SI 00501.020 Student - SSI in the POMS (https://secure.ssa.gov/apps10/poms.nsf/lnx/0500501020#c).

Social Security applies the 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 until the individual has reached the annual maximum. Social Security indexes SEIE amounts annually, meaning they go up (or at least remain the same) each year in January. You will find the past and current SEIE figures in the POMS (https://secure.ssa.gov/apps10/poms.nsf/lnx/0500820510).
Individual remains a student for the purposes of the SEIE when classes are out if they attend classes regularly just before the school break and:

- They intend to resume attending regularly when school reopens; or
- Do resume attending regularly when school reopens.

For most students, this would allow Social Security to apply the SEIE to summer employment when school is not 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 their intent to return, and does not 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 during this type of non-attendance.

Social Security verifies student status during the SSI redetermination 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 does not have any evidence to present, Social Security may contact the school to verify attendance. If Social Security is aware of the individual’s student status, Social Security will apply the SEIE 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.

You can read a helpful summary of the SEIE in a Social Security publication entitled **SSI Spotlight on the Student Earned Income Exclusion** (https://www.ssa.gov/ssi/spotlights/spot-student-earned-income.htm). You will find detailed information about the SEIE with examples of how this work incentive is applied in a VCU NTDC resource document entitled **Student Earned Income Exclusion factsheet** (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=7). You
Impairment Related Work Expenses (IRWEs) in the SSI Program

As under the Title II disability program, Impairment Related Work Expenses (IRWEs) for SSI recipients permit the deduction of the cost of goods or services that are:

1. Related to the disability or to an impairment for which the person is receiving treatment from a health care provider;
2. Necessary for work;
3. Paid out of the beneficiary’s pocket and not reimbursed by any other source,
4. Reasonable; and
5. Paid in the month the person received earnings, although Social Security may prorate the cost of durable items over a 12-month period.

The rules that apply to IRWEs are the same for Title II disability beneficiaries and SSI recipients. Those rules were described in Chapter 1 so we will not cover them again here. The only difference is the way the IRWE deduction is applied. Remember that in the Title II disability program, IRWEs may be applied to reduce countable earned income when Social Security is making an SGA determination. In the SSI program, the IRWE is deducted in the SSI calculation sheet so it actually allows someone to keep more of their SSI cash payment. The way the deduction is taken in the SSI calculation sheet (before the one-for-two offset) means that approximately 50% of the cost of the IRWE is recouped in the adjusted SSI cash payment.

Some important things to remember about how Social Security applies the IRWE deduction include the following:

- Social Security may deduct 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, whichever is most beneficial to the individual.

- 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 an SSI recipient rents or leases an item while working, the allowable deductible amount is the actual monthly charge. As with other costs approved as IRWEs, rental or lease payment is subject to the reasonable limits provision.

Social Security will verify IRWEs during the periodic redetermination process and SSI recipients must have receipts to prove they paid all approved expenses. It is possible that Social Security may deny IRWEs if the beneficiary cannot produce documentation proving the expense was actually paid.

You can read a helpful summary of the IRWE provisions in a Social Security publication entitled **SSI Spotlights - Impairment Related Work Expenses** (https://www.ssa.gov/ssi/spotlights/spot-impairment-relatedwork.htm). You will find detailed information about IRWEs and review some examples of how IRWEs are applied in the SSI Calculation Sheet in a resource document entitled **Impairment Related and Blind Work Expenses and SSI** found on the VCU NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=213).

You will also find an **IRWE Request Template** you may use to help a beneficiary formally request that Social Security review and approve potential IRWEs on the VCU NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=9).
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 blind individual pays out of pocket. The biggest difference between BWE and IRWE is that BWEs don’t need to be related to any impairment. Blind Work Expense provisions ONLY apply in the SSI program. This work incentive does not apply to individuals who receive a title II disability benefit based on blindness.

Blind work expenses may 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

Based upon the list of allowable expenses under BWE provisions, you can 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. CWICs 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.
In the SSI program, 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. 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.

Just like with IRWEs, the beneficiary must pay any cost and receive no reimbursement from any other source in order for Social Security to approve the expense under BWE rules. Social Security will verify BWEs during the periodic redetermination process and SSI recipients must have receipts to prove they paid all approved expenses. Social Security may deny BWEs if the beneficiary cannot produce documentation proving the expense was actually paid.


You will also find a [BWE Request Template](https://vcu-ntdc.org/resources/viewContent.cfm?contentID=9) you may use to help a beneficiary formally request that Social Security review and approve potential BWEs on the VCU NTDC website.

**Expedited Reinstatement (EXR) in the SSI Program**

We provided a detailed discussion of covered EXR in Chapter 1 so we will not repeat that information here. As a brief reminder, EXR affords eligible individuals a quick way to re-establish entitlement for Social Security disability benefits or SSI after the agency terminated those benefits due to earned income and work activity. To qualify for EXR, the former beneficiary must have the same or a related disability as the earlier entitlement, and the person must again be unable to perform Substantial Gainful Activity (SGA). For most eligible individuals, EXR
offers a faster way to get benefits back again as compared to re-
application. EXR also permits individuals to receive provisional
payments while Social Security is processing the reinstatement request.

EXR applies to both Title II disability benefits and SSI and the EXR rules
are the same for both programs. The one thing to remember is that to
be eligible for EXR, SSI recipients must be terminated from benefits –
not simply suspended. A person who is in a 12-month suspension does
not need to request EXR because they can simply start benefits back
again if and when they re-establish eligibility for SSI. In the SSI
program, the overwhelming majority of people do not terminate from
benefits due to earnings because they remain SSI eligible as long as
they retain Medicaid through 1619(b) Continuation of Medicaid. We will
cover 1619(b) in detail in Chapter 5, but for now all you need to know
is that people in this status are NOT terminated or suspended even
though they no longer receive an SSI cash payment.

**Next Steps**

We have presented a great deal of complex information in this chapter
and it is understandable if you feel a bit overwhelmed by it. As you
serve beneficiaries and learn to apply the information to real life
situations, you will gradually gain expertise and confidence. You will
also need to complete additional training and access technical
assistance from your NTDC Technical Assistance Liaison to continue to
develop competency. Here are some steps you should consider:
1. Keep in mind that the information in this chapter relates to SSI recipients who are engaging in wage employment rather than self-employment. You will need to complete additional training to be able to identify individuals who are self-employed and provide effective WIPA services to SSI recipients who are engaging in self-employment or planning to become self-employed. You can find detailed information about the effect of self-employment on SSI benefits by reading a resource document entitled **Self-employment and SSI** on the VCU NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=11). We also offer a web course on self-employment that we recommend you complete. Finally, when you encounter someone who is self-employed or planning to become self-employed, get support from your VCU Technical Assistance Liaison.

2. SSI is complicated by all of the rules that govern treatment of income and resources. In particular, CWICs tend to require additional training on deeming and in-kind support and maintenance (ISM) to achieve competency on these topics. Be sure to read the resources on these topics we referenced earlier in this chapter and seek out support from your VCU Technical Assistance Liaison when needed.

3. One of the most important parts of your job is to help beneficiaries identify work incentives that can ease the benefits transitions caused by working. You will find **archived supplemental training sessions** on all the SSI work incentives (SEIE, IRWE, BWE) on the NTDC website (https://vcu-ntdc.org/training/supplemental/archives.cfm). These sessions are self-directed and may be completed at any point after you achieve provisional certification.

4. Since SSI payments are affected by different forms of income, SSI recipients need to be diligent about reporting income they receive to Social Security to avoid overpayments. We will cover all aspects of wage reporting in Part II of this manual. We have a variety of **resource documents on the NTDC website that will help you understand various aspects of reporting** (https://vcu-ntdc.org/resources/resourceDetail_search.cfm?id=3).
Part I Chapter 4 – Understanding Plans to Achieve Self-Support (PASS)
Chapter 4 – Understanding Plans to Achieve Self- Support (PASS)

Learning Objectives

After you have read this chapter and completed the associated lectures and activities during WIPA Initial Training, you should be able to:

1. Describe the Plan to Achieve Self-Support (PASS) work incentive and how it benefits individuals with disabilities;

2. Describe the PASS requirements for work goals and earnings;

3. Describe the requirements for PASS expenses;

4. Describe the requirements for income and/or resources set aside to fund the PASS;

5. Identify characteristics of a likely PASS candidate; and

6. Identify under what circumstances Social Security suspends or terminates a PASS.

List of Acronyms

- CWIC – Community Work Incentives Coordinator
- FBR – Federal Benefit Rate
- POMS – Program Operations Manual System
- SGA – Substantial Gainful Activity
- SSDI – Social Security Disability Insurance
- SSI – Supplemental Security Income
- POMS – Program Operations Manual System
- RMA – Retrospective Monthly Accounting
- SEIE – Student Earned Income Exclusion
What is a 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 and/or resources for a period of time in order to pay for items or services needed to achieve a 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 that will help them meet their goal.

Social Security does not count income or resources set aside under an approved PASS. For someone who is already eligible for Supplemental Security Income (SSI), this means a PASS might help that person get a higher monthly SSI payment. For example, someone who had a reduced SSI cash payment because they received Social Security Disability Insurance (SSDI) could set aside the countable part of the SSDI to pay for the goods or services they outline in their PASS. Once approved, Social Security would disregard the set aside funds, and increase their SSI to replace the amount committed to the PASS up to the applicable Federal Benefit Rate (FBR).

PASS can also help someone establish or maintain SSI eligibility. For example, if a disabled individual received too much income to be eligible for SSI, they could commit part or all of that income to the PASS. If they met all other SSI entitlement requirements, they could become entitled to SSI. In most states, even receiving $1.00 in SSI would also entitle them to Medicaid; something we will cover in the next chapter. Social Security does not require that an individual already receive SSI to qualify for a PASS. If the goal is both reasonable and feasible, the person could set aside some or all of their SSDI and meet the SSI income requirements.

A PASS is a detailed written plan that describes an individual’s career goal, identifies specific items or services they need to achieve the career goal, identifies sources of income or resources to be set aside to
pay PASS expenses, and includes steps that person will take to achieve the career goal with timeframes. Individuals submit the completed plan to Social Security for approval. Social Security employees called PASS Specialists review the plan, help the beneficiary refine the plan (if needed), then monitor the individual’s progress on implementing the steps in the approved plan.

During WIPA Initial Training, your instructors will provide you with numerous examples of how PASS applies using the SSI Calculation Sheet. These examples will illustrate how to determine the amount to set aside in a PASS and how setting aside that income (or resource) affects a person’s eligibility for SSI and/or the SSI cash payment.

You can read more general information about what a PASS is and how this work incentive can help individuals with disabilities by reading the "The Redbook – A Guide to Employment Supports" (Publication No.64-030) on Social Security’s website (http://www.ssa.gov/redbook). You can also find a helpful brochure entitled "Working While Disabled—A Guide to Plan to Achieve Self-Support" that describes PASS in easy-to-understand terms on Social Security’s website (www.ssa.gov/pubs/EN-05-11017.pdf).

**PASS Requirements**

For Social Security to approve a PASS, the individual must include the following information in their plan:

**A Specific Work Goal**

A PASS must include a specific employment goal for the plan to be approved. For example, basic living skills or homemaking skills are not occupational goals, but Social Security can approve training in such skills if the individual needs them to achieve a work goal. Buying a car is also not a work or employment goal. It may be a means to achieving employment, but in and of itself, it is not an employment goal. The work goal contained in the PASS must meet several requirements:
Each PASS must specify and clearly describe a single work goal. The work 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 expected income is anticipated to be enough to cover all living expenses, all out-of-pocket medical expenses, and all work-related expenses.

The work goal must be “feasible.” This means that the individual must have a reasonable chance of performing the work associated with the occupational goal, considering the limitations of their impairment, their age, and the individual’s strengths and abilities.

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 Social Security 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, the work goal must result in enough earnings to substantially reduce or eliminate the SSI cash payment. The reduction must occur in a reasonable amount of time based on the specific milestones and timeframe outlined in the PASS application. If someone becomes entitled to SSI by committing their Title II disability benefit to fund the PASS, the work goal must be expected to result in earnings of more than the current Substantial Gainful Activity (SGA) level.

Social Security only permits one PASS per work goal. If an individual had a previous PASS with a goal, and the person was not successful in meeting that goal, it is not possible to develop another PASS for that same goal.

A Viable Plan for Achieving the Work Goal

Social Security will judge whether the plan is viable by considering the individual’s education and training needs, any assistive technology required, and the interval steps necessary to achieve the work goal. These interval steps or milestones should include timeframes and be
described in enough detail that Social Security can measure the individual's progress toward achieving the work goal. When deciding if the plan is viable, Social Security will also check to make sure the individual will have sufficient funds to cover PASS expenses, living expenses, and other necessary expenses.

**Specific and Reasonable Expenses for Items or Services Necessary to Achieve the Work Goal**

PASS is a work incentive intended for people who need help paying for items or to achieve a work goal. To be allowable, an expense must be directly related to the work goal and the PASS should include clear explanations as to why the goods and services are necessary. In addition, expenses must:

- Be itemized with costs indicated;
- Not have been paid before the individual began activities to achieve the work goal. Sometimes expenses can predate submission of the PASS and SSI eligibility. This is only true if the expense relates clearly to the work goal;
- Be of a reasonable cost. This means the price should reflect the usual cost for the item in the marketplace. Any cost estimates for items or services included in the PASS must show how the cost estimate was calculated; and
- Reflect start-up costs. Start-up costs refer to the expenses associated with someone first getting a job or starting a business. PASS expenses are limited to the start-up costs for the work goal.

Some examples of possible PASS expenditures include, but are not limited to:

- 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.;
• Dues and publications for academic or professional purposes;
• Attendant care;
• Certain transportation costs;
• Childcare;
• 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;
• Interview clothing, Uniforms or other specialized clothing, safety equipment;
• Modifications to buildings or vehicles to accommodate disability; or
• Licenses, certifications, and permits necessary for employment.

The PASS provisions prohibit certain types of expenses. A PASS expense that is not allowed is one that:

• Is not purchased by the individual;
• Is for items or services that the individual can readily obtain for free;
• Is for items or services for which the individual will be reimbursed; or
• Reflects an outstanding debt unrelated to the current PASS.

**A Source of Income and /or Resources to Fund the PASS**

To qualify for a PASS the individual must have some sort of income or resource to set aside that would otherwise cause a reduction in the SSI cash payment or cause ineligibility for SSI. The income or resource must be monetary. It is not possible to set aside an object or real property to fund a PASS.

If an individual has no countable resources that would cause ineligibility for SSI, and has no source of income other than SSI, a PASS is not possible. Social Security does not allow beneficiaries to set aside SSI
benefits to fund a PASS. Some types of income or resources individuals may use to fund a PASS include:

- Countable resources in excess of the current resource limits;
- Countable unearned income such as Social Security benefits, pension payments, rental income, child support, etc.;
- In-kind support and maintenance (ISM) valued under the Presumed Maximum Value (PMV) rule. If a beneficiary has ISM and the Value of the One-third Reduction (VTR) rule is being applied, it is not a form of unearned income. ISM valued under the VTR rule cannot be used to fund a PASS;
- Countable earned income after all exclusions and work incentives have been applied; or
- Deemed income from an ineligible spouse, parent(s), or sponsor.

The information contained in this chapter is a general summary of the PASS requirements. There are more details that PASS Specialists consider when they review a PASS. You can read more about the PASS requirements in Social Security’s Program Operations Manual System (POMS) at **SI 00870.006 Elements of a PASS** (https://secure.ssa.gov/apps10/poms.nsf/lnx/0500870006).

**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 could be eligible for a PASS is actually a good candidate for using this complex work incentive. Like all work incentives, PASS is not 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., Employment Network, United Cerebral Palsy, Goodwill Industries, etc.);
- Be 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 becoming self-supporting;
- 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. Others might qualify, but simply would not benefit from developing a PASS. Unlikely PASS candidates would include those who:

- Already secured the needed items and services under a previous PASS and have not 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 full retirement age (with some exceptions);
• Do not have any income or resources to set aside in the PASS or are unwilling to use set aside funds strictly for the PASS; and
• Do not require any additional items or services to meet a specific career goal, or are not interested in working or decreasing dependency on public benefits.

**Title II Disability Beneficiaries as PASS Candidates**

While PASS is known as an SSI work incentive, there is no rule prohibiting Title II disability beneficiaries from developing a PASS. Remember that the SSI program views 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 disregards this income when determining eligibility for SSI. If Social Security approves the PASS, the Title II payment continues, and the beneficiary sets it aside in the PASS 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.

When working with a Title II disability beneficiary who is interested in pursuing a PASS, keep in mind that the individual must meet all other SSI eligibility criteria for the PASS to be approved. It is also 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 work goal must be likely to result in work above the SGA level and lead to the eventual loss of the Social Security disability benefit.

There are many things to consider when counseling beneficiaries about PASS since not everyone who may want to develop a plan is a good candidate for having a PASS approved. To help determine if a
beneficiary is a good PASS candidate, you can use the **PASS Candidate Checklist** on the NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=58).

### Developing a PASS

An individual may develop and submit a PASS to Social Security at any time. The agency requires individuals to submit their plans in writing. Applicants may use a **standardized form, SSA-545-BK, or any format as long as it contains all of the information required on the SSA-545-BK found on Social Security’s website in PDF format** (https://www.ssa.gov/forms/ssa-545.html).

Individuals who develop a PASS but who do not yet receive SSI will have to apply for SSI and submit the completed PASS form at the same time. For Social Security to award the application, in addition to meeting the medical requirements, the person must meet the income and resource requirements once Social Security excludes the PASS set-aside amounts. In addition, if the person is not yet eligible for SSI, they may not be performing SGA at the time of application.

#### PASS Specialists

When a beneficiary submits a PASS to the local Social Security field office, the PASS is sent to 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 has contact with any claimant filing for a PASS when the applicant submits the PASS. In addition, the PASS Specialist must conduct periodic progress reviews to ensure the beneficiary is fulfilling PASS requirements as outlined in the plan. 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 individual resides. You can find a **listing of PASS Specialists with service areas and contact information** on Social Security’s website (http://www.socialsecurity.gov/disabilityresearch/wi/passcadre.htm).

#### Getting Help with Developing a PASS

Social Security allows beneficiaries to get help with developing a PASS and may even include fees paid for PASS preparation in the plan. A
PASS Specialist, a Community Work Incentives Coordinator (CWIC), a vocational rehabilitation counselor, other professionals providing benefits counseling, or anyone else may help with developing a PASS. Assisting someone with a PASS is an important part of your role as a CWIC providing WIPA services. CWICs who work in WIPA programs may not charge beneficiaries for PASS preparation.

**Things to Know Once the PASS is Approved**

Once Social Security has approved the PASS, the agency will continue to monitor the beneficiary’s progress by conducting periodic progress checks. The PASS Specialist generally makes an initial progress check within 30-60 days of approval, or by the first milestone, if earlier. A brief telephone call to check on progress may be sufficient. After this initial progress check, the PASS Specialist will set up a schedule of subsequent progress checks based on the circumstances of each PASS. The PASS Specialist will schedule regular progress reviews on 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 work goal; and
- Any other factor the PASS Specialist considers appropriate (e.g., the end of every semester – to check grades and the next schedule of classes).

There are many things beneficiaries need to do to keep their PASS moving forward. CWICs have a significant role to play in identifying possible PASS candidates, assisting individuals to develop their plans, and helping beneficiaries manage their plans after approval. To help you counsel beneficiaries with an approved PASS, the VCU NTDC developed a helpful resource document entitled **So, Your PASS was Approved - Now What?** that outlines all the things a beneficiary needs to do to keep their PASS on track. You can find this document on
the NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=61).

**Making Changes to a PASS**

A PASS may change in several ways. Social Security offers 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 explain the needed changes.

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 Specialists must approve any amendments to an existing plan.

You can find more information about amending a PASS using the POMS citation **SI 00870.050 Plan to Achieve Self-Support (PASS) Amendments** (https://secure.ssa.gov/apps10/poms.nsf/lnx/0500870050).

**Suspending or Terminating a PASS**

Social Security will suspend a PASS when the individual has not met scheduled milestones, accounted for all PASS funds or other circumstances are present and the individual has not provided a reasonable explanation. 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’s SSI benefits.

A PASS terminates when one of the following events occurs:

- 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 approved;
- Spent the set aside income or resources as outlined in the PASS;
- Kept records of the expenses including receipt; and
- Actively sought employment at the end of the PASS.

You can read more about suspending or terminating a PASS by going to the POMS at **SI 00870.070 Suspension, Termination Or Resumption Of A Plan to Achieve Self-Support (PASS)** (https://secure.ssa.gov/apps10/poms.nsf/lnx/0500870070).

**Next Steps**

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. While PASS is not a work incentive for everyone, it provides incredible advantages for individuals who truly want to establish a successful career that leads to economic self-sufficiency.
Facilitating use of work incentives such as PASS is a core component of a CWIC’s job. PASS is complicated and the information contained in this chapter provides only an overview of PASS provisions. You will need to access additional training and technical support to facilitate PASS development. For now, the most important thing is for you to be able to recognize when a beneficiary might be a good PASS candidate. When you identify someone who could benefit from a PASS, the next step is to contact your assigned NTDC Technical Assistance (TA) Liaison for assistance. Your TA Liaison will point you to additional resource documents you can read and training sessions you can complete to gain a deeper understanding of this powerful work incentive.
Part I Chapter 5 – Understanding Medicaid
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Chapter 5 – Understanding Medicaid

Learning Objectives

After you have read this chapter and completed the associated lectures and activities during WIPA Initial Training, you should be able to:

1. Describe the three mandatory Medicaid eligibility groups for people with disabilities: SSI eligible, 1619(b) eligible and Special Medicaid Beneficiaries.

2. Describe four optional Medicaid eligibility groups for people with disabilities: State Supplement Payment (SSP), Medically Needy, Medicaid Buy-in (MBI), and Home and Community Based Services (HCBS).

3. Describe how individuals apply for Medicaid, how states make Medicaid eligibility determinations, the Medicaid redetermination process, and how to appeal Medicaid determinations.

4. Describe how Medicaid interacts with Medicare and employer sponsored health insurance.

5. Describe the benefits of 1619(b) Medicaid while Working, the eligibility requirements for 1619(b) and the process Social Security uses to make 1619(b) determinations.

6. Describe the effect of work on Special Medicaid Beneficiary status.

7. Describe the effect of work on the optional Medicaid eligibility groups: State Supplement Payment (SSP), Medically Needy, Medicaid Buy-in (MBI), and Home and Community Based Services (HCBS).

8. Describe the conditions under which individuals lose eligibility for Medicaid.
List of Acronyms

- BBA – Balanced Budget Act
- BEP – Break-even Point
- BWE – Blind Work Expenses
- CDR – Continuing Disability Review
- COLA – Cost of Living Adjustment
- CMS – Centers for Medicare and Medicaid Services
- DHHS - U.S. Department of Health and Human Services
- EIE – Earned Income Disregard
- FBR – Federal Benefit Rate
- GIE – General Income Disregard
- HCBS – Home and Community Based Services
- HIPPI - Health Insurance Premium Payment
- ICF – Intermediate Care Facilities
- IRWE – Impairment Related Work Expense
- LTC – Long Term Care
- MA – Medical Assistance
- MBI – Medicaid Buy-in
- MSP – Medicare Savings Program
- PASS – Plan to Achieve Self-Support
- SDX – State Data Exchange
- SEIE – Student Earned Income Exclusion
- SSP – State Supplement Payment

Medicaid Basics

Medicaid, also known as Medical Assistance (MA), is a cooperative federal-state healthcare program authorized by Title 19 of the Social Security Act. Congress created Medicaid 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 implement a Medicaid program. Currently, Medicaid provides healthcare coverage to more than 78 million Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities.

Medicaid is a jointly funded and administered 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) administers Medicaid. CMS establishes Medicaid regulations and provides guidance about how states must operate their program. For a state to receive 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.

States may request a waiver from one or more of the federal regulations. However, to get a waiver, CMS must approve it, and the changes must improve the quality or efficiency of the Medicaid program. Federal regulations provide states with considerable flexibility in designing their Medicaid program. As a result, Medicaid programs vary significantly from state to state and 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 setting 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. Some states have even given their Medicaid program a unique name, such as Medi-Cal in California or TennCare in Tennessee.

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 describes how the state will meet the federal Medicaid requirements and defines the way that the state will implement specific options where states have flexibility. While the Medicaid state agency is also responsible for administering the program, it often delegates day-to-day Medicaid program operations to 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).

In creating their 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 – this means in a group that CMS requires states to serve. In many states, most if not all Medicaid eligibility groups have access to the same set of services listed in the State Plan. You can find a list of mandatory and optional Medicaid

Eligibility for Medicaid

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, there 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 may choose to include them in the State Plan. If a person meets the eligibility criteria of a mandatory and an optional eligibility group, their eligibility should default to the mandatory group. We will not cover the details of every Medicaid eligibility group in this chapter. Instead, we will provide detailed information about 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 for Individuals with Disabilities

There are a number of mandatory eligibility groups for individuals who are blind or disabled. This chapter 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 common mandatory eligibility groups are tied to receipt of SSI benefits. The other mandatory eligibility groups covered in this chapter are for people who had SSI at one time, but lost it due to very specific reasons.

**Mandatory Group #1: SSI Eligible Individuals**

In most states, Medicaid eligibility is automatic once Social Security determines that an individual is eligible for SSI. When Congress created SSI in 1972, it wanted states to provide Medicaid coverage to those who were SSI eligible. Some states supported this idea while other states did not. As a result, Congress decided to give states three options:

- **1634 States:** These states 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, they automatically receive 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:** These states 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 does not make any Medicaid eligibility decisions – the state makes all of them.

- **209(b) States:** These states use most, but not all, of the SSI income and resource rules to determine Medicaid eligibility. The 209(b) 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) and the state makes all Medicaid eligibility decisions. The Medicaid eligibility standards 209(b) states employ vary widely from state to state. These requirements may be more restrictive or
more liberal than the SSI program 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.

- **The important thing to remember** is that in most cases, as long as a beneficiary is eligible for SSI, they will be eligible for Medicaid benefits through the SSI eligible group. However, if you serve beneficiaries who reside in 209(b) states, there may be exceptions to this general rule.

**Mandatory Group #2: 1619(b) Eligible Individuals**

Section 1619(b) of the Social Security Act 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) do not receive SSI payments because their countable earned income is high enough to eliminate an SSI payment after Social Security applies all income exclusions and deductions. Social Security considers individuals in 1619(b) status to be SSI eligible, simply not in cash payment status. Due to this important distinction, in most cases, states are required to provide Medicaid coverage to individuals who meet the eligibility requirements for 1619(b). We will cover 1619(b) in detail further on in this chapter in the section on how work affects Medicaid eligibility.

**Mandatory Group #3: Special Medicaid Beneficiaries**

In most states, categorical Medicaid eligibility for people who are aged, blind, and disabled is directly tied to eligibility for SSI. For this reason, loss of SSI eligibility often results in loss of Medicaid coverage. Over the years, Congress has enacted special Medicaid continuation provisions to preserve critical Medicaid coverage for certain special groups of former SSI recipients who continue to meet Social Security’s definition of disability. A “Special Medicaid Beneficiary” is someone who lost SSI eligibility due to establishing eligibility for or receiving increases in Title II disability benefits, and who meets specific criteria that allows Medicaid coverage to continue. States are required to afford Special Medicaid Beneficiary status to individuals who lost SSI eligibility because of:
1. Any reason, but who are not currently entitled to SSI because of Cost-of-Living Adjustments (COLAs) in Social Security Disability Insurance benefits (SSDI);

2. Entitlement to or increase in Childhood Disability Benefits (CDB); or

3. Entitlement to Disabled Widow(er) Benefit (DWB) Special Medicaid Beneficiary status only applies to DWB beneficiaries until Medicare starts.

When determining Medicaid eligibility for these special former SSI recipients, state Medicaid agencies must exclude a portion of the eligible individual’s Title II disability benefit. Essentially, if the individual would otherwise be entitled to SSI or 1619(b) without counting that portion, that individual would be entitled to special Medicaid Beneficiary status. Eligibility for Special Medicaid Beneficiary status is complicated and beyond what CWICs are expected to understand at this stage. For now, you just need to know that this special Medicaid eligibility status exists and that it is a mandatory eligibility group. To learn more about Special Medicaid Beneficiaries you can refer to a resource document found on the NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=136).

Optional Medicaid Eligibility Groups for People with Disabilities

Over the years, Congress has created a number of optional Medicaid eligibility groups that states can choose to cover. Because the availability of these eligibility groups varies substantially from one state to another, we only describe the most commonly used groups by people with disabilities in this chapter. Many of the optional eligibility groups have 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 below is for background. You will need to learn the categories that exist in the states you serve.

Optional Group #1: State Supplemental Payment (SSP) Eligible

Some states provide a cash payment called a State Supplement Payment (SSP) to supplement the federal SSI benefit. The maximum SSP amount varies by state as well as by factors such as marital status, living
situation, and whether or not the person is blind. Income and resource limits also vary by state. If a person is eligible for State Supplement Payments, they may also be able to get Medicaid through this related Medicaid eligibility group.

In some states, **Social Security administers the SSPs** (https://www.ssa.gov/ssi/text-benefits-ussi.htm) instead of the state Medicaid agency. When Social Security administers the SSP, it is treated as if it were a regular SSI benefit. As a result, a person who is eligible to receive a dollar of SSI, whether it is federal SSI, or the SSP, is eligible for full Medicaid coverage. In addition, an eligible individual who loses federal SSI or a Social Security administered SSP due to earned income can use 1619(b) to maintain Medicaid. With state administered SSPs, the state sets its own policies governing whether loss of SSP due to earned income will result in loss of the related Medicaid. Not all states provide this coverage, and those that do may determine their own eligibility requirements.

**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, CMS requires that these states 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 rules governing what forms of income and resources count during Medically Needy eligibility determination. The federal government requires that the state’s method for deciding financial eligibility may not be more restrictive than the rules for the SSI program. This requirement does not apply to 209(b) states. These states have at least one more restrictive eligibility rule than the SSI program, and may offer different services under Medicaid.

When a person has too much income, the applicant must meet a “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 is for goods or services the Medicaid state plan does not cover.

**Optional Group #3: Medicaid Buy-In (MBI)**

Congress specifically created the Medicaid Buy-In (MBI) option, 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 provides health coverage to working people with disabilities who, because of increased earnings, resources, or both, do not qualify for Medicaid under another category. When using MBI, people with disabilities who are working may pay monthly premiums for their Medicaid coverage.

CMS gives states lots of room to set their own rules for their MBI program. Some states have no cap on earned income or resources. Other states are very restrictive as to who is initially eligible, but have more liberal rules on earnings and resources once the person is enrolled in the MBI. Each state’s MBI is unique in its mix of features within the federal rules with which it must operate.

CMS provides an [overview of the Medicaid Buy-In option](https://www.medicaid.gov/medicaid/ltss/employmment/index.html) on the Medicaid website.

**Optional Group #4: Home and Community Based Services (HCBS) Group**

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, 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 facilities (ICF), intermediate care facilities for those with intellectual disabilities (formerly called ICF/ID), or hospitals. Over the years, Congress has created several options for states to provide LTC services to support people to live in the community, rather than in a Medicaid funded
institution. The most common option is to develop a Home and Community Based Services (HCBS) program through a waiver with CMS.

HCBS waivers provide a set of special Medicaid services for targeted populations, thereby making it possible for the individuals to live with maximum independence in the community rather than in an institution (e.g., nursing facility). 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 residential, habilitation, leisure/recreational and vocational services. HCBS programs may also cover non-medical services such as minor home modifications like ramps or special safety devices. HCBS programs may also be designed to serve specific disability groups such as individuals with intellectual disabilities, individuals with traumatic brain injuries, or individuals with spinal cord injuries. Some states have several different HCBS waivers targeted to different populations. Enrollment in HCBS programs is often limited due to state Medicaid budget constraints and many programs have long waiting lists.

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 the SSI resource limits, and meet other eligibility requirements for the HCBS program set by the state. 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. States vary widely in terms of the types of HCBS waivers they provide and the eligibility requirements they establish for each waiver program.


How to Apply for Medicaid

The process people use to apply for Medicaid varies by state and by the category of Medicaid coverage. For example, if you live in a 1634 state,
Social Security automatically enrolls you in Medicaid when you become eligible for SSI. In 1634 states, Social Security also makes eligibility determinations for 1619(b) and notifies the Medicaid agency when an individual moves from SSI cash benefits into 1619(b) status. In SSI criteria or SSI eligibility states, individuals have to apply for Medicaid separately after Social Security determines that they are eligible for SSI. This means SSI recipients have to apply through the state agency that performs Medicaid eligibility determinations. In these states, when a person loses SSI cash payments due to earned income, they need to contact the Medicaid agency to apply for 1619(b) status to make sure that they keep their Medicaid coverage.

In all states, individuals who want to apply for Special Medicaid Beneficiary status or any of the optional Medicaid groups should contact their state Medicaid agency. In most states, the state Medicaid agency website will provide instructions for applying and information about the eligibility requirements and determination process. You will find a [state Medicaid program locator](https://www.medicaid.gov/about-us/beneficiary-resources/index.html#statemenu).

**Medicaid Redeterminations and Appealing Medicaid Decisions**

CMS holds state Medicaid agencies responsible for ensuring that individuals who are eligible for Medicaid remain enrolled as long as they meet eligibility criteria. In addition, states are required to perform periodic redeterminations to make sure Medicaid enrollees continue to meet program eligibility requirements. Individuals who no longer meet the eligibility requirements for the group in which they are enrolled will either be terminated from the Medicaid program entirely or moved into another coverage category for which they are eligible. States vary widely in terms of how they conduct Medicaid redeterminations.

Under federal Medicaid law, a Medicaid applicant or recipient is entitled to an administrative hearing after any decision that affects their right to Medicaid or to any service for which they are seeking Medicaid funding. This is known as a “fair hearing” and is available in all states.
A person is entitled to a letter when the state denies or terminates Medicaid benefits or right to services funded by Medicaid. 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 and Advocacy program). States may establish their own time limits for requesting hearings. Typically, states will permit the Medicaid beneficiary a time limit (up 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 they will request continued services pending the appeal. Federal Medicaid law requires states to continue benefits pending the appeal if the beneficiary requests a hearing before the effective termination date and requests the continuation of benefits.

**Medicaid and Other Health Insurance**

Many beneficiaries worry that when they become eligible for Medicare or an employer-sponsored health insurance plan, they will lose their Medicaid coverage. Fortunately, there are many options for individuals to maintain Medicaid if they enroll in other insurance programs.

Since it is a financial needs-based program, Medicaid is a payer of last resort. As a result, Medicaid programs encourage beneficiaries to pursue other health insurance options. When Medicaid enrollees access additional health insurance, the Medicaid program saves money, because the other insurance becomes the primary payer. Some states require Medicaid beneficiaries to enroll in Medicare if they are eligible. If a Medicaid beneficiary’s 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 beneficiaries become eligible for new health care coverage, they must report this to the state Medicaid agency. Timely reporting ensures that the forms of insurance correctly coordinate.
Medicaid and Medicare

A number of the beneficiaries you work with will receive both SSI and Title II disability benefits. Social Security calls these individuals “concurrent beneficiaries”. In most states, these beneficiaries will eventually be eligible for both Medicare and Medicaid. When a person is eligible for both Medicare and Medicaid, CMS considers them to be “dually eligible” with regard to their health insurance. It is 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 dually 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. 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 through Medicaid or by enrolling in Medicare Savings Programs (MSPs). We discussed MSPs in Chapter 2.

Medicaid and Employer-Sponsored Health Insurance

In some states, if a beneficiary can get health insurance through their own employer, their spouse’s employer, or their 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 beneficiary for details about the health insurance policy including 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 is cost effective, in order to maintain Medicaid, the state may require the beneficiary to enroll in 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 copayments and deductibles. If Medicaid doesn’t consider the plan cost effective, generally the state will not require the beneficiary to take the
new health insurance option. The beneficiary could still choose to take it, but the state generally will not pay the premium.

**Medicaid and Work**

Medicaid provides critical healthcare coverage for some of the most vulnerable Americans – those with disabilities who have low incomes. Disability beneficiaries often fear that going to work will cause ineligibility for Medicaid while their earnings are not sufficient to purchase other forms of insurance that will cover essential medical services. Fortunately, under the current regulations, Medicaid continues uninterrupted for most eligible individuals who work but retain some SSI cash payment. Even after SSI cash payments stop due to earned income, individuals who meet the eligibility requirements for 1619(b) may continue to receive Medicaid indefinitely.

**Understanding 1619(b) Medicaid While Working**

To benefit from the 1619(b) provisions, an individual must meet all five of the eligibility criteria described below. Medicaid may continue indefinitely under the 1619(b) provision. **If, however, at any point a beneficiary fails to meet one or more of these criteria, the individual will not be eligible for Medicaid coverage under 1619(b).**

1. **Eligible individuals must continue to meet the Social Security disability definition.** Individuals in 1619(b) status continue to be subject to medical continuing disability reviews (CDRs). If the person is found to no longer meet the disability requirements, 1619(b) Medicaid stops.

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) is not 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 SSI 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 by applying something called the “Medicaid Use Test.” This “test” has three parts, but a person only needs to meet one of the parts to pass. An individual needs Medicaid coverage if they:
   - 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.

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 cannot have earnings sufficient to replace SSI cash benefits, Medicaid benefits, and publicly funded personal or attendant care.** Social Security uses a “threshold” concept to measure whether an individual has sufficient earnings to replace these benefits. The threshold is a specific dollar amount of annual countable earned income an individual may have and still qualify for 1619(b) continued Medicaid. In most cases, if a person’s annual countable earned income is over the threshold figure, they will not be eligible for 1619(b) Medicaid. Due to the way Social Security calculates the threshold figure, different states have different threshold amounts. The threshold amounts also change 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 current state threshold amount, they meet this threshold test.

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). You will find a listing of the **current threshold amounts for each state** in the POMS (https://secure.ssa.gov/poms.nsf/lnx/0502302200).

### How Earnings are Evaluated during the Threshold Test

Social Security makes threshold determinations prospectively for a 12-month period beginning the first month an employed SSI recipient’s countable earned income causes SSI cash payments to cease. When estimating future earnings, Social Security personnel generally use the amounts the beneficiary earned in the past few months, but the agency may consider any indication given by the individual that they expect a change in earnings. Social Security will also consider any Impairment Related Work Expenses (IRWE) or Blind Work Expenses (BWE) the person has, as well as income excluded under an approved Plan to Achieve Self-Support (PASS). Social Security will exclude these work incentive expenses from estimated gross earnings to determine estimated countable earnings. If the beneficiary has estimated countable annual earnings under the current state threshold amount and meets all other eligibility requirements, Social Security will find the person eligible for 1619(b).

If estimated countable annual earnings are over the standard state threshold amount, Social Security checks to see if the individual is eligible for an individualized threshold amount. A person may get a higher individualized threshold amount if they have above-average Medicaid costs. Social Security also considers the value of publicly funded 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. 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.

Social Security reviews earnings during 1619(b) re-determinations, as it does all other forms of unearned income, resources and other relevant eligibility information. In addition to the periodic re-determination required for Section 1619(b) cases, Social Security must verify earned income and exclusions from earned income. If during these reviews the annual estimate for the upcoming 12-month period exceeds the current threshold amount and if there is no indication that an individualized threshold calculation is in order, eligibility for 1619(b) Medicaid may stop. If Social Security finds an individual ineligible for 1619(b) because of excess resources or earned or unearned income, Social Security does not terminate the person’s SSI eligibility immediately. Rather, 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 cash benefits or 1619 (b) Medicaid without the individual needing to file a new application. Individuals in 1619(b) status are considered to be SSI eligible, simply not getting a cash benefit. The protections of the 12-month suspension period apply to individuals in 1619(b) status in the same way they apply to someone getting SSI cash payments.

**1619(b) in 209(b) States**

As mentioned before, certain states have their own eligibility criteria for Medicaid. Called “209(b)” states, they have a more restrictive definition of disability than that of the SSI program. Individuals who are eligible for Medicaid under 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 Medicaid. The state must continue Medicaid coverage so long as the individual continues to be eligible under section 1619(b).
1619(b) for Eligible Couples

There are some important details about 1619(b) and eligible couples. As a reminder, an eligible couple exists when two SSI recipients are married to each other or are holding themselves out as married to the local community. 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 is working, continued Medicaid under 1619(b) only applies to that person, and not the unemployed spouse. Because 1619(b) is a work incentive, it is only available to persons who are working. The non-working spouse will lose the SSI-related Medicaid, though they may be eligible under a different Medicaid group.

1619(b) Eligibility Determinations 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 Social Security personnel make a determination, they 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.

1. **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.

2. **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.

Once Social Security determines a person is eligible for 1619(b), the agency will conduct periodic re-determinations. Social Security conducts these re-determinations to ensure that individual continues to meet the 1619(b) eligibility criteria.

You can read more about 1619(b) policies (https://secure.ssa.gov/apps10/poms.nsf/lnx/0502302000) by starting with POMS SI 02302.000 Continuing Benefits and Recipient Status Under Sections 1619(A) and 1619(B) for Individuals Who Work - Subchapter Table of Contents found online (https://secure.ssa.gov/apps10/poms.nsf/lnx/0502302000). You can also refer to a detailed resource document entitled Understanding 1619(b) found on the NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=140).

**Work and Special Medicaid Coverage**

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 establishing eligibility for this category of Medicaid. This is important for you to remember when counseling Special Medicaid beneficiaries who work. Only a portion or possibly none of their Title II benefit will count when the state Medicaid agency determines countable income.

Both 1634 and SSI eligibility states treat earned income for Special Medicaid Beneficiaries the same way as the SSI program. States apply the $20 General Income Exclusion (GIE) to unearned income (the Title II benefit minus the amount disregarded due to Special Medicaid Beneficiary status). The regular SSI earned income exclusions included in the SSI Calculation Sheet also apply in the standard order:

- Student Earned Income Exclusion (SEIE)
• Earned Income Exclusion (EIE)
• Impairment Related Work Expenses (IRWE)
• One-for-Two Offset
• Blind Work Expenses (BWE)
• Plans to Achieve Self-Support (PASS)

Only what is left after these deductions will count in determining eligibility for Special Medicaid. Just like in the SSI program, as long as an individual’s total countable income is below the current FBR, and they meet the resource limit, the individual will continue to be eligible for Special Medicaid coverage. Even if countable earnings exceed the current FBR, some states allow Special Medicaid status to continue as long as the countable earned income stays under the state’s 1619(b) threshold amount.

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.

**Work and Optional Medicaid Eligibility Groups**

Remember that not all states choose to offer Medicaid coverage to every optional eligibility groups and when they do, CMS allows them to establish their own eligibility standards within broad federal parameters. That means we cannot provide you with specific information about how earned income might affect eligibility for these optional Medicaid groups in your state. You will need to conduct research into how each of your state’s optional Medicaid programs treat earned income during eligibility determinations. We can give you a little direction

**State Supplemental Payment (SSP) Eligible**

When Social Security administers the SSP, it is treated as if it were part of the federal 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.

**Medically Needy Group**

When a person using Medically Needy Medicaid begins working, it generally means they will have an increase in the amount of their spend-down. The spend-down acts like a deductible that the beneficiary must pay or incur before coverage begins. The higher a person’s spend-down is, the more difficult it may be to retain eligibility for Medically Needy Medicaid. States vary significantly in how they count income when determining how much an individual’s spend down is. You will need to conduct research to find your state’s income and resource limits associated with this eligibility group, as well as the basics for how to calculate the spend-down.

**Medicaid Buy-In Group**

Congress specifically created the Medicaid Buy-In (MBI) option to provide Medicaid eligibility for workers with a disability. CMS gives states a wide berth to set their own income and resource rules for the MBI. Some states have no cap on earned income and/or resources. Other states are very restrictive as to who gets in, but have more liberal rules on earnings and resources once the person is eligible for and enrolled in the MBI. Each state’s MBI is unique in its mix of features within the federal rules with which it must operate. You will need to conduct research to find out if your state offers an MBI, and if so, what the earned income limits are (if any).

**Home and Community Based Services (HCBS) Group**

To maintain the HCBS waiver services, a 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 they continue to meet the criteria for the target disability group. The third criterion is the waiver’s financial requirements - the person must continue to meet the income and resource limits applicable for the waiver from which they are receiving services. HCBS waiver participants who work will have increased income. Depending on the income rules for the waiver, an individual could lose entitlement to HCBS Medicaid. You will need to conduct research to find
out which HCBS waivers your state offers and what the eligibility criteria are for each waiver program.

**When Medicaid for Individuals with Disabilities Stops**

Medicaid coverage stops when an individual no longer meets the eligibility requirements for the group in which they are enrolled. For people enrolled in disability-related categories of Medicaid, this includes:

1. When an individual no longer meets Social Security’s definition of disability; or
2. When an individual no longer meets the applicable income and resource requirements.

When eligibility for one group ends, it might be possible to establish eligibility under another group. This may be a different group for people with disabilities, or a Medicaid category of eligibility unrelated to disability. Remember, we have only covered the most common disability-related eligibility categories in this chapter, but there are other Medicaid eligibility categories that do not have a disability requirement. In most cases, if a Medicaid beneficiary loses entitlement to one group, state Medicaid eligibility workers will check all other eligibility categories available in the state to make sure an individual does not needlessly lose access to critical health insurance.

Finally, an important thing to remember is that Medicaid eligibility established in one state is not portable across state lines. Even for those who are in mandatory eligibility groups, if a beneficiary moves to a different state, they need to contact the state Medicaid agency in their new state to make sure coverage continues. Since eligibility requirements for various Medicaid groups can vary from state-to-state, individuals may need to re-apply for Medicaid in order to continue coverage.

**Next Steps**

As you can see from the discussion in this chapter, the Medicaid program is complex. The fact that states vary so widely in terms of which groups
they cover and how they define eligibility adds to this complexity. Once you achieve provisional CWIC certification, you will need to conduct research into how the Medicaid program operates in each state your WIPA program serves. Your NTDC Technical Assistance Liaison can help you get started, but this is not an area in which they have specific expertise. Social Security requires that WIPA programs access training on how state specific benefit programs are affected by work and Medicaid is the most important one of all. As you work to understand your state’s Medicaid policies, you can build competency in the federal policies by taking the following steps:

1. The NTDC website has an entire section of resource documents focused on Medicaid. You will find the Medicaid resources on the NTDC website (https://vcu-ntdc.org/resources/resourceDetail_search.cfm?id=5). In particular, these documents provide you with more detail about 1619(b) and how work affects Special Medicaid Beneficiaries. These are two very important areas for CWICs to understand as they provide work incentives counseling to beneficiaries.

2. VCU’s NTDC offers a comprehensive web course on Medicaid several times each year. We recommend that you complete this training after you achieve provisional certification to enhance your understanding of this complex healthcare program. Once you achieve provisional certification, you will start receiving email notices of upcoming web courses and other supplemental training through the National WIPA Listserv. You may visit the calendar of upcoming supplemental training on the VCU NTDC website (https://vcu-ntdc.org/training/supplemental/upcoming.cfm).

3. The NTDC also offers recorded teleconference and webinar supplemental trainings each year and these archived trainings can be found on the NTDC website (https://vcu-ntdc.org/training/supplemental/archives.cfm). These training sessions may be completed at any time and there are several that cover important aspects of the Medicaid program.
Part I Chapter 6 – Understanding Concurrent Beneficiaries
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Chapter 6 – Understanding Concurrent Beneficiaries

Learning Objectives

After you have read this chapter and completed the associated lectures and activities during WIPA Initial Training, you should be able to:

1. Define the term “concurrent beneficiary” and describe under what circumstances an individual would become a concurrent beneficiary.

2. Describe the effect of paid employment on a concurrent beneficiary’s cash benefits (SSI and the Title II disability benefit).

3. Describe the effect of paid employment on a concurrent beneficiary’s Medicaid and Medicare coverage.

4. Describe the effect of paid employment on eligibility for the Medicare Savings Program (MSP).

5. Describe the effect of paid employment on the Medicare Part D Low-income Subsidy (LIS).

Acronyms

- BEP – Break-even Point
- CDB - Childhood Disability Beneficiary
- COLA – Cost of Living Adjustment
- CWIC – Community Work Incentives Coordinator
- DWB – Disabled Widow(er)s Beneficiary
- EPE – Extended Period of Eligibility
- FBR – Federal Benefit Rate
- FPL – Federal Poverty Level
- GIE – General Income Exclusion
- IRWEs – Impairment Related Work Expenses
Introduction

Social Security defines a “concurrent beneficiary” as someone who is eligible for both Supplemental Security Income (SSI) and a benefit authorized under Title II of the Social Security Act at the same time. Concurrent beneficiaries receive two separate payments each month and these payments usually come on different days of the month. In the WIPA program, most concurrent beneficiaries receive a Title II disability benefit – Social Security Disability Insurance (SSDI), Childhood Disability Benefits (CDB) or Disabled Widow(er)s benefits (DWB). However, you may encounter individuals who get SSI paired with child’s benefits, early retirement benefits, child-in-care benefits, or another Title II benefit unrelated to disability. In this chapter, we will focus on concurrent beneficiaries who receive benefits based on disability.

Concurrent Beneficiary Status

Concurrent beneficiary status may occur in several ways:

- Beneficiaries who receive monthly Social Security disability benefits that are less than the current Federal Benefit Rate (FBR) may become eligible for an SSI benefit that supplements their Title II cash payments, provided they meet all other SSI eligibility criteria. The SSI program views the Title II benefit as unearned income. The $20 General Income Exclusion (GIE) reduces the gross unearned income (Title II payment), and
Social Security subtracts the remaining balance from the individual’s applicable FBR to determine the reduced SSI cash payment.

- SSI recipients who work and earn less than the Substantial Gainful Activity (SGA) guideline can establish “insured status” and eventually become eligible for Social Security Disability Insurance (SSDI). If the countable SSDI benefit is more than the current FBR, the person’s SSI will stop, but if the benefit is below the SSI FBR plus the $20 General Income Exclusion (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.

- An SSI recipient over the age of 50 may become a concurrent beneficiary if a current or former spouse dies and the individual establishes eligibility for Disabled Widow(er)s benefits (DWB). The SSI cash payment will be reduced by the countable portion of that monthly benefit.

- If an individual receives a Title II disability benefit, and then becomes entitled to SSI through use of a Plan to Achieve Self-Support (PASS), that individual also becomes a concurrent beneficiary.

Keep in mind that SSI is the payer of last resort. If an individual is eligible for any other Social Security benefit, Social Security must provide 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.
Work and Concurrent Beneficiaries

Social Security treats earned income for concurrent beneficiaries in the same way as other SSI recipients or Title II disability beneficiaries. There are no special work incentive rules for concurrent beneficiaries; the only difference is that concurrent beneficiaries have two different forms of disability benefits and earned income affects each benefit differently. An added complication is that the Title II benefit counts as unearned income for SSI, so changes in the Title II benefit will affect the SSI cash payment. The other thing to keep in mind is that most concurrent beneficiaries are also dually entitled to Medicaid and Medicare. The work incentives for these healthcare programs are the same for concurrent beneficiaries as they are for SSI recipients and Title II disability beneficiaries, but things can get complicated since concurrent beneficiaries often are enrolled in a Medicare Savings Program and may get help from the Low-Income Subsidy (LIS) to pay for the costs of Medicare Part D. Community Work Incentives Coordinators (CWICs) have lots of different benefits to consider with concurrent beneficiaries who go to work. Let’s take a look at how all of this works.

Work and Cash Payments for Concurrent Beneficiaries

When a concurrent beneficiary starts working, typically the first thing that happens is either a reduction in or loss of the SSI cash payment. This is due to the earned income, in combination with the unearned income (the Title II benefit payment), causing the person to lose entitlement to SSI cash payments. You learned about the SSI Calculation Sheet, how Social Security determines countable income, and how countable income reduces the SSI cash payment in Chapter 3. Concurrent beneficiaries already have reduced SSI cash payments before they go to work because Social Security counts the Title II cash payment as unearned income. Some concurrent beneficiaries have small SSI cash payments and it may not take much earned income to cause total countable income to make the person ineligible for SSI payments. Losing SSI cash payments due to earned income does not mean the person becomes ineligible for SSI. As long as an individual...
meets the requirements for 1619(b) Medicaid While Working, they will still be considered SSI eligible, simply not due a payment.

Now let’s look at the Title II disability benefit. Let’s assume the beneficiary has not worked since he or she became entitled to benefits. If the beneficiary has earnings under the current Trial Work Period (TWP) amount, they will not use any work incentives and benefits will continue unchanged. If the beneficiary has earnings over the TWP amount, but under the SGA guideline, they will use TWP months, but benefits will continue unchanged. If the beneficiary has countable earnings over the current Substantial Gainful Activity (SGA) guideline on an ongoing basis, they will use their TWP and Social Security will eventually cease the Title II cash payment. While the beneficiary remains in the Extended Period of Eligibility (EPE), Social Security will not terminate Title II benefits but will suspend them due to countable earned income over SGA. If the beneficiary continues to work above the SGA level work after the EPE, Social Security will eventually terminate the beneficiary from Title II disability benefits. Remember in the Title II disability program, benefits are not reduced by earned income. Beneficiaries either get their full benefit amount or no benefit at all.

For concurrent beneficiaries, if the Title II benefit stops due to SGA, SSI cash payments may resume or increase as long as total countable income is below the person’s highest SSI payment and the individual has maintained eligibility for 1619(b) or is in the 12-month suspension period. In many cases, the loss of the Title II payment means the countable income will now be low enough that a cash SSI payment is due. This interaction between SSI and the Title II disability benefits for working concurrent beneficiaries may seem confusing, but during initial training, your instructors will walk you through some examples and teach you how this works.

All of the special work incentives that apply in the SSI program and the Title II disability program also apply for concurrent beneficiaries with no differences. For individuals who have Impairment Related Work Expenses (IRWEs), the same expenses may be used to reduce countable earned income for both benefits at the same time. For example, an individual who had IRWEs of $100 each month would apply this expense to reduce countable earnings and keep more of the SSI cash payment. If the beneficiary had gross wages above the SGA
guideline, they could apply that same $100 of IRWEs to reduce how much earned income counted during an SGA determination.

The only exception to this is for beneficiaries who meet Social Security’s blindness definition. In that case, the Social Security can deduct the amount of the IRWE as an IRWE for Title II, but Social Security will deduct that same expense as a Blind Work Expense (BWE) for SSI. BWE does not exist in the Title II program.

Keep in mind that concurrent beneficiaries often are strong candidates for a Plan to Achieve Self-Support (PASS) since the Title II payment is a form of unearned income that can be used right away to fund the PASS. CWICs should explore PASS potential with all concurrent beneficiaries to ensure they do not overlook this possibility.

**Work and Healthcare Benefits for Concurrent Beneficiaries**

In most cases, as long as a concurrent beneficiary retains a small SSI payment, Medicaid eligibility will continue. If the SSI cash payment stops due to earnings, the beneficiary will move into 1619(b) Medicaid status – assuming they meet all five eligibility requirements for this provision. Social Security still considers the individual an SSI recipient while in 1619(b) status, even though the individual receives no cash payment. As long as an individual remains eligible for 1619(b), they have the ability to move back into SSI cash benefit status without filing an application if countable income drops below that person’s maximum potential SSI payment. The individual also will retain access to the 12-month suspension period protection in case they lose SSI eligibility for reasons other than earned income (e.g. excess unearned income or resources).

With regard to Medicare, as long as the beneficiary remains eligible for a Title II disability benefit, Medicare will continue unchanged. If the beneficiary completes their TWP, engages in SGA, and eventually terminates from Title II benefits, Medicare may continue for at least 93 months after the end of the TWP due to the Extended Period of Medicare Coverage (EPMC) provision.
Work and Medicare Savings Programs (MSPs)

In Chapter 2, we discussed how the Medicare Savings Programs (MSPs) help Medicare beneficiaries cover some or all of the out-of-pocket costs associated with Medicare, including premiums, co-payments and deductibles. There are four different Medicare Savings programs:

- Qualified Medicare Beneficiaries (QMB),
- Special Low-Income Medicare Beneficiaries (SLMB),
- Qualified Individuals (QI), and
- Qualified Disabled Working Individuals (QDWI).

Concurrent beneficiaries often are enrolled in an MSP because they have income and resources low enough to qualify for a partial SSI benefit. Because MSPs are all financial needs-based programs, when a person begins working, their eligibility could change from one level to another, or end altogether. In some states, as long as a beneficiary retains Medicaid eligibility, the state will continue to pay the Medicare Part B premium, but this does not happen in all states. To evaluate the effect of work on MSPs, you should take the following steps:

1. Get to know the MSP rules for the states within your service area. Some states have chosen to set higher income and/or resource levels than the minimum levels required by federal law.

2. If the beneficiary lives in a state that continues to pay Part B premiums as long as they retain SSI-related or 1619(b) Medicaid eligibility, check to make sure they will meet the requirements for SSI-related Medicaid or 1619(b) Medicaid While Working. If so, no further steps will be necessary. If the beneficiary does not live in a state that provides this benefit, or if the beneficiary would not qualify for 1619(b), move to the next step.

3. Calculate total countable income. To do this, CWICs use a special MSP calculation sheet that is very similar to the SSI Calculation Sheet. The MSPs use the same income methodology as the SSI program, so all of the income deductions and exclusions that apply in the SSI program also apply to income when the state Medicaid agency is determining...
eligibility for an MSP. You will find a copy of MSP Calculation Sheet on the NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=184).

4. Compare total countable income to the MSP income levels in your state. These are percentages of the current Federal Poverty Level (FPL) used in most states.
   - **QMB**: 100% FPL
   - **SLMB**: 120% FPL
   - **QI**: 135% FPL
   - **QDWI**: 200% FPL

5. Identify if the beneficiary will remain in the same coverage level, move to a lower coverage level (QMB to SLMB or QMB to QI), or lose eligibility for MSPs altogether.

Determining countable income for the MSPs is nearly identical to the process Social Security uses in the SSI program. The main difference is that with the MSPs, the countable income is not compared to the FBR, but to the appropriate percentage of the current FPL. You will have an opportunity to practice using the MSP Calculation Sheet during initial training.

**Medicare Part D Low-income Subsidy (LIS) and Earnings**

As you recall from Chapter 2, there is another special program that helps Medicare beneficiaries cover the costs of the Part D prescription drug program called the Low-income Subsidy (LIS) or Extra Help. Like the MSPs, the LIS is a means-tested program, so beneficiaries who go to work could earn enough to lose eligibility entirely.

An important thing to remember about the LIS is that some people are “deemed” eligible for the program without requiring Social Security to evaluate income or resources. The following groups are deemed LIS eligible:
   - Medicaid enrollees;
   - SSI recipients; and
• Individuals enrolled in certain MSPs (QMB, SLMB, or QI).

The good news is that most concurrent beneficiaries are deemed eligible for LIS and remain eligible after they work because they remain in a deemed eligible group. As long as a working concurrent beneficiary would still be eligible for an SSI payment, qualify for Medicaid (including 1619(b) coverage) or remain eligible for certain MSPs (QMB, SLMB, or QI), they will continue to get LIS benefits. There is no need to calculate countable income for someone who is deemed eligible for LIS.

Individuals who are eligible for LIS (but not deemed eligible) must continue to meet the income and resource requirements to remain eligible for LIS. Depending on how much countable income a person has after they start working, they could lose eligibility for the LIS. You will find an LIS Calculation Sheet on the NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=185).

Do not worry if the LIS calculations seem complicated. You will have an opportunity to practice using the LIS Calculation Sheet during Initial Training. Remember – most concurrent beneficiaries will remain deemed eligible for extra help even after they begin working. You will not need to perform countable income calculations for these individuals.

**Reporting Income and Resource Changes and LIS Redeterminations for Those Not Deemed Eligible**

To determine LIS eligibility for those not deemed eligible, 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 LIS eligibility based on income projected for 12 months, the computation is not linked to a particular calendar year. The LIS 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 applies for LIS, 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 LIS until Social Security processes a redetermination or a subsidy-changing event.
This sounds confusing, so let’s look at an example. Let’s say Ms. Smith files for LIS in August. The LIS 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 Cost of Living Adjustment (COLA), or the expected increase in the FPL limits due to the annual FPL update (usually in February). The LIS determination system needs this type of computation because the individual’s income for next January and next year’s FPL amount aren’t available in August when Social Security is processing the claim.

Social Security makes LIS determinations for a calendar year and will not change them during the year unless the individual:

- Appeals the determination;
- Reports a subsidy-changing event; or
- Becomes eligible for SSI, Medicaid, or an MSP and is therefore deemed eligible for LIS.

Two types of events can affect the LIS determination:

- Subsidy Changing Events, which are effective the month after the month of report, and
- Other Events, which are events that may change the LIS determination, but do not become effective until the January following the report (or later in some cases).

There are six Subsidy Changing Events that will result in the re-determination of LIS eligibility for 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
Events other than the six Subsidy Changing Events listed above may affect a beneficiary’s LIS eligibility, 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. Social Security does not require LIS beneficiaries to report changes as they occur. **There are NO mandatory reporting rules in the LIS program.**

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 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.


**Next Steps**

Providing WIPA services to concurrent beneficiaries can be complicated since they receive two very different types of disability benefits, both Medicaid and Medicare, and in many cases, help with Medicare out-of-pocket costs from Medicaid or an MSP and the LIS. In some cases, concurrent beneficiaries have additional complicating factors such as being married, or having children who also receive some form of benefit that paid employment might affect. During initial training, you will work through a case study and get some practice determining the effect of work on a concurrent beneficiary. You will still need to get additional training and technical assistance to develop the competence you need to provide comprehensive WIPA services to this population. Here are some steps you can take:
• You can begin by reading a resource document on the NTDC website entitled **Concurrent Beneficiary Issues and Considerations** ([https://vcu-ntdc.org/resources/viewContent.cfm?contentID=76](https://vcu-ntdc.org/resources/viewContent.cfm?contentID=76)). This will provide you with a good overview of the work incentives counseling issues specific to this group of beneficiaries and provides tips for working with this group.

• Understanding the effect of work on the MSPs and the LIS is one of the most complex aspects of working with disability beneficiaries – especially concurrent beneficiaries. You will find several **archived supplemental training sessions** about these areas on the NTDC website ([https://vcu-ntdc.org/training/supplemental/archives.cfm](https://vcu-ntdc.org/training/supplemental/archives.cfm)). We have already referenced **several resource documents** that cover these provisions that you can find on the NTDC website ([https://vcu-ntdc.org/resources/resourceDetail_search.cfm?id=5](https://vcu-ntdc.org/resources/resourceDetail_search.cfm?id=5))

• Make sure you contact your assigned NTDC Technical Assistance Liaison the first time you have a referral for a concurrent beneficiary. You probably are going to need some help to figure out all of the information you need to gather and verify since concurrent cases can be so complex. Before you provide individualized counseling, you may also need your TA Liaison to review the information you gathered to make sure you have not overlooked anything. It’s important to do this BEFORE you submit a concurrent case for review during Part II of the certification process.

• The multi-step concurrent beneficiary exercise you will complete during initial training will provide you with a lot of valuable information. Be sure to keep all of the material you used during initial training so you can refer to it when you have an actual concurrent case.
Part I Chapter 7 – Social Security Disability Determinations, Medical Disability Reviews, Appeals Process, and Overpayments
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Chapter 7 – Social Security Disability Determinations, Medical Disability Reviews, Appeals Process, and Overpayments

Learning Objectives

After you have read this chapter and completed the associated lectures and activities during WIPA Initial Training, you should be able to:

1. Describe the application process for Supplemental Security Income (SSI) and the Title II disability benefits;

2. Describe Social Security’s definition of disability and identify the three core components of this definition;

3. Identify the steps the Disability Determination Services (DDS) follows when making disability determinations;

4. Describe how Social Security conducts ongoing medical reviews (called Continuing Disability Reviews or CDRs);

5. Describe the process beneficiaries may use to appeal initial disability determinations, CDRs, or other determinations when they disagree with Social Security’s decisions; and

6. Describe Social Security’s overpayment recovery process and how beneficiaries may request a waiver of overpayment.

List of Acronyms

- AC – Administrative Council
- LJ – Administrative Law Judge
- CDR – Continuing Disability Review
- CE - Consultative Examination
- CWICs – Community Work Incentives Coordinators
- DDS – Disability Determination Service
Introduction

This chapter will provide you with a basic understanding of the following key concepts:

- The application process for Supplemental Security Income (SSI) and the Title II disability benefits;
- How Social Security defines disability and the process the agency uses to determine if a claimant meets this definition;
- How Social Security conducts ongoing medical reviews (called medical Continuing Disability Reviews or medical CDRs) to ensure that disability beneficiaries continue to meet the disability standard after initial entitlement;
- The process beneficiaries may use to appeal initial disability determinations or CDRs when they disagree with Social Security’s decisions; and
- What happens when Social Security pays an individual more in benefits than is due, how the agency recovers those funds, and options beneficiaries have for dealing with overpayments.

For the most part, the processes we cover in this chapter apply in the same manner to both SSI benefits and the Title II disability benefits. However, there are a few notable exceptions to this rule that we will point out and explain. Our discussion of the processes in this chapter will be summary in nature as these processes fall outside of the main role Community Work Incentives Coordinators (CWICs) perform when working with beneficiaries. As a CWIC, you need to understand that you have a limited role in helping beneficiaries with initial applications, supporting beneficiaries during the medical CDR process, or helping
with appeals or overpayments. It is important that CWICs gain a basic understanding of these processes to better inform their primary duties, but Social Security does not expect CWICs to develop expertise in these areas or provide services in these areas beyond their work scope.

Applying for Social Security Disability Benefits

Before we discuss the disability determination process, let’s provide a brief overview of how people go about applying for disability benefits. While CWICs work with individuals who are already receiving benefits, there can be times when a beneficiary is potentially eligible for a different Social Security benefit and you might need to provide information about the application process. Individuals may apply for the Title II disability benefits or SSI benefits in three ways:

1. **Apply online by going to the Social Security website** (https://www.ssa.gov/applyfordisability/#a0=0).

2. Apply at the nearest **Social Security field office**. You can find an office locator on the Social Security website (https://secure.ssa.gov/ICON/main.jsp). Individuals should call the local field office first to make an appointment rather than just stopping by. Due to the COVID pandemic, some field offices may not be able to accept in-person appointments.

3. 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.

Beneficiaries who choose to apply online can find a [checklist of information they will need to complete the online application](https://www.ssa.gov/hlp/radr/10/ovw001-checklist.pdf) at Social Security’s website. An important part of the application process for adults is completing a form called the **Adult Disability Report** (https://www.ssa.gov/forms/ssa-3368-bk.pdf).
Individuals who apply in person or by phone need to be prepared to provide names, addresses, and phone numbers of the doctors, caseworkers, hospitals, and clinics that would have information about the disability. In addition, Social Security will ask for medical records from doctors, therapists, hospitals, clinics, and caseworkers and names of all medicines with dosage. The application process also requires claimants to provide a summary of work history and documentation of recent earnings such as a copy of the most recent W-2 form (Wage and Tax Statement).

Individuals who are applying for SSI need to provide some additional information such as proof of living arrangements with documentation of living expenses, proof of earned or unearned income, and proof of resources. This extra documentation is required because SSI is a mean-tested program with income and resource limits. There are also some special procedures for children who apply for SSI that you find on Social Security’s website (https://www.ssa.gov/benefits/disability/apply-child.html).

Social Security offers helpful Disability Starter Kits (https://www.ssa.gov/disability/disability_starter_kits.htm) to help claimants get ready for a disability interview or online application. Kits are available for adults and for children under age 18.

The starter kits provide information about the specific documents and the information that Social Security will ask for. The kits also provide general information about the disability programs and Social Security’s disability decision-making process that can help take some of the mystery out of applying for disability benefits.

Once an individual submits their application, Social Security will provide confirmation of receipt - either electronically or by mail. Social Security will contact the individual if they need more information or documentation. For more information about how to apply for Social Security disability benefits refer to Social Security’s website (https://www.ssa.gov/disability/disability.html).
Overview of Social Security’s Initial Disability Determination and Medical Review Processes

To be found eligible for disability benefits, claimants first need to meet certain non-medical requirements that we discussed in detail in Chapters 1 and 3. For example, in order to qualify for Social Security Disability Insurance (SSDI), individuals must have earned enough credits from working to be insured for disability. For SSI benefits, non-medical requirements include having income and resources under certain limits. Social Security field offices are responsible for verifying all non-medical eligibility requirements including age, employment, marital status, or Social Security coverage information. If the claimant meets all of the non-medical requirements, the field office then sends the case to a special state agency called the Disability Determination Service (DDS) for evaluation of disability. Social Security personnel do not make disability decisions – those are performed exclusively by DDS.

Understanding the Disability Determination Service Agencies

The State Disability Determination Services (commonly referred to as DDS) are fully funded by the federal government to perform disability evaluation. In some states, the DDS may go by another name such as the Disability Determination Bureau. These state agencies are responsible for developing medical evidence and determining whether the claimant is or is not disabled or blind under Social Security law.

When evaluating disability, the DDS usually 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 is reviewed by quality review analysts at the state DDS office or at a federal Social Security branch. After quality review, cases are 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 notifies the claimant and retains the file in case the claimant decides to appeal the determination.

**Ongoing Medical Reviews**

Medical evaluation does not stop after Social Security initially determines a beneficiary to be disabled and eligible for disability benefits. Social Security is required by law to conduct periodic medical reviews of all disability beneficiaries to determine if they continue to meet the agency’s disability standard. If Social Security determines that an individual no longer meets the disability standard, benefits will stop. These periodic medical reviews are called medical Continuing Disability Reviews (medical CDRs).

Social Security contracts with the DDS agencies to perform medical CDRs in addition to initial disability determinations. 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 to make initial determination. Once individuals are entitled to benefits, the DDS does not 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 is sufficient medical improvement, Social Security terminates the person’s benefits.

**Understanding Your Role in Initial Disability Determinations and Medical Continuing Disability Reviews**

Social Security has some important rules that CWICs who work for WIPA programs must follow when providing services to disability beneficiaries. These rules place certain limits on the kinds of services
CWICs are allowed to provide to ensure that CWICs spend the bulk of their time focused on work incentives counseling. As you review the information in this chapter, keep the following limits on your role in mind:

1. WIPA services are restricted to individuals who have already been found eligible for Social Security disability benefits. Since individuals who are not already on disability benefits are not eligible for WIPA services, CWICs would not typically be able to help with initial applications.

2. There will be instances when an individual who already receives a disability benefit from Social Security may potentially be 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 as appropriate. Your role in these cases is to provide information, but not to help with completing the application.

3. Social Security does not allow CWICs to assist beneficiaries during medical CDRs other than providing basic information about the process and answering questions.

4. CWICs are not permitted to assist with the appeal process beyond providing basic information and answering questions. Social Security prohibits CWICs from representing beneficiaries during appeals.

5. CWICs should be cautious about the amount of time they spend helping beneficiaries with overpayments. Your role is to provide basic information about the options available – appeal or requesting a waiver of overpayment recovery. You may help get the beneficiary the necessary forms and explain how to complete them. You should not provide direct assistance with completing these forms.
Understanding the Initial Disability Determination Process

To meet the definition of disability under the Social Security Act, an adult claimant 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. The definition of disability under the Social Security Act quoted in the section above has three distinct criteria:

1. **The Earnings Test**: The person must be unable to perform SGA because of the impairment.

2. **The Medical Test**: The person must have a medically determinable impairment that can be documented by a qualified medical examiner. In addition, the disability must meet a certain level of severity as defined by Social Security.

3. **The Duration Test**: The disability must meet the duration requirement meaning that it must have lasted or can be expected to last for a continuous period of at least 12 months.

To receive benefits, the person must meet all three of these tests. In the Social Security system, there is no partial disability. A claimant either is found to meet the definition of disability or not. No benefits are provided to individuals who do not meet Social Security’s definition of disability. In addition, during initial disability claims, the burden of proof lies with the person filing the claim, not with Social Security.

The Sequential Evaluation Process

Social Security’s process for determining whether a claimant meets the definition of disability is called “the Sequential Evaluation Process”. This is the process that Social Security and DDS uses when they perform disability evaluations. The Sequential Evaluation Process consists of five questions that are asked in a prescribed order:
Step 1: Is the claimant performing SGA?

Social Security uses specific dollar amounts of monthly earnings to evaluate whether work activity is SGA. We provided a detailed explanation of the SGA guidelines and how Social Security makes SGA determinations in Chapter 1, so that information will not be repeated here. You can find the past and current SGA guidelines in Social Security’s Program Operations Manual System (POMS) (https://secure.ssa.gov/apps10/poms.nsf/lnx/0410501015#a).

Basically, if a claimant’s average countable earned income is above the applicable SGA guideline, they generally cannot be considered to have a qualifying disability. If the claimant is not working or is working but not performing SGA, Social Security will send your application to the DDS and they will complete Steps 2 - 5 of the sequential evaluation process to make the decision.

Step 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 does not meet the disability standard. If the impairment(s) is severe, the DDS continues to Step 3.

Step 3: Is the claimant’s impairment in 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) is not 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. The Listing of Impairments is available at
Social Security’s website
(https://www.ssa.gov/disability/professionals/bluebook/general-info.htm). If the medically determinable impairment does not meet or medically equal a listed impairment, the DDS goes to Step 4.

**Step 4: Can the claimant do the work that they did before?**

At this step, the DDS decides if the impairment(s) prevents the claimant from doing their past work as they 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 at this step. If past work is precluded, the DDS goes on to Step 5.

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

If the claimant cannot do the work they 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 cannot 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).

**Understanding Statutory Blindness**

In both the Title II and the SSI disability benefit programs, Social Security makes a distinction between individuals who are “disabled” and individuals who are “blind”. Social Security does this because there are several significant differences in the disability benefit rules for individuals who are blind. For example, SSI claimants who meet Social Security’s definition of statutory blindness are not subject to the first
step of the sequential evaluation – the SGA test. Statutorily 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 meeting income and resource limits.

To receive Social Security disability benefits due to blindness, individuals must meet the Social Security definition of being “statutorily blind”:

“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.” (20 CFR 404.1581)

To learn more about the differences in Social Security’s program rules for individuals who are blind, refer to a resource document on the NTDC website entitled Disability Program Differences for Individuals who are Blind (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=75).

**Childhood Definition of Disability in 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 SSI claimants under age 18 disabled if they have 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).
Age-18 Redeterminations in the SSI Program

Since the definition of disability for children in the SSI program is so different from the adult definition of disability, Social Security has to review the eligibility of all 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 unique review process the “age-18 redetermination”. The age-18 redetermination process only applies to SSI recipients. Title II disability beneficiaries are not 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.

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.

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 does not 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 disability criteria. The agency considers age-18 redeterminations to be initial eligibility decisions and applies the sequential evaluation process to make determinations with one notable difference. Social Security bypasses the first step of the sequential evaluation (are you currently engaged in SGA?) during an age-18 redetermination.

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 who 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.

For more information about the age-18 redetermination process, refer to a resource document on the NTDC website entitled Understanding Age 18 Re-determinations (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=22). You can also go to Social Security’s online Program Operations Manual System (POMS) DI 13006.000 Title XVI Age 18 Medical Redeterminations (https://secure.ssa.gov/apps10/poms.nsf/lnx/0413006000) and read about age 18 redeterminations.

Understanding the Continuing Disability Review Process

Once an individual initially meets the disability requirements, the DDS sets a date called a “diary” when it will review the individual’s disabling condition again to see if the disability continues. The “diary” is set for a certain period of time based on an assessment of how likely it is that the beneficiary’s medical condition will improve. There are three primary diaries: Medical Improvement Expected (MIE), Medical Improvement Possible (MIP), and Medical Improvement Not Expected (MINE).

1. 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.
2. 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 to five years.

3. Medical Improvement Not Expected (MINE)

MINE reviews apply to individuals with impairments that Social Security does not expect to improve either at initial entitlement or later, after further review. These are 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.

Medical Improvement Review Standard (MIRS)

The DDS applies a different standard when conducting medical CDRs than they apply during initial disability determinations. First, during a medical CDR, the burden of proof is on DDS to produce evidence that the beneficiary’s medical condition has improved. During an initial disability determination, the burden of proof lies with the beneficiary. Second, during medical CDRs, the DDS does not use the sequential evaluation process to decide if the beneficiary meets Social Security’s definition of disability since that was already established during the initial disability determination. Instead, DDS applies a different process to determine if the beneficiary meets something called the Medical Improvement Review Standard (MIRS).

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). Like the initial determination, the MIRS definition has two parts:
medical improvement and the ability to perform SGA. Under the MIRs,
Social Security will determine that a beneficiary is no longer disabled
only if the evidence demonstrates medical improvement related to work
since the last favorable disability determination and the ability to
engage in SGA.

In addition to the regularly scheduled medical CDRs, there are two
additional times when the DDS applies the MIRS instead of the initial
disability standard:

1. When Social Security conducts age 18 re-determinations in the
   SSI program, and

2. During medical decisions DDS makes for individuals who are
   applying for Expedited Reinstatement (EXR) of benefits.

The Medical CDR Process

When Social Security initiates a medical CDR, not all beneficiaries are
subjected to a full review of medical evidence. 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.

More information about the CDR process is available in the POMS
starting with DI 28005.000 - The CDR Evaluation Process

You can find a helpful brochure about the medical CDR process entitled
How We Decide If You Still Have A Qualifying Disability on Social

Protection from Medical CDRs

The Ticket to Work and Work Incentives Improvement Act of 1999
created two provisions that protect beneficiaries from medical CDRs:
1. 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 Part II of this manual.

2. 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 CDR. A beneficiary does not need to have a Ticket or be using a Ticket to be afforded this second medical CDR protection.

**Continued Payments under Section 301 of the Social Security Act**

When Social Security personnel conduct a medical Continuing Disability Review (CDR) or an age-18 redetermination, they may find that a beneficiary no longer meets the medical requirements to receive disability benefits. If that happens, Social Security usually stops the individual’s cash benefits and associated health insurance (Medicare and/or Medicaid). However, Social Security may continue to provide cash disability payments and medical insurance (Medicare and/or Medicaid) to certain individuals who are participating in programs that may enable them to become self-supporting. This includes the Ticket to Work program or another program of vocational rehabilitation (VR) services, employment services, certain special education programs, or other support services if Social Security determines that completion or continuation of the program will increase the likelihood of the individual’s permanent removal from the disability benefit rolls. Social Security refers to this special continuation of benefits as “Section 301” because the initial legislative authority for continued payment of benefits to individuals in a VR program was provided in Section 301 of the Social Security Disability Amendments of 1980. Continued benefits under Section 301 applies to both SSI and title II disability benefits.

Beneficiaries may qualify for continued payments under Section 301 when they meet the following criteria:
1. They are participating in an appropriate VR program or similar services that began before the month of their disability stopped under Social Security’s rules; and

2. Social Security reviews the program and decides that if the beneficiary continues in the program, they are not likely to resume disability benefits. Some examples of appropriate VR programs include:

   • An Individualized Education Program (IEP) for a youth who is age 18 through 21.
   • A VR agency using an individualized plan for employment
   • Support services using an individualized written employment plan.
   • A written service plan with a school under Section 504 of the Rehabilitation Act.
   • An approved Plan to Achieve Self-Support (PASS).

Under Section 301, benefits may continue until the beneficiary completes the program, stops participating in the program or Social Security determines that continued participation in the program is unlikely to keep the beneficiary from coming back onto disability benefits.

The process by which benefits may be continued under Section 301 is very complex. We provide a brief overview in this chapter so that CWICs gain an awareness that in some rare cases, benefits may be temporarily continued even after Social Security has determined that an individual no longer meets the disability standard. To gain a deeper understanding of Section 301 determinations, refer to a resource document entitled Understanding Section 301 available on the NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=25).

**When Beneficiaries Disagree with Social Security**

A Social Security claimant or beneficiary who disagrees with an initial determination or decision has a right to request further review. This is
called an appeal and there are several levels to this process. Beneficiaries must make most requests for reconsideration within 60 days of the date they received the notice of the decision. Social Security assumes beneficiaries will have received the notice within five days of the date Social Security mailed it. If an individual requests an appeal past the 60-day appeal window, they may lose the right of further review unless they can show good cause failing to make a timely request for review.

Individuals must request an appeal in writing and there are several ways to start this process. Individuals may call Social Security and ask for an appeal form or mail in a written note requesting to make an appeal. Beneficiaries can also download the Request for Reconsideration (Form SSA-561) from Social Security’s website (https://www.ssa.gov/forms/ssa-561-u2.pdf) and send the completed form to their local field office. The fastest and easiest way to file an appeal of a decision is by visiting Social Security’s appeal webpage (https://www.ssa.gov/benefits/disability/appeal.html?tl=0). Individuals can file an appeal request online and upload documents online to support their appeal, which will help decrease the time it takes to receive a decision.

Levels of Appeal

The appeal process 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 1) Reconsideration 2) Administrative Law Judge (ALJ) hearing, and 3) Appeals Council (AC) review as listed below. 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.

1. Reconsideration

In most cases, reconsideration is the first step in the administrative review process for individuals who disagree with the initial determination. Social Security also 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.

2. Administrative Law Judge Hearing
If a beneficiary disagrees with the determination Social Security made at the reconsideration level, they may ask for a hearing. An administrative law judge who had no part in the original determination or the reconsideration of the case conducts the hearing. When Social Security schedules hearings they consider what’s convenient and close for the beneficiary. They usually schedule hearings within 75 miles of a person’s home. In certain situations, hearings may be held via video at a hearing site, in person at one of our hearing offices, or from another location.

3. 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.

The AC review completes the administrative review process. If an individual is still dissatisfied, they may request judicial review by filing a civil action in a federal district court.

Each of the appeal steps has required forms and timeframes. 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 Social Security will need to make a decision.

For more information, refer to POMS GN 03101.001 - Summary of Administrative Review Process (https://secure.ssa.gov/apps10/poms.nsf/lnx/0203101001).
You can also find a helpful brochure entitled *Your Right to Question The Decision Made On Your Claim* on Social Security’s website (https://www.ssa.gov/pubs/EN-05-10058.pdf).

**Overpayment of Benefits**

An overpayment occurs when Social Security pays a beneficiary more than they should have 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 provides an overview of the appeal and waiver rights.

If the beneficiary agrees that Social Security paid them 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 Federal Benefit Rate (FBR) each month to recover the overpayment. If the beneficiary cannot afford this, they may ask that Social Security withhold less each month. Beneficiaries may also request that they pay back the overpayment at a rate greater than 10 percent. Social Security will not start deducting money from the SSI payments until at least 60 days after the agency notifies the beneficiary of the overpayment.

Beneficiaries who no longer receive SSI, but continue to receive Social Security disability benefits, can pay back the SSI overpayment by having Social Security withhold up to 10 percent of the monthly Title II benefit. If the beneficiary is not receiving any benefits from Social Security, 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 is not receiving benefits and does not pay back the amount by using one of the above options, Social Security can recover the overpayment by withholding federal income tax refunds due to the beneficiary or, in some cases, from wages if the beneficiary is working. Social Security can also recover overpayments from future SSI or Social Security benefits.

Social Security provides lots of helpful information about overpayments on their website (https://www.ssa.gov/overpayments/?tl=0%2C1%2C2%2C3).

**Overpayment Appeal and Waiver Rights**

Beneficiaries who do not agree that an overpayment occurred, or believe the amount is incorrect may file an appeal using the same procedures described previously. The appeal request should also include any evidence the beneficiary has to support their argument. For example, if a beneficiary is appealing an overpayment related to work activity, and Impairment Related Work Expenses (IRWE) were not considered as part of the determination, the beneficiary should present IRWE receipts.

Beneficiaries who agree that an overpayment occurred, but believe they should not have to pay the money back may request a waiver of collection. Beneficiaries must submit Form SSA-632 to request a waiver and you can find this SSA-632 form [Request for Waiver of Overpayment Recovery](https://www.ssa.gov/forms/ssa-632.html). Beneficiaries can also get the form by calling or visiting the local Social Security office. To have the overpayment waiver request approved, the beneficiary will have to prove that:

- The overpayment was not their fault; and
- Paying it back would cause financial hardship or be unfair for some other reason.

Social Security will stop recovering the overpayment until it decides on the appeal or approves a waiver of overpayment recovery. There is no time limit for filing a waiver request.
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 should not 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. Social Security refers to this re-examination process as a “reopening”.

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 do not 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 (https://secure.ssa.gov/apps10/poms.nsf/lnx/0427505000); or SI 04070.010 Title XVI Administrative Finality - Reopening Policies (https://secure.ssa.gov/apps10/poms.nsf/lnx/0504070010).
Next Steps

CWICs need to have a basic understanding of the concepts covered in this chapter, but should understand that these areas are all outside of the primary work performed by a CWIC who works in a WIPA program. In most cases, when you have a question about disability determinations, medical CDRs, Social Security’s appeals process, or overpayments you should reach out to your assigned NTDC TA Liaison. If you would like to develop more advanced competence in any of these areas, you may complete the following next steps:

1. Beneficiaries often ask CWICs questions about what to do when an overpayment occurs. While CWICs do not spend a great deal of time helping with overpayments, they do need to provide information to beneficiaries about how to manage them. For detailed information about overpayments in the Social Security disability system, you may complete an archived training entitled Social Security Disability Benefit Overpayments - What CWICs Need to Know on the NTDC website (https://vcu-ntdc.org/training/supplemental/archives.cfm).

2. The SSI age-18 redetermination process is an area that CWICs need to have a solid understanding of when they provide services to transition aged youth. We have a resource document you may read to gain a deeper understanding of this process entitled SSI and Age-18 Redeterminations found at the NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=22). You will also find an archived training that covers age-18 redeterminations on the NTDC website (https://vcu-ntdc.org/training/supplemental/archives.cfm).

3. Finally, Section 301 Continuation of Coverage is a very complex topic that is particularly important to understand when you provide WIPA services to transition age youth. You will find a detailed resource document entitled Understanding Section 301 on the NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=25).
Part I Chapter 8 – The Effect of Work on Other Common Benefits
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Chapter 8 – The Effect of Work on Other Common Benefits

Learning Objectives

After you have read this chapter and completed the associated lectures and activities during WIPA Initial Training, you should be able to:

1. Describe what a “household” is for the purposes of the Supplemental Nutrition Assistance Program (SNAP).

2. Describe the basic eligibility requirements for SNAP.

3. Describe the basic resource and income rules that apply to SNAP.

4. Describe the basic effect of paid employment on the SNAP allotment and eligibility.

5. Identify and describe the three common forms of rental subsidy provided through the federal housing programs administered by the U.S. Department of Housing and Urban Development (HUD).

6. Describe HUD’s income definitions and what constitutes a “family”.

7. Describe the basic calculations Public Housing Authorities (PHAs) use to determine countable income for rental subsidies.

8. Identify the common income exclusions and deductions PHAs apply when determining countable income for rental subsidies.

9. Describe the Earned Income Disregard (EID) and how the EID applies to reduce countable income when PHAs determine rental subsidy for those beneficiaries allowed to complete their EID period prior to the elimination of EID as of January 2026.
List of Acronyms

- COLA – Cost of Living Adjustment
- CWIC – Community Work Incentives Coordinator
- DoD – Department of Defense
- EBT – Electronic Benefits Transfer
- EID – Earned Income Disregard or Disallowance
- FPL – Federal Poverty Level
- HUD – Department of Housing and Urban Development
- PHA – Public Housing Authority
- SNAP – Supplemental Nutrition Assistance Program
- TANF – Temporary Aid to Needy Families
- USDA – U.S. Department of Agriculture
- VA – Veterans Administration

Overview

In addition to the disability benefits administered by Social Security, many beneficiaries receive assistance from other federal, state or local income support programs. Most of these benefits are means-tested and paid employment may affect the level of assistance a beneficiary receives or cause ineligibility entirely. This chapter only covers the two most common benefit programs CWICs encounter: the Supplemental Nutrition Assistance Program (SNAP) and the rental subsidies provided by the U.S. Department of Housing and Urban Development (HUD). These are the benefits you are most likely to see when you begin providing benefits counseling services after you achieve provisional certification. Social Security requires Community Work Incentives Coordinators (CWICs) to gain competency in understanding how paid employment affects a variety of additional benefit programs, including:

- Unemployment Insurance;
- Workers’ Compensation;
- Benefits provided to veterans by the U.S. Department of Veterans Affairs (the VA) and the U.S. Department of Defense (DoD);
- Temporary Assistance to Needy Families (TANF); and
• Other benefits such as Low-income Home Energy Assistance Program (LIHEAP), Black Lung benefits, and Railroad Retirement benefits.

To help CWICs gain the necessary competency in how paid employment may affect the benefit programs listed above, Social Security requires provisionally certified CWICs to complete a detailed web course offered by VCU’s NTDC. You will need to complete this course after you achieve provisional certification. Completing this course is mandatory for full certification.

The material presented in this chapter and the required web course reflects only the federal rules governing each program or benefit. Some programs permit state variance and even encourage it. This means that developing competency in these areas does not stop with this manual, but merely begins here. You must conduct independent research into each of the programs listed above to gain a functional knowledge of the state-specific variations that may apply in the areas you serve.

There are a variety of resource documents covering various federal, state, and local benefits available on the NTDC website (https://vcu-ntdc.org/resources/resourceDetail_search.cfm?id=4).

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. Until 2008, SNAP was known as the Food Stamp program. Individuals eligible to receive SNAP may include those who work for low wages, people who are unemployed or who work part-time, 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 Medicaid and the Temporary Aid to Needy Families (TANF) program. You will find a directory of state SNAP agencies and other resources on the USDA website (https://www.fns.usda.gov/snap/state-directory).
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 is 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 are several special exceptions to this rule for elderly persons and disabled persons living in group settings.

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 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.

**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. The rules below apply in all states:

- In order to qualify for SNAP benefits, all members of the household, including children, must have a Social Security number. A household member who does not have a Social Security number can choose not to apply for benefits, but the
program will still count their income and resources to determine eligibility for the remaining household members.


- Generally, students, ages 18 through 49, who are enrolled in college at least half time are not eligible for SNAP unless they meet certain specific exemptions (https://www.fns.usda.gov/snap/students).

- If all members of a household are receiving Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI), the household may be deemed “categorically eligible” for SNAP because they have already been determined eligible for another means-tested program. In some states, the SSI application is also an application for SNAP if the individual lives alone. You will find information about SNAP and other nutritional programs on Social Security’s website (www.ssa.gov/pubs/EN-05-10100.pdf).

- 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. The SNAP work requirements do NOT apply to individuals with disabilities.

**SNAP Resource Limits**

Currently, to qualify for SNAP, households may have up to $2,750 in countable resources, or $4,250 in countable resources if at least one person is age 60 or older, or is disabled. These amounts are updated annually. 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 lower determinations of household assets. Some states exclude the value of all vehicles entirely while others totally exclude the value of at least one vehicle per household. For more information concerning state specific vehicle policies, check with the state agency that administer the SNAP programs in your service area.

**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 states, 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 Federal poverty level (FPL) 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 dependent care deduction when needed for work, training, or education;
- Medical expenses for elderly or disabled members that are more than a specified amount per month if they are not paid by insurance or someone else;
- In some states, legally owed child support payments;
• Some states allow homeless households a set amount for shelter costs;
• Funds set aside in an approved Plan to Achieve Self-Support (PASS); 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 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. You will find the current SNAP deduction amounts on the USDA SNAP website (https://www.fns.usda.gov/snap/recipient/eligibility). It is important to understand that the deductions described above are only the most common ones. There are many other income exclusions and some types of income do not count at all. The SNAP income rules are quite complex and may vary significantly by state.

**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 income 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.

**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 them 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.

**Effect of Work on SNAP Benefits**

Since SNAP is a means-tested program, changes in income, including earned income may cause a reduction in benefits or program ineligibility. Fortunately, the SNAP program does include a standard 20 percent deduction from earned income. In addition, funds set aside in an approved PASS are excluded during SNAP income determinations.

In some states, the state agency that administers SNAP or a local human service agency has created an online calculator to estimate a SNAP benefit amount. Beneficiaries may use these online calculators to estimate how much their SNAP allotment will be after they begin working. You will need to conduct research in your state to determine if a state-specific SNAP calculator is available.
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 an “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 are not 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.

The work requirements of the SNAP program do not 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. Beneficiaries must provide proof of medical expenses and insurance payments to receive the deductions.

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 to the allowable amount of the deduction, but for a household with an elderly or disabled member the SNAP agency may deduct all shelter costs over half of the household's income.

For more information about **SNAP rules that apply to individuals who are elderly or disabled**, refer to the USDA Food and Nutrition website (https://www.fns.usda.gov/snap/eligibility/elderly-disabled-special-rules).

**Rights and Responsibilities under SNAP**

Beneficiaries have certain rights under the SNAP program, including the right to:

- Receive an application and have SNAP accept it on the same day.
- Receive SNAP benefits 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 is also the beneficiary’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.

**Federal Housing Assistance Programs**

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. If family income decreases, their share of the rent usually goes down as well. 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 funds a variety of rental-subsidy programs. The three main programs are:

1. **Public Housing:**

   PHAs own and operate public housing, although the funding comes from HUD. Subsidies apply to different housing options, 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](https://www.hud.gov/program_offices/public_indian_housing/programs/ph) is available on HUD’s website.

2. **Project-based Section 8:**

   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](https://www.hud.gov/program_offices/public_indian_housing/pr) is available on HUD’s website.

3. **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.
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).

All three programs apply very similar rules to determine the amount a family will pay for housing.

**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 next. 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** (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. Certain HUD programs are only available to “Disabled or Elderly Families.” This means families 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 is someone who meets Social Security’s adult definition of disability or is determined by HUD regulations to have a significant physical, mental, or emotional impairment.

**Applying for Rental Subsidy**

Individuals apply for housing subsidies by contacting their local PHA. You will find PHA contact information on the HUD website (https://www.hud.gov/program_offices/public_indian_housing/pha/contracts).

**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 family income. PHAs can choose different calculation methods to set total tenant payment, so long as they do not yield amounts higher than the standard method.

Calculating Adjusted Income

• To compute adjusted income, the PHA adds all included income (less any income that is excluded) and subtracts income deductions. With respect to the family, income includes, but is not limited to:

• All amounts, not specifically excluded, received from all sources by each member of the family who is 18 years of age or older or is the head of household or spouse of the head of household, plus unearned income by or on behalf of each dependent who is under 18 years of age; and

• When the value of net family assets exceeds $50,000 (adjusted annually) and the actual returns from a given asset cannot be calculated, imputed returns on the asset based on the current passbook savings rate, as determined by HUD.

Excluded Income

PHAs do not 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:

• Any imputed return on an asset when net family assets total $50,000 or less (adjusted annually) and no actual income from the net family assets can be determined.

• 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.

• Amounts received by a participant in other publicly assisted programs which are specifically for or in reimbursement of out-
of-pocket expenses incurred and which are made solely to allow participation in a specific program.

- 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.
- Payments made by or authorized by a State Medicaid agency or other state or federal agency to a family to enable a family member who has a disability to reside in the family’s assisted unit. Authorized payments may include payments to a member of the assisted family for caregiving services the family member provides to enable a family member who has a disability to reside in the family’s assisted unit. 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.
- Amounts directly received by the family as a result of Federal or State refundable tax credits and Federal or State tax refunds.

**Income Deductions**

PHAs deduct these amounts from family income under mandatory HUD rules:

- $480 per year (adjusted annually) for each dependent who is under age 18, disabled, or a full-time student.
- $525 per year (adjusted annually) for a disabled or elderly family.
- Any reasonable child care expenses necessary to enable a member of the family to be employed or to further their education. The amount of the following two expense types that exceed 10 percent of gross family income:
a. Unreimbursed medical expenses for all members of a disabled or elderly family.

b. Unreimbursed reasonable attendant care and auxiliary apparatus expenses for each member of the family who is a person with a disability, to the extent necessary to enable any member of the family (including the member who is a person with a disability) to be employed. This deduction may not exceed the combined earned income received by family members who are 18 years of age or older and who are able to work because of such attendant care or auxiliary apparatus; 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).

Utility Allowance

If a family pays for utilities separately from their rent, the PHA or housing 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.

Reexaminations of Income

PHAs conduct annual reexaminations of a family’s income if the family pays an income-based rent. In addition, the PHA must conduct an interim reexamination when the adjusted income decreases (or is estimated to decrease) by 10% or more due to a change in income or family composition. PHAs have the discretion to establish a lower
threshold that is more generous to the family. The PHA must also conduct an interim reexamination when the adjusted income increases by 10% or more. However, PHAs may decline to conduct the interim reexamination when increase in income occurs in the three months prior to the regular annual examination.

PHAs may not consider increases in earned income in determining the necessity of an interim reexamination unless, based on PHA policy, the family received an interim reduction during the same certification period. This means that individuals whose income has increased solely due to earnings from employment will not experience a corresponding increase in rent until the annual examination. When counseling beneficiaries, CWICs should advise beneficiaries of this time frame so they are aware of when any estimated change to their rental subsidy will occur.

**Determining Net Family Assets or Resources**

Starting in 2024, the Public Housing, Housing Choice Voucher, and Project-based Section 8 Programs mentioned above will implement a $100,000 resource limit. HUD allows self-certification from the family for documentation of assets less than $50,000. Like most means-tested benefits programs, not all resources count. For example, retirement accounts recognized by the IRS are excluded. More information on Resource Exclusions is available at https://www.hudexchange.info/resource/6880/hotma-assets-asset-exclusions-and-limitation-on-assets-resource-sheet/.

Another important resource exclusion is funds put aside in a Family Self-Sufficiency (FSS) program account. Greatly expanded upon in 2022, the FSS program is the nation’s largest asset-building program for low-income families, funding over 1,300 coordinators who serve over 60,000 residents in public, voucher, and multifamily housing. The FSS program is completely voluntary and helps families in HUD-assisted rental housing to increase their earnings and build financial capability and assets. FSS Program Coordinators provide coaching, refer to services, and assist in establishing a family escrow savings account, which is excluded from the resource determination.

Not every PHA participates in the FSS program. To see the new FSS awardees, visit https://www.hud.gov/sites/dfiles/PA/documents/State_Report_NEW_FS
How Work Affects Rental Assistance

Federal rental subsidies are means-tested programs so when a beneficiary begins working, it is possible for their rental subsidy to decrease which means they may pay more in rent each month. However, because interim reexaminations cannot be conducted based solely on increased earnings, changes in rent due to working should occur only after the annual examination.

Earned Income Disregard or Disallowance (EID)

Prior to 2024, HUD rules included an important work incentive for individuals known as the Earned Income Disregard or the Earned Income Disallowance (EID). The EID enables certain family members with certain HUD rental subsidies to go to work without having the family’s rent increase immediately. Instead, HUD phases in the rent increase over time. Those eligible for EID include any adults in public housing as well as any adults with disabilities who receive assistance from the Housing Choice Voucher program and a few other assistance programs.

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:

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.

3. 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 did not work the entire time and was not able to use the benefit of the disregard for all 24 months.

Due to recent legislation, HUD is phasing out the EID. HUD directed PHAs to begin applying the EID to any newly eligible family’s rental subsidy through December 31, 2023. After this, PHAs can only apply the EID to families whose EID period started prior to 2024. Those families are allowed to finish their two-year EID period in 2024 and 2025. Therefore, the EID will be completely phased out by January 1, 2026.

Given this, CWICs should no longer recommend EID to any beneficiary who has not already started to use it prior to 2024. For those who started using it prior to 2024, CWICs should confirm or help the beneficiary confirm when their EID period will end and how the rental subsidy will change during and after their EID period.

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 they meet all federal requirements. The federal

Individuals should contact their local PHA for a copy of the grievance procedure if they wish to file a grievance about a determination.

**Next Steps**

This chapter provided you with a summary of the eligibility requirements for SNAP and HUD rental subsidies as well as a brief overview of how paid employment affects these benefits. When you begin to provide WIPA services to disability beneficiaries who also have SNAP benefits or federal housing subsidies, you will need to conduct additional research to discover how the states in which you provide WIPA services administer these programs. Your assigned VCU NTDC Technical Assistance (TA) Liaison can help you understand the requirements for these programs, but cannot help you with any state specific rules. Social Security requires WIPA programs to acquire training on state specific rules for all benefit programs with state variance. You also need to remember that there are many different forms of federal, state or local benefits an individual may receive that could be affected by paid employment. You should take the following steps to ensure that you have the information you need to provide accurate and comprehensive work incentives counseling:

1. Begin by meeting with your WIPA Program Director or knowledgeable members of your WIPA team to get information about state-specific rules that govern benefits in your area. Once you achieve full CWIC certification, you will have access to report writing software called BSADocs that includes templates customized for each state including all of the state-specific information for each type of benefit. You can get a copy of these templates from your Program Director. This will save you a lot of time in conducting research.
2. You are required to complete a detailed web course on other federal, state and local benefits that is offered several times each year by VCU’s NTDC. Once you are provisionally certified, you will start to receive notices of these training sessions when registration is open. Successful completion of this web course is a requirement for attaining full CWIC certification.

3. There are a variety of **resource documents covering various federal, state, and local benefits** available on the NTDC website (https://vcu-ntdc.org/resources/resourceDetail_search.cfm?id=4). When you encounter an individual who receives something other than SNAP or HUD rental subsidies, refer to this web page to find helpful informational materials. Your TA Liaison can help you understand these materials, but will not be able to assist you with any state specific rules.
Part II Chapter 9 – Community Relations and Education in the WIPA Program
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Chapter 9 – Community Relations and Education in the WIPA Program

Learning Objectives

After you have read this chapter and completed the associated lectures and activities during the WIPA Initial Training, you should be able to:

1. Identify and describe the three major objectives WIPA personnel have when conducting community relations and education activity;

2. Describe why developing strong relationships with key Social Security personnel is important for CWICs;

3. Describe the main functions performed by key Social Security personnel including Service Representatives (SRs), Claims Specialists (CSs), Work Incentives Liaisons (WILs), and Area Work Incentives Coordinators (AWICs);

4. Describe the purpose of the Ticket-to-Work Help Line and how the Helpline assists WIPA programs;

5. Describe effective strategies for conducting community education activities to increase awareness of WIPA services; and

6. Describe effective strategies for conducting community education activities to increase understanding of how paid employment affects Social Security disability benefits.

List of Acronyms

- AWIC – Area Work Incentives Coordinator
- BPQY – Benefits Planning Query
- BSS – Beneficiary Support Specialist
- CS – Claims Specialist
- CWIC – Community Work Incentives Coordinator
- DO – District Office
- FO – Field Office
The Importance of Community Relations and Education

WIPA services cannot be provided effectively in a vacuum. CWICs need to interact with numerous groups in their local communities including disability beneficiaries, Social Security field offices, agencies that administer other federal, state or local benefits, and entities that make referrals for WIPA services. CWICs have three major objectives when they conduct community relations and education activity in the WIPA program:

1. Build positive relationships with key community partners to increase appropriate WIPA referrals, facilitate efficient verification of benefits, and improve interagency communication and collaboration that supports the employment of disability beneficiaries.

2. Raise awareness of WIPA services within the disability community by educating beneficiaries and community partners about what WIPA services include and whom Social Security intends the program to assist.

3. Promote employment of people with disabilities by educating beneficiaries and community partners on how earned income affects Social Security disability benefits and how work incentives can help achieve employment goals.
Social Security’s Requirements Related to Community Relations and Education

Social Security requires that WIPA programs work to develop relationships with the local Field Offices, Work Incentives Liaisons (WIL), Area Work Incentives Coordinators (AWIC), and staff who support beneficiaries with Plans to Achieve Self-Support (PASS) or PASS Specialists. In addition, WIPA program staff must become familiar with the Employment Networks (EN) within their service area and refer beneficiaries to those ENs when appropriate. EN’s hold agreements with Social Security to provide employment services to beneficiaries. WIPA program staff must also become familiar with the Protection and Advocacy for Beneficiaries of Social Security (PABSS) agencies within their service area and must refer beneficiaries to those agencies when appropriate. PABSS grantees provide legal advocacy and support to assist beneficiaries who face barriers to employment. Finally, WIPA program staff should work cooperatively with federal, state, local, private, and other organizations that serve beneficiaries with disabilities seeking employment.

Social Security also imposes certain limits on WIPA outreach activity. For example, WIPA programs may only use outreach materials (brochures, fliers, presentations) that Social Security has reviewed and approved. VCU’s NTDC has developed a variety of standard WIPA outreach materials that are pre-approved to help with this process. We provide you with links to these materials further on in this chapter. In addition, WIPA programs are required to limit travel costs associated with outreach efforts and coordinate outreach events with community partners including AWICs, PABSS grantees, State VR agencies, America’s Job Centers, and other programs that may benefit WIPA clients. From year to year, there may be additional requirements related to how much outreach activity WIPA programs are allowed to perform or other limits. These requirements will be described in the current WIPA Terms and Conditions document that is part of your agency’s cooperative agreement with Social Security. Your WIPA Program Director can provide you with a copy of the Terms and Conditions. It is important for you to read this document so you understand what Social Security expects.

Social Security also requires WIPA programs to focus outreach activity on certain high priority groups. WIPA projects must target outreach to
U.S. Military Veterans with disabilities and beneficiaries experiencing barriers to work due to their characteristics or circumstances such as persons of color; members of religious minorities; LGBTQ+ persons; persons with underserved disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. In addition, Social Security requires that WIPA programs target outreach to transition aged youth. Social Security defines transition aged youth as disability beneficiaries between the ages of 14 and 25. Outreach to youth should include communication with schools, vocational rehabilitation programs, and parents. Check with your WIPA Program Director to find out what outreach activities your agency performs that target these special groups.

Getting Started with Community Relations and Education

The activities in which you will participate that promote community relations and education will be varied. Relationship building activities will include introductory meetings with key personnel at Social Security, State Vocational Rehabilitation Agencies, and agencies that administer other federal, state and local benefits. Community education activities may include attending conferences, community meetings, or resource fairs to disseminate WIPA educational materials, or providing presentations to beneficiaries or partner agencies. To find out more about your role in conducting WIPA community relations and outreach, you should begin by talking to your WIPA Program Director. Each WIPA program uses different approaches to build relationships with key partners and educate community members about WIPA services. Many WIPA programs have been operating for a long time and already have strong relationships with Social Security field offices and other key partners. As a new staff person, you will need to find out what is already in place before you attempt to conduct outreach. Your WIPA Program Director will provide you with the information you need to get started.
Building Relationships with Key Community Partners

CWICs perform outreach to develop collaborative relationships with key personnel within community partner agencies. The most important agencies you will interact with are:

- The Social Security Administration
- The Ticket to Work (TTW) Help Line
- Employment Networks (ENs)
- State Vocational Rehabilitation (VR) agencies
- Protection and Advocacy for Beneficiaries of Social Security (PABSS)
- Other agencies that administer federal, state and local benefits

CWICs rely on strong collaborative relationships with these entities to access critical information they need to perform high quality benefits counseling services. You will need positive relationships with Social Security personnel in order to verify Social Security disability benefits and get answers to questions about benefits and work incentives usage. Establishing relationships with agencies that administer other federal, state or local benefits will help you access critical training on how these benefits are affected by employment and facilitate efficient benefits verification. You will also need to nurture positive relationships with agencies that make WIPA referrals to ensure that referrals meet program priorities and to help process referrals smoothly. Quite simply, CWICs who take the time to build functional networks with community agencies provide better WIPA services to beneficiaries in a timely manner. Let’s take a closer look at some of the key agencies with which you need to develop relationships and some proven strategies for relationship development.

Working with the Social Security Administration

To collaborate with Social Security, CWICs 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 do not provide services to beneficiaries directly. You can find a listing of Social Security Regional Offices with contact information on Social Security’s website (https://www.ssa.gov/slge/specialists.htm).

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 1,300 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, there are six processing centers and the 130 hearing offices that 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 types of Social Security employees who are on the front line in delivering service to beneficiaries and applicants: Service Representatives (SRs) and Claims Specialists (CS). Let’s take a look at the duties for each position.

**Customer Service Representatives**

In most field offices, the first Social Security employee a beneficiary or applicant has contact with is a Customer Service Representative, often shortened to just Service Representative (SR). 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 cannot resolve, a Claims Specialist typically provides assistance.

**Claims Specialists**

This is the key position through which Social Security achieves its major operating objective of bringing direct personal service to the public. Duties performed by Claims Specialists (CS) include (but are not 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, assisting beneficiaries to provide required evidence;

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

● Recognizing the need for and approving the selection of representative payees for individuals unable to handle their own benefits;

● Developing, investigating, and resolving discrepancies in earnings and determining amounts to be posted or deleted from individual records. Claims Specialists also determine countable earned income for both Title II and SSI benefits and apply work incentives when making decisions about how earned income affects benefit eligibility and payment amounts; and

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

**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 (CS) act as the designated Work Incentive Liaison (WIL) in addition to their regular CR duties. These are not 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 an experienced 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. 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 beneficiary-specific work incentives issues for WIPA programs.

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.

**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.

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 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**

Building functional relationships with key Social Security personnel will help you provide better WIPA services. 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. Claims Specialists 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. In other areas, the AWIC is the contact person for help with BPQY questions. You will learn more about the BPQY report and how to use those reports in your daily work by reading the chapter in this part of the manual on verifying benefits.

You also need to build relationships with key Social Security staff so that you can get questions answered about beneficiaries you are serving. Not everything you need to know will be on a BPQY report. There are often instances in which you need to communicate directly with the AWIC, WIL or Claims Specialist to gather more information, answer questions or confirm various benefits issues. There is no way for a CWIC to provide comprehensive and individualized WIPA services to disability beneficiaries without the ability to occasionally communicate with Social Security staff.

The first step in your relationship building effort should be meeting with your WIPA Program Director to find out who the key players are in each field office you will be serving. Your Program Director and WIPA colleagues probably have already established relationships with the Field Office Managers, WILs, AWICs, and key Claims Specialists. You do not want to waste time duplicating work they have already done to build collaborative relationships. Once you have the names and contact information of the key Social Security personnel, you should introduce yourself by email. In the email, you should request a time to speak by phone. The important things to review during your conversations with
Social Security staff are what WIPA services include, which beneficiaries are a priority for services, and how to contact you.

**Working with the Ticket to Work Help Line**

For general questions or guidance, 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. The Ticket to Work (TTW) Help Line is often a beneficiary’s first point of contact in their return to work efforts.

The TTW Help Line is staffed by Beneficiary Support Specialists (BSSs). These staff persons provide information about the Ticket program, confirm beneficiary eligibility, and respond to specific questions. Help Line BSSs also offer callers a list of service providers in their area that includes ENs, State Vocational Rehabilitation (VR) agencies, WIPA programs, 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 “Find Help” tool on the Choose Work website, where callers can create and print their own list. BSSs mail more than 4,000 lists every month. BSSs 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 program.

The Help Line is a critical referral source for WIPA programs and they provide a valuable service by screening callers to identify those who are a high priority for WIPA services. To ensure appropriate beneficiary referrals, BSSs:

- Identify callers who are working, have job offers, or are interviewing for jobs;

- Provide basic information to help beneficiaries understand the SSI and title II disability 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 program 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 referrals for services, such as PABSS (Protection and Advocacy for Beneficiaries of Social Security) programs and other organizations responsible for local or state benefits programs and resources, as appropriate.

Prior to making a referral to the WIPA programs, Help Line BSSs screen 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 BSSs also collect demographic information and record information on Ticket status, employment status, the beneficiary’s county of residence. Once the BSS has determined that a beneficiary is eligible for WIPA services and appropriate for referral, the BSS generates a referral to the servicing WIPA program using an encrypted email system. WIPA programs check for Help Line referrals on a daily basis and are responsible for contacting beneficiaries to initiate service within certain time frames.

To learn more about your role in working with the TTW Help Line you can refer to an archived training entitled *Engaging Ticket to Work Help Line Referrals* found on the NTDC website (https://vcu-ntdc.org/training/supplemental/archives.cfm).

**Working with Employment Networks**

An Employment Network (EN) is an entity that enters into an agreement with Social Security to either provide or coordinate the delivery of services to Social Security disability beneficiaries. The EN can be an individual, a partnership/alliance (public or private) or a consortium of organizations collaborating to combine resources to serve
eligible individuals. ENs participating in the Ticket to Work Program (Ticket Program) must adhere to certain rules and regulations. 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 do not 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. You can find a listing of ENs on Social Security’s website (https://choosework.ssa.gov/findhelp/).

Your objective when establishing relationships with local ENs is to gain an understanding of the services each one provides so that you can provide appropriate referrals. In addition, you need to make sure that local ENs are aware of your WIPA program and the services you provide, and know how to make a referral. We will provide more information about how WIPA programs interact with ENs in Chapter 11.

**Working with Protection and Advocacy for Beneficiaries of Social Security (PABSS)**

Social Security provides funding to the State Protection and Advocacy (P&A) systems to assist beneficiaries with disabilities in their efforts to begin and to maintain employment. This program is called Protection and Advocacy for Beneficiaries of Social Security (PABSS). PABSS services include:

- Advocacy and related services for beneficiaries participating in the Ticket to Work Program;
- Information and advice about receiving vocational rehabilitation and employment services; and
- Advocacy or other related services that Social Security beneficiaries may need to secure or regain gainful employment.
The PABSS program helps Social Security disability beneficiaries who need assistance with issues involving their employment service providers, employers, WIPA programs, 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 Ticket-to-Work issues. To find the PABSS serving your area, visit https://choosework.ssa.gov/findhelp/.

Your objective when establishing relationships with your state PABSS program is to gain an understanding of the types of advocacy services they provide so that you can make appropriate referrals. Each PABSS program is different in terms of the types of cases they will accept and the advocacy areas in which they focus. In addition, you need to make sure that the PABSS advocates are aware of your WIPA program and the services you provide, and know how to make a referral. We will provide more information about how WIPA programs interact with PABSS programs in Chapter 11.

## Working with Other Agencies that Administer Federal, State, and Local Benefits

Many of the individuals you will serve will have additional benefits beyond the Social Security disability program. This may include food stamps, Medicaid, federal rental subsidies, energy assistance, workers compensation or unemployment insurance. All of these benefits may be affected by paid employment, so the counseling you provide must cover all benefits an individual receives. WIPA program staff are required to verify the type and amount of other federal, state or local benefits an individual receives, so you need to establish relationships with the local agencies that administer those programs to access that information.

The first step in working with all of these other agencies is to check with your WIPA Program Director to get local contact information and learn how these agencies process requests for benefits verification. Once you have this information, you can begin to make introductory calls or send introductory email messages. It is very important for you to spend the time necessary to develop relationships with key personnel within these local agencies. Without these relationships, you will not be able to verify critical information you need to perform comprehensive
individualized WIPA services. We provide you with more information about how to work with local agencies to verify benefits in Chapter 12.

**Performing Community Education Activities**

WIPA programs perform community education activities to raise awareness of WIPA services within the disability community. These activities focus on educating beneficiaries and community partners about what WIPA services include and whom Social Security intends them to assist. Social Security places some limits on this type of outreach activity, so be sure to discuss outreach with your WIPA Program Director before performing any community education activities.

Community education activities often include making presentations to community groups either in person or using meeting software. When CWICs make presentations, 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 is not eligible for services to attract appropriate referrals. Do not assume the audience knows who to refer or who would benefit from WIPA services. Provide written information listing eligibility criteria. The more you educate your referral sources, the less time you will waste handling inappropriate referrals. It’s also important to 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
programs provide representative payee services. WIPA personnel should never engage in this function. Sometimes referral sources think that WIPA projects report all wages to Social Security. CWICs should assist beneficiaries to make their own wage reports, not make the report directly. If referral sources have unrealistic expectations about what the program does, they will make inappropriate referrals or be disappointed in the services. Manage expectations by providing clear written information during presentations. Keep in mind that any material you disseminate must be approved in advance by Social Security. The VCU NTDC website contains a **pre-approved WIPA PowerPoint presentation** WIPA personnel should use when describing the WIPA program to community partners (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=194).

WIPA 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. It is quite possible for Social Security beneficiaries with disabilities to work and retain cash payments and 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 work incentives can ease the fear and uncertainty about employment many beneficiaries and the professionals who serve them feel. Knowledge of Social Security and other work incentives truly is power in this instance.

You will find approved **outreach materials** including PowerPoint presentations about how work affects disability benefits on the NTDC website (https://vcu-ntdc.org/resources/resourceDetail_search.cfm?id=7).

**Next Steps**

In this chapter, we provided a very basic overview of community relations and education within the WIPA program. Once you begin serving beneficiaries, you will need to learn more about how to build
effective relationships with key community partner agencies and how to educate stakeholder groups about WIPA services and how paid employment affects Social Security disability benefits. As we have stated several times in this chapter, the first step is to meet with your WIPA Program Director to learn more about the key players in your service area and how your program conducts outreach. As part of a larger WIPA program team, you need to provide outreach that is consistent with your colleagues. You also do not want to waste time searching for key contacts when that information already exists. After you have met with your program director and WIPA team, here are some additional sources of information you can access:

1. Begin by reviewing all of the WIPA outreach resources available to CWICs by going to the NTDC website (https://vcu-ntdc.org/resources/resourceDetail_search.cfm?id=7). You will find PowerPoint presentations, resource documents and specialized resources for targeted populations such as transition age youth. Remember that you may only use materials that Social Security has reviewed and approved. Social Security has reviewed all materials on the NTDC website as a resource for your use.

2. Working collaboratively with the ENs that serve your area is very important. You can learn more about developing relationships with ENs by reading a resource document The Role of CWICs in Supporting ENs under the TtW Program found on the NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=88).

3. Serving transition age youth is a high priority for Social Security. Conducting outreach to this special population can be challenging. To learn more about that, you can take an archived training session entitled Providing WIPA Services to Transition Age Youth found on the NTDC website (https://vcu-ntdc.org/training/supplemental/archives.cfm).
Part II Chapter 10 – Managing Initial Requests for WIPA Services
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Chapter 10 – Managing Initial Requests for WIPA Services

Learning Objectives

After you have read this chapter and completed the associated lectures and activities during WIPA Initial Training, you should be able to:

1. Describe the role of the Ticket to Work Help Line in making direct referrals for WIPA services.
2. Describe the WIPA eligibility requirements and distinguish between beneficiaries who are eligible from those who are not.
3. Describe the CWIC’s role in assisting individuals who are ineligible for WIPA services.
4. Describe Social Security’s five priorities for individualized WIPA services and distinguish between beneficiaries who are in a priority situation from those who are not in urgent need for services.
5. Describe the difference in services provided to beneficiaries who are in a priority situation for individualized WIPA services and those who are not.
6. Describe the CWIC’s role in assisting eligible individuals who are not in a priority situation for individualized services.
7. Identify beneficiaries who are in a priority situation for individualized WIPA services who have urgent needs for services.

List of Acronyms

- BS&A – Benefits Summary and Analysis
- BSS – Beneficiary Support Specialist
- CDB – Childhood Disability Beneficiary
- DWB – Disabled Widow(er) Benefits
- EN – Employment Network
- MQGE – Medicare Qualified Government Employee
Importance of Managing Initial Requests for WIPA Services

When managing initial requests for service, CWICs must focus on providing work incentives planning and assistance services that support employment. 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 to successfully maintain paid employment over time by helping them anticipate benefit changes, report earnings, and manage work incentives; and
- Provide work incentives counseling that enables beneficiaries to meet their employment and earnings goals.

Social Security has developed very clear boundaries for you to follow when determining who to serve and what type of services to deliver. 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 will have less time available to perform the services Social Security requires.

WIPA Referral Sources

The majority of referrals for WIPA services come from the Ticket to Work Help Line. This is a call center operated by Cognosante through the Ticket Program Manager contract. Social Security requires WIPA programs to include the Ticket to Work Help Line contact information on websites, in brochures, and within presentations. WIPA programs may also include the WIPA program direct contact information in outreach materials.

Help Line Beneficiary Support Specialists (BSS) verify that callers are eligible for WIPA services and screen callers to determine if they meet...
the priorities for direct referral to WIPA programs. BSSs also provide general information about the Ticket to Work program and Social Security work incentives, and can provide referrals for other services as needed. Virginia Commonwealth University’s (VCU) National Training and Data Center (NTDC) trains Help Line BSSs about WIPA eligibility and services.

Many WIPA programs also accept referrals directly from beneficiaries, their representatives, and local agencies. You will need to meet with your Program Director to learn more about referral sources in your area and the referral protocols your WIPA program requires.

**Determining Eligibility for WIPA Services**

Not everyone who contacts a WIPA program will be eligible for services. When screening WIPA referrals, your first task is to determine whether the caller is eligible for services. The current WIPA Terms and Conditions Document defines eligibility as:

WIPA projects serve beneficiaries who are between age 14 and full retirement age, who receive any of the following benefits based on their own disabilities:

- SSDI including Disability Insurance Benefits for disabled workers, Childhood Disability Benefits (CDB) for adult children with disabilities of disabled, retired, or deceased workers, and Disabled Widow(er)’s Benefits (DWB) for widows and widowers with disabilities who are at least aged 50;
- SSI benefits based on blindness or disability;
- Medicare under the Extended Period of Medicare Coverage (for former disability beneficiaries performing substantial work);
- Medicaid under Section 1619(b) of the Social Security Act (for SSI beneficiaries ineligible for payment due to work income) who use Medicaid;
- A state supplementary SSI payment (even if the beneficiary is not due a Federal SSI payment); or
- Medicare coverage based on disability and Medicare Qualified Government Employment (MQGE).
You will find more specific information about **WIPA eligibility requirements** on the NTDC website at https://vcu-ntdc.org/resources/viewContent.cfm?contentID=65eligibility

**Making WIPA Eligibility Determinations**

Your first contact, or initial call, with the beneficiary begins the process of intake services. During your initial call with the beneficiary you will determine or confirm WIPA eligibility. Determining WIPA eligibility is straightforward for people referred by the Ticket to Work Help Line. As explained earlier, Help Line Beneficiary Support Specialists (BSSs) verify that callers are eligible for WIPA services and screen callers to determine if they meet the priorities for direct referral to WIPA programs. If the Help Line referred the person, you can find the type(s) of Social Security benefit listed on the SSA-4567 Help Line Referral form attached in the encrypted referral email. In these cases, you should confirm the type of benefits received with each person during the initial call. If there are discrepancies between what the beneficiary says they receive and what shows in the referral section, ask additional questions to clarify.

For beneficiaries who contact you directly, during your initial call, you will need to establish that the person meets the eligibility requirements first. 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?
• Do you have any letters from Social Security that you could read to me?

These questions are just a beginning. Depending on how the individual responds, you may need to ask additional questions to determine exactly what type of Social Security benefits the individual is receiving and whether or not the benefit is based on disability. In the majority of cases, you will be able to know if a caller is eligible by using phone interview techniques.

If you cannot 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 their record of annual earnings, benefit amount, and payment information. Beneficiaries can change their address, phone number, and direct deposit through this portal. Beneficiaries can [sign in or create a my Social Security account](https://www.ssa.gov/myaccount) at www.ssa.gov/myaccount.

**What to do about Ineligible Callers**

When you identify an ineligible caller, begin by stating that you are unable to provide WIPA services and offer a short explanation of the WIPA eligibility requirements. Ask the caller what the presenting need is and recommend alternate referral sources that could potentially assist the individual. Be polite and professional when assisting ineligible callers, but do not allow these calls to consume a lot of your time.

**Determining the Priority Level of Eligible Individuals**

Once you determine that an individual is eligible for WIPA services, the next step of your initial call is determining whether or not the beneficiary is in a high priority situation for individualized WIPA services.

Social Security requires that WIPA programs prioritize services to beneficiaries who are most vulnerable to overpayment, and most in need of immediate attention. The current Terms and Conditions states
that WIPA programs must serve beneficiaries meeting the following priority order, regardless of the referral source:

1. Beneficiaries who are working full-time, are self-employed full-time or are about to start full-time work.

2. Beneficiaries who are working part-time, are self-employed part-time or about to start part-time work.

3. Beneficiaries who have had a job interview within the 30 days prior to their first contact with the WIPA program or who have a job interview within the two weeks following initial contact with the WIPA program.

4. Beneficiaries seriously considering employment, who are currently receiving services from a State Vocational Rehabilitation (VR) agency, or who have assigned their Ticket to an Employment Network (EN) or other vocational program, or who indicate serious intent to work.

5. Other beneficiaries seeking work incentives counseling if the WIPA program has capacity to serve them.

**Note:** Beginning with referrals in calendar year 2024, the Ticket to Work Help Line will focus on referrals fitting the first two priority categories above.

Once you have established that a caller is eligible for WIPA services, you should begin asking questions about the person’s employment. Employment status is the factor that determines whether someone is in a high priority situation for in-depth benefits analysis and work incentives counseling. After determining that the beneficiary fits a high priority category for individualized WIPA services, take time to explain those services, how they will benefit the individual, and the next steps you need to take to provide those services. Once you have determined an individual meets eligibility, fits high priority requirements and you have explained next steps you are ready to move to the next step of intake services which will be covered in the next chapter.

**Understanding Individualized WIPA Services**

Individualized work incentives planning and assistance requires CWICs to perform extensive information gathering by conducting a
comprehensive intake interview verify all benefits an individual receives, analyze the effect of the individual’s employment on benefits, and provide accurate information about work incentives. 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 follow the written BS&A report with counseling and direct assistance to complete wage reporting responsibilities, apply work incentives, and resolve any problems that may occur. CWICs typically provide this assistance over a period of weeks, months, or even years.

Social Security developed the priorities described above to guide CWICs in managing the high volume of WIPA service requests. WIPA eligible beneficiaries who are in situations that do not meet Social Security’s priorities do receive assistance, but typically do not get intensive benefits analysis or ongoing work incentives counseling and support. CWICs address the needs of this group by providing basic summary information about benefits, work incentives, programs or services. This type of service does not require extensive information gathering or verification of benefits. Most often, CWICs handle these requests with 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. Services to this group do not usually involve repeated contacts with the beneficiary.

What to do About Beneficiaries in Priority Situations Who Decline Individualized WIPA Services

Keep in mind that beneficiaries who are in high priority situations for WIPA services must have an interest in receiving individualized, employment-focused benefits counseling in order for you to provide the services. You need to get the beneficiary’s permission to move forward with information gathering, benefits verification, and benefits analysis. Be careful when you are discussing this with beneficiaries. Never assume that a caller who begins by asking questions about benefits issues unrelated to employment is uninterested in WIPA services. Beneficiaries may have many benefits issues they want to discuss and questions related to employment may only be a part of the puzzle. When you ask beneficiaries if they want to move forward with individualized WIPA services, some beneficiaries will decline to
participate. When this happens, be sure to describe the valuable information and support you can provide to avoid future benefit problems. Make sure beneficiaries understand that you cannot provide this customized service without conducting a thorough intake interview and verifying benefits with Social Security and other agencies. Use your best persuasive skills to engage beneficiaries in individualized work incentives counseling – particularly those who are already employed. If they decline, respect that, but offer an invitation to call back if their needs change in the future.

**What to do About Eligible Beneficiaries Who Are Not in a Priority Situation for Individualized WIPA Services**

You will receive some 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. Many beneficiaries at this stage have no clear vocational goal and have taken few, if any, steps to prepare for employment. You will also encounter some beneficiaries who state they are not interested in working, or feel they are unable to work. Sometimes, beneficiaries say they are not interested in working because they are fearful about how paid work will affect benefits. They may be unsure of what they are able to do or would require significant workplace supports in order to be successful. These are people who need information you can provide, even though they are not candidates for individualized benefits analysis and work incentives counseling.

When talking to beneficiaries who are not in a high priority situation for individualized WIPA service, 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 is possible to attempt work for a period of time and not lose benefits.

- Refer beneficiaries who need vocational counseling or other employment support to agencies providing those services. Assure beneficiaries that work place supports provided by the vocational services agencies and job site accommodations can help even those with the most severe disabilities be successful in employment.
• Discuss barriers to employment beneficiaries’ face. Offer information and referrals about services and supports that could help overcome these barriers.

• Be sure to answer any questions beneficiaries pose and provide basic information and referral services to meet presenting needs – even those unrelated to employment. We describe information and referral services in detail in Chapter 11.

• Provide general information about how work will affect Social Security disability benefits or Supplemental Security Income and send beneficiaries written information such as the Redbook or factsheets about work incentives so they have something to refer back to later.

• Explain that Medicare, Medicaid, Medicare Savings Programs and the Medicare Part D Low-income Subsidy protections may permit them to keep health insurance even if they earn wages.

You should not make further proactive contact with individuals who are not a priority for individualized WIPA services. You would also not conduct any further information gathering or verification of benefits since these tasks are only required when you provide in-depth benefits analysis and work incentives counseling. In many cases, this initial phone call will be the only contact you have with the person. However, you should encourage beneficiaries to contact you again to request individualized WIPA services when they make the decision to pursue employment and have a clear earnings goal. By providing a bit of encouragement, targeted information, and counseling early on, some beneficiaries may later decide that work is a viable option after all.

**Determining Which Beneficiaries Have an Urgent Need for WIPA Services**

When beneficiaries have an urgent need for WIPA services, it means that they are at imminent risk of a potential benefits problem related to employment such as an overpayment or unexpected loss of cash payments or health insurance. In the WIPA program, urgency relates to how quickly a CWIC needs to provide individualized work incentives counseling and support in order to avoid or resolve a potential problem.
Here are some examples of the types of urgent issues that high priority beneficiaries might present:

- Caller has a job offer and needs immediate assistance to understand how the job will affect cash benefits and public health insurance.

- Caller just started working full-time and needs information about how to report wages to Social Security.

- Caller is considering a promotion at work but needs information about how the promotion would affect benefits.

- Caller has been working part-time for over six months, but her SSI cash payment has never changed. She is afraid that Social security never got the wage information she submitted.

- 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 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 much of his income, called “patient liability” to the waiver provider, which would consume almost all of his wages.

- Caller is working and has expenses that appear to be IRWEs, but needs help getting Social Security to review and approve the expenses.

These examples are beneficiaries with an urgent need for employment-focused benefits counseling and assistance. When you encounter a beneficiary with an urgent need, you must move quickly to conduct an intake interview, verify all benefits, and begin providing individualized WIPA services, including help resolving the presenting problem. We describe all of these important components of WIPA services in detail in subsequent chapters.
Handling Calls from Beneficiaries who are not in a Priority Situation for Individualized Services, but who have Urgent Benefits Issues

You will get calls from beneficiaries who do not meet a priority category for individualized services, but do have a problem(s) with their benefits that they would like you to help with. Some of these problems are truly urgent in that they are likely to cause an overpayment, loss of critical benefits, or both. Here are some examples:

- Caller is not interested in employment but has just received notice from Social Security that her benefits are 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 Medicaid waiver. He has received an inheritance and is at risk of losing Medicaid coverage due to excess resources.

- Caller is not working or pursuing employment in any way, but recently became engaged and wants to know how getting married will affect his benefits.

- 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 was not reported. The beneficiary is in a non-vocational day program and is not seeking paid employment.

You need to be careful how much time you spend working on urgent issues for beneficiaries who are not a priority for individualized WIPA services. These issues are common and if you do not limit your efforts, you will spend far too much time reacting to these non-employment related crisis situations. Remember – the priority of WIPA services is providing employment-focused benefits counseling. You need to spend the bulk of your time and expertise supporting beneficiaries who are working or actively pursuing employment.

Although these individuals described above are not in a priority category for in-depth work incentives counseling, they do require your
assistance. It is not ethical to simply ignore these urgent pleas for help. The problem CWICs face is how to assist without going too far. Here are the steps you should take:

1. Make sure you understand the presenting problem. Ask questions to piece together the chain of events and grasp what occurred to create the problem.

2. Explain to the beneficiary what the problem is and how it occurred.

3. Provide clear and specific information about steps the beneficiary can take to resolve the problem.

4. If possible, send beneficiaries written information or forms they may need to complete to resolve the problem (i.e. Request for Reconsideration form, Request for Waiver of Overpayment form)

5. Provide referrals to other sources of assistance as needed and available.

Although you may want to tell the beneficiary to contact you again later with questions, you should not offer to contact the individual proactively. Make sure the individual understands the limits to the support you can offer.

**Next Steps**

This chapter provided an overview of the WIPA referral process and how CWICs should manage initial requests for service. The most important aspect of managing referrals is 1.) Determining which callers are eligible for WIPA services; and 2.) Determining which of the eligible callers meet Social Security’s priorities for receiving individualized WIPA services. When CWICs screen callers for eligibility and priority efficiently, they are better able to manage their daily work and achieve the goals of the WIPA program.

The role CWICs play in screening and triaging referrals is critically important as it sets the stage for all subsequent work. Here are some next steps you can take to make sure you manage initial requests for service correctly:
1. Begin by meeting with your WIPA Program Director to find out how your program handles referrals. In some programs, there is a central point of contact for all referrals. In other programs, all CWICs accept referrals from the Help Line, beneficiaries or other referral sources.

2. If possible, you should “shadow” experienced CWICs to learn how they handle initial referrals. Experienced CWICs can help you develop scripting to guide initial calls or offer tips about questions to ask and in what order.

3. When questions arise, be sure to reach out to your assigned NTDC Technical Assistance Liaison. That person can help answer your questions about beneficiary eligibility and priority. You can also refer to several resource documents about WIPA eligibility and priority available on the NTDC website at https://vcu-ntdc.org/resources/resourceDetail_search.cfm?id=6#DeterminingEligibility,GatheringInformationandVerifyingBenefits.
Part II Chapter 11 – Providing Effective Information and Referral Services in the WIPA Program
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Chapter 11 – Providing Effective Information and Referral Services in the WIPA Program

Learning Objectives

After you have read this chapter and completed the associated lectures and activities during the WIPA Initial Training, you should be able to:

1. Describe what information and referral (I&R) services are and their purpose in the WIPA program.

2. Describe successful strategies for providing I&R services to beneficiaries.

3. Identify which beneficiaries should receive general information about Social Security disability benefits and how these benefits are affected by paid employment.

4. Identify the circumstances under which a CWIC would refer a beneficiary to Social Security.

5. Describe the four goals of providing employment focused I&R services in the WIPA program.

6. Identify common sources of referrals for financial assistance, help with physical and Mental Health, advocacy / legal assistance, and crisis Intervention.

List of Acronyms

- AJC – American Job Center
- BS&A – Benefits Summary and Analysis
- CAP – Client Assistance Program
- CIL – Center for Independent Living
- EN – Employment Network
- I&R – Information and Referral
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 enables 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.

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, associated 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 pursuing their employment goals; and

3. To link beneficiaries with local community resources and support services that address additional needs, such as specialized transportation, personal assistant services, assistive technology, or financial education.

Beneficiaries who reach out to a WIPA program 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 their presenting need and then provide the specific information to answer questions and make service referrals to get those needs met. 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.) CWICs provide I&R services to beneficiaries during every interaction.

While every beneficiary who contacts a WIPA program 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 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 I&R support on a variety of topics provided over multiple contacts in addition to customized benefits analysis and advisement.

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 toward their employment goal? What problem is the beneficiary experiencing that you could help resolve by making a referral? The process of determining a beneficiary’s I&R needs is not always easy. 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 are going to say while the beneficiary is talking. Instead, actively listen to what the beneficiary is saying.

- You should not assume that the initial request for information is all that the beneficiary wants or needs to know. Gently probe with follow-up questions to make sure the beneficiary does not want additional information. 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 you 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:

- 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, acronyms, 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.

- If you mention a specific agency, program, or service, ask the beneficiary if they have heard of it before. Be prepared to provide an overview of what the agency or program does and who it serves.

- Follow-up your verbal explanations with written material that the beneficiary can refer 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 their 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.

- You 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.

**Providing I&R about Social Security Benefits**

As we discussed in Chapter 10, not all beneficiaries who are eligible for WIPA services receive individualized work incentives counseling services. Because demand for WIPA services exceeds the current program capacity, Social Security directs WIPA programs to reserve individualized counseling for high priority beneficiaries who are currently
employed, about to enter employment, or pursuing a specific employment goal. So, what should you 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. You 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://vcu-ntdc.org/resources/resources.cfm). Social Security publications, such as *The Red Book*, a pamphlet entitled *Working While Disabled*, and a publication on **Plans for Achieving Self-Support (PASS)** are available on the Social Security website (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 on the Social Security website (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).

**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 provide answers without having complete information. The preferred 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 Benefits Summary and Analysis (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. 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 is best to refrain from providing extensive generic information until you have the opportunity to discuss the value of individualized services and benefit analysis. CWICs should answer questions briefly to alleviate any immediate concerns about working, but should educate the beneficiary about why individualized services are worthwhile.

Without verifying benefits, it is easy to give the right answer to the wrong question. For example, a person receiving SSI may ask a question about the Trial Work Period that you answer correctly, but the answer does not apply to that person’s benefits. Even though your answer to the question was correct, the beneficiary walked away from
that interaction with information that does not apply to them, and the misunderstanding may hurt them in the future.

**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 are not 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 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 recently passed away. 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 is 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

CWICs serve as an active and integral part of the vocational services team for the beneficiaries they serve. While work incentives planning and assistance continues to be the core work performed by CWICs, there is more to supporting employment outcomes than only assisting beneficiaries with work incentives. To be effective in supporting beneficiaries in their efforts to work, CWICs must expand their counseling skills to help beneficiaries set employment goals and identify the services needed to achieve these goals. 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 (VA).

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.

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 Vocational Rehabilitation (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:

- State VR agency;
- ENs;
- Community Rehabilitation Agencies offering short- and/or long-term employment services;
- AJC/Workforce Centers operated by the Department of Labor;
- Veterans services (Veterans Rehabilitation and Employment Programs);
- Private-for-profit entities such as staffing agencies, private rehabilitation companies, etc.; and
- **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 they have no clear employment objective is obviously in need of career counseling, and CWICs should refer them 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 truly 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 help 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 do not 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 website (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 Ticket to Work 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 assist beneficiaries. CWICs should do more than merely hand out a list of agency names with contact information when providing information about employment services. 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. You can find a listing of approved ENs and contact information for the state VR agencies on the Choose Work website (https://choosework.ssa.gov/findhelp/).

Connecting Beneficiaries with the Specific Employment Services and Supports They Need to Obtain and Maintain Paid Employment

CWICs often help beneficiaries by making 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. 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 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 Veterans 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 two websites provide access to a wealth of great information about the VBA programs:

1. **Veterans Benefits Administration** (https://www.benefits.va.gov/benefits/)
2. **Benefits.gov** (https://www.benefits.gov/)

The Benfits.gov website provides access to Frequently Asked Questions, an online “Ask a Question,” and listing of toll-free numbers under the Contact Us tab.

**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 off-track, CWICs must be available to help. In some cases, the beneficiary may need to appeal unfavorable eligibility determinations that limit a beneficiary’s ability to access services. CWICs must be well versed in the various ways agencies handle
complaints or appeals and must be able to explain these to beneficiaries as well as offer support to complete these procedures.

**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 and Advocacy (P&A) 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?

**Protection and Advocacy for Beneficiaries of Social Security (PABSS)**

As described in Chapter 9, PABSS is a program provided by state P&A 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 am interested in going back to work, but 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 number 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 the beneficiary may need some assistance. 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**

There are many income support programs available in local communities. These include:

- Supplemental Nutrition Assistance Program (SNAP)
- Temporary Assistance for Needy Families (TANF)
- Federal Housing Assistance Programs
- Veterans Benefits
- Unemployment Insurance
- Workers Compensation
- **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. 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 2-1-1 (http://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?

**Referrals for Physical and Mental Health Resources**

Beneficiaries often pose non-employment related questions about health insurance including issues such as coverage, payment for services, eligibility, or enrollment. When this occurs, it is often best to refer the individual directly to the administering agency.

To find answers to most beneficiary questions related to Medicare, beneficiaries may call 1-800-MEDICARE or visit the [Medicare.gov](http://www.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. 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 SHIP website ([https://www.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 ([https://www.medicaid.gov/index.html](https://www.medicaid.gov/index.html)). For state specific information, start with state program overviews on the Medicaid website ([https://www.medicaid.gov/state-overviews/index.html](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)** (https://www.healthcare.gov/). In addition, the Kaiser Family Foundation operates an excellent website for helping people understand **general health insurance concepts** (https://www.kff.org/understanding-health-insurance/).

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).

### 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 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

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).

Next Steps

The I&R component of WIPA services requires CWICs to be very knowledgeable about a wide range of services available in the local community, particularly employment supports. The best way to learn about services in your coverage area is to meet with your WIPA Program Director and team members. Many WIPA programs have lists of local resources they have compiled over the years that they can share with new CWICs. From there, you can continue to conduct research and refine your list of referral sources. If you encounter a question that you are unable to answer, check back with your WIPA team to see what they recommend.
Part II Chapter 12 – Intake Services and Benefits Verification
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Chapter 12 – Intake Services and Benefits Verification

Learning Objectives

After you have read this chapter and completed the associated lectures and activities during WIPA Initial Training, you should be able to:

1. Describe why thorough information gathering and benefits verification are essential components of WIPA services.
2. Identify categories of information CWICs need to gather from beneficiaries in order to provide accurate and complete benefits analysis.
3. Describe the process for conducting an effective intake interview.
4. Describe strategies for conducting efficient and effective intake interviews.
5. Identify which benefits CWICs need to verify prior to providing work incentives counseling.
6. Describe when to verify benefits and describe basic strategies for verification.
7. Describe what the Benefits Planning Query (BPQY) report is, how to request this report from Social Security, and the limits to this report.
8. Describe how to document benefits verification.

List of Acronyms

- AWIC – Area Work Incentives Coordinator
- BPQY – Benefits Planning Query
- BS&A – Benefits Summary and Analysis
- DCF – Disability Control File
- EN – Employment Network
- EPE – Extended Period of Eligibility
- IRWE – Impairment Related Work Expenses
Importance of Information Gathering

In order to provide in-depth benefits analysis and thorough work incentives counseling, CWICs must begin by conducting an intake interview to gather comprehensive information about all benefits an individual receives that paid employment could affect. CWICs cannot provide high quality individualized WIPA services without first investing time and effort in gathering and verifying all relevant information. Keep in mind that not all beneficiary situations require individualized services. CWICs should only conduct intake interviews to collect information with beneficiaries who are appropriate and for and interested in individualized WIPA services.

Required Information Gathering Form

Social Security requires the Ticket to Work Help Line to use a standard form to gather a minimum amount of data about each beneficiary they refer for individualized benefits analysis and work incentives counseling. This form is “Help Line WIPA Referral (SSA-4567)”. The Ticket to Work Help Line completes the SSA-4567 when they refer beneficiaries directly to WIPA programs. That referral will include most of the contact information you need to reach out to a beneficiary during your initial call, plus information about the type of Social Security benefits the person receives and their current employment status.

Conducting Initial Calls

CWICs gather the information necessary for benefits analysis by conducting structured interviews with beneficiaries in person, over the
phone, or by using distance technology. Prior to conducting the intake interview CWICs should complete the initial call. The initial call should accomplish the following tasks in this order:

1. **Confirm the referral for WIPA services** - Make sure the beneficiary understands why the Help Line referred them and provide a brief explanation of WIPA services.

2. **Verify eligibility for WIPA services** – The Help Line will have already screened for eligibility, but if you accept referrals from other sources, you will need to verify eligibility yourself.

3. **Verify that the beneficiary requires individualized WIPA services** – Remember that individualized WIPA services are most useful for eligible beneficiaries who are already employed, have a job offer pending, are actively engaged in a job search, or are a transition youth under age 18. You need to determine that beneficiaries are appropriate for individualized services before you start gathering all the information on the SSA-4565.

The SSA-4565 is a form SSA developed for WIPA programs to use to gather information CWICs need to provide services. The SSA-4567 and SSA-4565 are similar but separate forms. You will find that some of the information fields on the SSA-4565 are duplicative of what you receive from the Help Line on the SSA-4567. You will need to complete all the fields on the SSA-4565 for a full intake. The SSA-4567 Help Line WIPA Referral form is not a complete intake document.

**Note:** Social Security has combined these forms in a single document, but requires approval from the Office of Management and Budget to use it. They will release the updated, combined, form as soon as they receive permission.

4. **Explain next steps in the process** of providing individualized WIPA services including having beneficiaries sign releases of information needed to verify benefits and scheduling a time to conduct an intake interview.
**Tips for Sending Releases and a Welcome Packet**

Before you end the initial call, make sure the beneficiary understands that you must first verify all of the benefits they receive before providing individualized counseling. Here are some tips for helping the beneficiary understand what to expect next:

- Let beneficiaries know that you will be mailing them a Welcome Packet with several release forms that they should sign and return to you. For each release, be sure to explain what information you will gather and how you will use this information in the process of providing services. Stress the importance of returning the required forms back to you quickly, so you can move forward with individualized counseling.

- 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 ask some additional questions at that time. CWICs may need to explain the need for additional verification depending on the beneficiary’s answers.

- Repeat that the most valuable part of WIPA services is the individualized counseling and on-going services. Explain that you will go over how the employment or earnings goal is likely to affect their benefits. You will explain everything verbally, and then summarize it in a special report called a Benefits Summary and Analysis report or BS&A report.

- Thank the beneficiary for their time. End the conversation with information about when the beneficiary can expect to hear from you again. Specifically, a reminder statement about the date and time of the intake interview. Always encourage the beneficiary to contact you with questions or concerns as they may arise.
Tips for Conducting Effective Intake Interviews

The purpose of the intake interview is to meet with the beneficiary to gather all information needed to complete the WIPA Intake form SSA-4565. The interview also gives you an excellent opportunity to get to know the beneficiary and establish trust. The interview should be a conversation with the beneficiary – not just a series of standard questions that might feel more like an interrogation.

To help you get started, we provide an Initial Interview Guide for CWICs on the NTDC website at https://vcu-ntdc.org/resources/viewContent.cfm?contentID=197. This guide provides scripting that will help you become familiar with conducting interviews. In the meantime, here are some practical tips for conducting effective intake interviews:

1. You may not be able to complete the intake interview in one meeting. Be sure to ask the beneficiary how much time they have before you begin so you know in advance. Take your time gathering the information you need and check to make sure the beneficiary is not getting tired or feeling the need to end the meeting. Schedule a time to meet again if you are not able to cover all the bases in one meeting.

2. Be sure to complete the entire interview process using the SSA-4565 as a guide. Do not skip questions unless you are certain they do not apply to the beneficiary. For example, questions about unearned income and resources might not be relevant to Title II beneficiaries. Before you end the meeting, double check to make sure you have all of the information you need.

3. It is helpful to explain why you need information that some beneficiaries may be reluctant to provide. For example, if you ask an SSI recipient about bank accounts or other resources, that might feel intrusive. Be sensitive to the fact that you are asking for some very personal information. When beneficiaries understand how you will use the information, there is a greater likelihood they will be comfortable sharing their information.

4. Do not provide a lot of general work incentives information in the intake interview, as this may discourage the beneficiary from engaging in individualized services. More importantly, you may
be giving the right answer to the wrong question. For example, someone may misunderstand the type of benefit he or she receives, and you could give misinformation for that person’s situation. Another example, you could provide information about Trial Work Period to a beneficiary with work that Social Security has not reviewed. Explain that you cannot provide accurate counseling until you have a complete understanding of their unique benefits situation.

5. Do not provide individualized benefits counseling until after you have gathered information and verified benefits. Make sure the beneficiary understands that providing counseling based on current and accurate information is in their best interests.

6. 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 mailing addresses. Be sure to ask beneficiaries which methods of contact they prefer and make a note about that in your SSA-4565. When beneficiaries provide an email address, ask if they check email regularly. If calling is the preferred method of contact, ask about the best times to call. When beneficiaries provide a cell phone number, check to see if they prefer calls or text messages. If a beneficiary uses a transcription or videophone service, ensure you have the information and that you use that method of communication. Be sure to provide your contact information to the beneficiary as well.

7. End the interview by asking beneficiaries if they have any questions or concerns. Make sure beneficiaries know what the next steps are in the process, so they know what to expect from you moving forward.

Gathering Information about Current Employment

For employed individuals, do not assume that the job they currently have is the one they eventually want, or that it is the only one they have had since entitlement to benefits. One of your primary objectives is to support beneficiaries to achieve improved financial stability. An important way to
achieve this result is moving up the career ladder or retooling to attain a higher paying job. In order to help beneficiaries achieve future employment or earnings goals, you need to know their employment goals.

Helping beneficiaries connect with the employment services and supports that would help them to achieve their career goals is an important part of a CWIC’s job. Determine which services a beneficiary is already receiving and gather specific information about other agencies or professionals the beneficiary accesses. As you work through the interview, you may need to explain how the State VR agency works or answer questions about other employment service providers (e.g. Employment Network, American Job Center, or Center for Independent Living) – 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 or an EN. You should take your time with this part of the interview and fully explain how the employment services system for people with disabilities works so beneficiaries know what to expect.

Ask specific questions about existing employment barriers (e.g. inability to navigate public transportation or unstable housing) or unmet vocational service needs. This applies to all beneficiaries for whom you plan to provide individualized WIPA services, even if they are already involved with an EN or State VR agency.

**Gathering Information about Past Employment**

Past employment since entitlement is important because it could 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 they have already used Trial Work Period (TWP) or Extended Period of Eligibility (EPE) months, or performed Substantial Gainful Activity and may have an overpayment.

Beneficiaries may not remember when they worked, the names and addresses of companies, or even how much they earned. Research into past employment since entitlement 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. Social
Security developed the Benefits Planning Query (BPQY) to help work incentives counselors understand the person’s situation as recorded by Social Security. We provide detailed information on the BPQY later in this chapter.

During the interview, assure beneficiaries that it is okay if they are unclear about the details of the past work, as you can work on that later on if needed. At this point, you just need a basic list of the different jobs the person may have had, an idea about the timeframe the beneficiary worked in those jobs, and an estimate of how much the person may have earned. Be aware that this conversation may cause some anxiety – be sensitive to that possibility. Beneficiaries may be nervous of the impact past employment might have on their current benefits. CWICs should remain supportive and explain how they will use this information in providing individualized counseling.

**Gathering Information about Dependent Family Members who also receive Social Security or Other Benefits**

Many of the beneficiaries you will serve are members of families, with dependent children or a spouse living in the same household. Some dependent family members also receive benefits that income or resources affect. Changes in 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 double check on dependent family members with every beneficiary and explain why you need the information. Be aware that some beneficiaries may not accurately know what benefits family members get or how much the benefit payments are. These situations will require extra benefits research and verification.
Gathering Information about Health Insurance and Healthcare Needs

Income and resources may affect some forms of health insurance, including Medicaid. In some cases, beneficiaries may be more concerned about losing health insurance than they are about losing 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) have. In particular, there are many ways to qualify for Medicaid. A beneficiary may even be enrolled in more than one Medicaid program at the same time. Work affects different Medicaid programs in different ways, so it is important that you research the Medicaid program in the beneficiary’s state of residence and 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 earnings will most likely affect these programs. This includes Medicare, Medicaid, and the VA healthcare system.

When Information Gathering Should Go Beyond the Usual Requirements

Certain groups of beneficiaries have issues that require you to have additional information. 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 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 information you need. A Veterans Information Gathering Tool is available on the VCU NDTC 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. Youth nearing age 18 may require a special interview in addition to the basic information-gathering process to identify potential problems or opportunities. CWICs can use the Age 18 Benefits Check-up for Transition Age Youth: A Guide for Students, Families, and Professionals (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=71) to track the changes that might occur when a transition-age youth reached the age of 18.

Other beneficiaries with complicated benefits situations may also require extra research. For example, SSI eligible couples with children who receive benefits can present very complex situations. In addition, beneficiaries who receive uncommon forms of benefits such as Railroad Retirement or Black Lung benefits may require additional information gathering. Be as thorough as possible when interviewing beneficiaries before beginning your analysis and counseling.

Strategies for Performing Information Gathering

The WIPA service model directs CWICs to provide services via distance methods wherever possible. In the face of limited resources and larger service areas, providing services using distance technology is efficient and cost effective. Social Security supports the use of teleconferencing, videoconferencing, Zoom, FaceTime, and related technologies to meet with beneficiaries. Although Social Security does not prohibit face-to-face meetings with beneficiaries, you should only use them when distance communication techniques are not possible or appropriate.

You can conduct the intake services process very successfully by phone. Here are some tips:

- When you make initial contact with a beneficiary, ask for a phone appointment to conduct an intake interview. You never know what you might be interrupting when you make that first call, and you cannot expect the beneficiary to be available right then for an intake interview. Explain what the intake service process is and why it is necessary. Be sure you and the beneficiary have set
aside enough time to conduct the intake interview. It is common for the intake interview to take one hour.

- You may need several sessions to gather all of the necessary information from the beneficiary. It is best practice to keep calls to an hour. Set up the next session before you complete the call if you need to gather more information.

- Have a conversation. It is possible to gather the information you need by simply having a friendly chat. Try not to read any information-gathering templates or interview guides you use, but spend time getting to know the person, and rephrase the questions in conversational language. CWICs can gather and document information within the SSA-4565 according to the flow and direction of the conversation with the beneficiary. The information does not need to be gathered in the exact order in which presented within the SSA-4565. The goal is to establish trust and rapport while gathering the information you need to perform in-depth individualized benefits analysis.

- Never mail or email the SSA-4565 to the beneficiary and ask them to fill it out and return it to you. Social Security designed the SSA-4565 for CWICs to complete. You will learn much more about the beneficiary and end up with fewer informational gaps if you conduct the interview with the beneficiary. The answers to many of the questions within the SSA-4565 may lead to a CWIC to ask follow up questions and gather additional information.

- Some of the questions you pose may seem intrusive. 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 does not want to answer certain questions, do not pressure them. Make a note to follow-up on that question later and move on.

The intake process is complete once you have completed the Initial Call, sent out the Welcome Packet and releases, and conducted the intake interview to gather all necessary information to complete the SSA-4565.
Verifying Benefits

Verifying the information you gathered during the intake interview process is a required and critical step for WIPA services. Benefits verification may begin as soon as a beneficiary returns releases. This may occur before, during or after the intake interview is complete. Individualized counseling should only occur after you verify all of a beneficiary’s benefits from a reliable 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 is 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 takes time, and sometimes a significant amount of time. It is 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.

When to Verify Benefits

Before writing a Benefits Summary and Analysis (BS&A) report or telling the beneficiary how the employment goal may affect benefits, you must verify all benefits that paid employment could affect. 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 will need to review their benefits to determine if changes may have occurred and if you need to update verifications. The general rule is that if it has been six months or more since you last verified benefits, plan to conduct a new intake interview and re-verify all benefits. If it has been less than six months since you last verified benefits, discuss what may have changed with each benefit. If there has only been a change in one of the benefits, it is only necessary to re-verify that one. If there is any doubt as to whether a change has occurred, re-verify.

What to Verify

You must verify all public benefits the beneficiary receives, including:

- All Social Security benefits, including SSI state supplements
- Medicare – all parts including Part C Advantage Plans or Dual Special Needs Plans
- Medicare Savings Programs (MSPs)
- Medicaid – all forms including Medicaid Home and Community-based waivers
- Supplemental Nutrition Assistance program (SNAP)
- Temporary Assistance for Needy Families (TANF)
- Federal rental assistance or other housing programs that paid employment could affect
- Worker’s Compensation
- Unemployment Insurance
- Veterans Pension/Compensation
- Low Income Home Energy Assistance Program (LIHEAP)
- Black Lung benefits, and Railroad Retirement benefits
- If a beneficiary 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.
- Other Healthcare Coverage-Employer-Private, VA, TriCare, etc.

It is not enough to verify that the beneficiary receives a benefit. Be prepared to verify information such as entitlement date, amount of benefit, time-limited income exclusions, and use of special programs within a benefit program. Because each benefit program is unique, what you may need to verify will differ from one program to another.

In most situations, the benefits you are verifying are those of the beneficiary you are serving. In some situations, though, it may be necessary to verify a 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. CWICs should obtain an additional signed release to verify these additional benefits.
How to Verify Benefits

The first step in verifying benefits is to explain to the beneficiary why you need to verify their benefits and obtain signed releases of information. You will need a release of information to verify each benefit the beneficiary, their spouse, or children 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.

The second step is to contact the agency that administers the benefit. How you 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. Because there are numerous state and local benefits that you must verify, you will need to identify the process for verifying these state or local benefits for your service area. Establishing the means for verifying benefits requires an effort of networking and relationship building on your part. In most agencies administering benefits, personnel have substantial workloads and that can result in delays in responding to requests for benefit verification. In these situations, you will need to build and use a network to find alternate avenues or approaches for obtaining verification. Be sure to meet with your WIPA Program Director before you start verifying benefits to make sure you understand the exact strategy to use with each agency.

The third step in verifying benefits is to review all verifications to determine if there are any inconsistencies with the information the beneficiary shared about their situation. Sometimes, the verification information will raise additional questions. It is a critical part of your job to know how to identify these issues and how to correct them. Make sure you know the best contact within each agency to answer questions. For example, a CWIC might have to contact the WIL or AWIC to answer questions.

You can find a **Benefits Verification Quick Reference Guide** on the VCU NTDC website at https://vcu-ntdc.org/resources/viewContent.cfm?contentID=226. This useful tool provides a detailed list of all the benefits you should verify with specific instruction about how to go about requesting verification.
Verifying Social Security Disability Benefits – the Benefits Planning Query (BPQY)

The Social Security Administration’s BPQY (SSA-2459) contains comprehensive information about an individual’s disability benefits and work activity that Social Security has reviewed. 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 some work history (if reported and reviewed). 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 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 requires CWICs to submit the SSA-3288 Release of Information form when requesting a BPQY. This is the only form for requesting a BPQY, because it meets all the criteria for disclosure of Social Security information and records required by Social Security regulations.

Social Security will assume the consent is for a one-time only disclosure unless the beneficiary documents on the SSA-3288 that Social Security can disclose records beyond the one time. The beneficiary must document on the SSA-3288 the timeframe in which Social Security can disclose the information (for example, disclose information for one year from the date I signed this form). If you have follow-up questions about the BPQY and the original SSA-3288 does not document the timeframe for the consent to disclose information, you will need a second release requesting specific information. This is always true if you are requesting more information about an overpayment.

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 is available on the Social Security website (https://www.ssa.gov/disabilityresearch/documents/BPQY_Handbook.pdf).
The BPQY Handbook also includes an SSA-3288 exhibit with the appropriate information for requesting a BPQY inserted. We also provide you with a **Sample SSA-3288 for Requesting BPQYs** on the VCU NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=232). CWICs should use this pre-populated form when requesting BPQYs from Social Security.

Send the completed release form 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 Specialists or Service Representatives. Be sure to research how each local office in your service area prefers you to submit BPQY requests, and follow the proper procedure for each office.

The Area Work Incentive Coordinator (AWIC) is also a valuable resource if you have challenges receiving BPQYs or other information from the local Social Security office. The AWIC provides training and technical support to the local offices on work incentive issues, and he or she may know how best to obtain the BPQY.

**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. Some WIPA programs have established secure email and can email releases. CWICs should check with their WIPA manager to determine if their program is a Social Security approved secure email partner. If you do not receive the BPQY in the expected timeframe, follow up with Social Security, and submit a second request if necessary. It is a good idea to retain a copy of the releases you submit.

3. Ask beneficiaries to get the BPQY themselves by calling Social Security’s toll-free number, or, if the beneficiary is able, by visiting the local Social Security field office.

**Reviewing the BPQY**

Social Security generates the BPQY by pulling from several different data sources. If any information in these data systems is outdated or incorrect,
the information on the BPQY will be outdated. For example, if the beneficiary did not report earnings or if they did report, but Social Security has not yet processed a work CDR, the work incentive information on the BPQY may be outdated. Even when a beneficiary receiving Title II reports using electronic methods, the earnings will not become part of the BPQY until a Social Security Claims Technician has made a decision about the effect of those earnings on the person’s benefits through a work CDR. You can help identify errors in any item on the BPQY by bringing this to the beneficiary’s attention and helping them resolve this through the local Social Security office, the WIL, or the AWIC, depending on the service structure in your area, to avoid future misunderstandings or potential overpayments. A notice to the beneficiary, or subsequent BPQY should confirm that Social Security made the correction(s). It is important to keep in mind that the BPQY, as with all verifications, is a starting point. You must review it carefully for inconsistencies or missing information.

Social Security’s 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 their representative and ask questions about the information on the BPQY. You need to know if it matches what the beneficiary remembers about their 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 it. Make sure you have a signed release of information before you make a request of this nature. You may need to complete an additional SSA-3288 for any questions you ask about the BPQY.

3. 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 their 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.

**Limits to the BPQY**

The BPQY is a critically important tool CWICs use to verify benefits, but it does not contain all of the information you may need. You will need to conduct additional information gathering and verification in the following areas:

1. **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 assigned their Ticket (month and year), to whom their Ticket is currently assigned, when their last Timely Progress Review occurred, and if their 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 the beneficiary is with you in person or on conference call. Ticket Call Center personnel cannot speak with you unless the beneficiary is present.

2. **Medicaid:** Since Social Security does not administer the Medicaid program, there is very little the BPQY can tell you about someone’s Medicaid status. Verify Medicaid status by contacting the Medicaid agency in the state where the beneficiary lives. Be sure to discuss methods for contacting the state Medicaid agency with your WIPA Program Manager.

3. **Medicare:** The BPQY can verify that a beneficiary is enrolled in Parts A and B with the dates of enrollment. It can also verify whether the state is paying the Medicare Part B premium. The BPQY does not provide you with any information about Parts C or D. It also will not tell you which Medicare Savings Program an individual has—only that the state is paying the premium. The best way to verify Medicare information is to have the beneficiary call the Medicare toll-free line at 1-800-MEDICARE. Beneficiaries can also set up a ["my Medicare" online account](https://www.medicare.gov/account/create-account) by going to the Medicare website at https://www.medicare.gov/account/create-account.
Interpreting BPQYs will take time for you to master. To get started, you should refer to a useful resource document entitled **Tips for Interpreting BPQYs** on the NTDC website at https://vcu-ntdc.org/resources/viewContent.cfm?contentID=222.

**Verifying Other Benefits**

Remember, providing benefit information or advice without verifying the benefit status can result in you providing harmful misinformation to the beneficiary. While the BPQY can verify a substantial amount of information, most beneficiaries have additional benefits that provide critical supports. You must also verify these benefits, which means the process for verification generally involves more than just obtaining the BPQY. You should begin by reading a resource document entitled **Benefits Verification Quick Reference Guide** (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=226). The next step is to meet with your WIPA Program Director to find out how to verify the various benefits in the state(s) where the beneficiary lives.

**Documenting Verifications**

CWICs keep 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 they 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, form SSA-4566. The SSA-4566 should include the date of the conversation, the name of the person with whom you spoke, and details about what information you verified. We also provide a **Verbal Benefits Verification Form** on the NTDC website at https://vcu-ntdc.org/resources/viewContent.cfm?contentID=235. CWICs should always complete a SSA-4566 to document the verification. Additionally, copies of relevant releases of information should be on file to verify that the beneficiary granted permission to obtain information from agencies.
Next Steps

We have provided you with an overview about information gathering through the Intake Interview and verification in the WIPA program. You will need to confer with your WIPA Program Director to learn more about your agency’s approach to this essential task.
Part II Chapter 13 – Performing Benefits Analysis and Developing Benefits Summary and Analysis Reports
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Chapter 13 – Performing Benefits Analysis and Developing Benefits Summary and Analysis Reports

Learning Objectives

After you have read this chapter and completed the associated lectures and activities during the WIPA Initial Training, you should be able to:

1. Describe what a Benefits Summary and Analysis (BS&A) report is and the purpose of these reports.
2. Identify and describe three factors that determine which beneficiaries should receive individualized benefits analysis and a BS&A report.
3. Describe how BSADocs is used in the WIPA program to develop BS&A reports.
4. Identify and describe successful strategies for planning a BS&A report.
5. Describe strategies for reviewing BS&A reports with beneficiaries.

List of Acronyms

- BPQY – Benefits Planning Query
- BS&A – Benefits Summary and Analysis
- BWE – Blind Work Expenses
- EN – Employment Network
- EPE – Extended Period of Eligibility
- EPMC – Extended Period of Medicare Coverage
- EXR – Expedited Reinstatement
- IRWE – Impairment Related Work Expense
- ISM – In-kind Support and Maintenance
- LIS – Low-income Subsidy
- MSP – Medicare Savings Program
- QDWI – Qualified Working Disabled Individual
- QMB – Qualified Medicare Beneficiary
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 want to work have access to complete and accurate information about how paid employment will affect benefits and how to use work incentives to support their employment efforts.

The cornerstone of the 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 an individual in meeting their goals. CWICs provide this counseling through numerous discussions with beneficiaries during which CWICs describe specific work incentives, answer questions about benefits and work, explain advantages and disadvantages of available options, and offer expert advice. CWICs provide lots of valuable and complex information during these interactions with beneficiaries. To help beneficiaries better understand and retain this information, CWICs summarize the benefits counseling they provide in a document called a Benefits Summary and Analysis report or BS&A report.

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.

Developing BS&A reports is only one part of the WIPA program. CWICs should not confuse the BS&A report with delivering individualized WIPA services. The BS&A report summarizes and documents the counseling you provide to beneficiaries over the course of many 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. Individualized WIPA service includes ALL of the following components:

- In-depth personalized information gathering and benefits verification;
- Comprehensive benefits analysis covering the impact of employment on 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 high-quality BS&A report summarizing this counseling;
- 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;
- 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, giving beneficiaries a BS&A report does not replace personalized counseling – it merely documents the information you provide in a written format.
Understanding Benefits Analysis

The most important aspect of WIPA services is individualized benefits analysis. This service has six components:

1. Detailed descriptions of how a beneficiary’s earnings goal will affect ALL benefits that person, and any dependent family members, receive. This includes Social Security benefits, associated medical insurance (Medicare and/or Medicaid) and any other federal, state or local benefits (food stamps, federal rental housing subsidies, energy assistance, workers compensation, unemployment insurance, etc.) If the beneficiary has several different earnings goal options in mind, benefits analysis would include a comparison of how each earnings goal would affect all benefits.

2. Descriptions of any special work incentives that might apply to the beneficiary with information about how Social Security would apply the work incentive during work determinations and instructions on how to request the work incentive. This includes providing comparisons of how the earnings goal would affect benefits with and without accessing the work incentive.

3. Identification of any problems the beneficiary is currently having or may be expected to have in the near future related to benefits with explanations of how to resolve each problem.

4. Identification of additional benefits the individual might access with instructions on how to apply.

5. Identification of any employment supports or services the beneficiary could use to achieve their earnings goal with instruction on how to access those services.

6. Explanation of what the beneficiary needs to do to report earnings to Social Security and any other applicable agency.

Effective benefits analysis requires excellent analytical thinking skills, strong communication skills and significant attention to detail. The analysis is the valuable service – the BS&A report simply summarizes the results of that analysis. CWICs only produce high quality BS&A reports when they perform comprehensive benefits analysis.
Overview of BS&A Reports

The BS&A report summarizes the beneficiary’s current benefit status and provides customized case-specific information about the past, current, and future use of work incentives to support a beneficiary’s earnings goal. CWICs prepare a BS&A report for beneficiaries who need individualized, case-specific benefits and work incentives information. The BS&A report documents the information a beneficiary needs to make informed decisions about work. In the WIPA program, BS&A reports must contain ALL of the following components:

1. Confirmation of all verified benefits an individual (and dependent family members) receive that paid employment could affect;
2. Confirmation of the beneficiary’s current employment and/or future earnings goal;
3. Detailed descriptions of how the earning goal(s) will affect all benefits the individual (and dependent family members) receive;
4. Description of specific work incentives applicable to the beneficiary;
5. Recommendations for employment supports that could help the beneficiary achieve the specific earning goal(s); and
6. Identification of any benefit problems with options for resolving those problems.

Determining When a Beneficiary Should Receive a BS&A Report

The need for a BS&A report is related to three factors:

1. How close the beneficiary is to employment;
2. Whether the beneficiary has an employment or earnings goal; and
3. How willing the beneficiary is to complete the information gathering and verification process required for comprehensive, individualized benefits analysis.
People who are the closest to employment are those whom Social Security has indicated are the highest priority for individualized WIPA services. This includes:

- Beneficiaries who are working full-time, are self-employed full-time or are about to start full-time work;
- Beneficiaries who are working part-time, are self-employed part-time or about to start part-time work;
- Beneficiaries who have had a job interview within the 30 days prior to their first contact with the WIPA program or Ticket to Work Help Line, or who have a job interview within the two weeks following contact with the Help Line or initial contact with the WIPA program; and
- Beneficiaries seriously considering employment, who are currently receiving services from a State Vocational Rehabilitation (VR) agency, or who have assigned their Ticket to an Employment Network (EN) or other vocational program, or who indicate serious intent to work.

The closer a beneficiary is to employment, the more urgent 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.

In order for a CWIC to perform individualized benefits analysis, a beneficiary needs to have an employment and earnings goal. This is because the analysis focuses on how that employment or earnings goal will affect the beneficiary’s unique benefits situation. Without a monthly earnings goal, it is not possible for the CWIC to be specific during benefits analysis. For beneficiaries who are already working, the earnings goal may be the current wages, or it may be an aspirational earnings goal involving a job change, a raise, or an increase in hours. If the beneficiary has identified an employment goal, but has no specific monthly earnings amount in mind, you can determine an earnings goal by estimating the number of hours the person feel they can work and multiplying that by an estimated hourly wage. In some cases, the beneficiary may be unsure how much they are able to earn. When this
happens, you can use a range of monthly earnings to perform benefits analysis rather than a single amount.

Finally, CWICs require lots of information about a beneficiary in order to provide benefits analysis and develop a BS&A report. In order for CWICs to get the necessary information, beneficiaries must sign release of information forms and participate in lengthy intake interviews. Unfortunately, for a variety of reasons, some beneficiaries are not willing to provide the required releases or complete the information gathering process. Without verified benefits information, CWICs can only provide general information about how work may affect benefits rather than individualized benefits analysis.

**Addressing the Information Needs of Beneficiaries Who Do Not Require a BS&A Report**

If a BS&A report is not appropriate, necessary or possible, 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 do not need in-depth benefits analysis and a BS&A report, 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 Expense). **Approved resource materials** are available on the VCU NTDC website (https://vcu-ntdc.org/resources/resources.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 SSI spotlight factsheets (https://www.ssa.gov/pubs/).

Keep in mind that a beneficiary’s status related to employment may change at any time. A beneficiary may not require benefits analysis initially, but later may begin a job search, get a job offer or start working. You need to be prepared to provide individualized WIPA services at any point after a beneficiary enrolls in WIPA services.

### Using BSADocs for BS&A Report Development

In the current WIPA Terms and Conditions document, Social Security requires that WIPA programs use standard report-writing software to generate BS&A reports. VCU’s NTDC purchases a customized BS&A preparation software called “BSADocs” for each WIPA program. The purpose of this software is to produce accurate, comprehensive, and uniform BS&A reports across all WIPA programs. VCU’s NTDC provides training to all WIPA personnel on how to use BSADocs and provides support to answer questions about the software when they arise.

In BSADocs, there is a “template” that functions 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, CWICs 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 initial 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, they click 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, CWICs 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 programs review their state-specific benefit information and confirm whether any changes have occurred in the benefit rules. If changes occur, the WIPA programs provide details on those changes and works 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 uploads the updated version to an online hub for CWICs to use.

BS&A Report 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 use the BS&A format posted on the VCU NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=92).

BS&A Report 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 possible, do not proceed to develop the BS&A report until you have clarified any outstanding issues.

2. Using 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 remembered everything. 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 cannot develop a BS&A report without having some sort of earnings goal to analyze. If you are uncertain, contact the beneficiary one more time to clarify.

4. Make sure you have identified any problems the individual has with their benefits and list any questions the person asked about benefits that you need to address in the BS&A report.

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 most appropriate category and do not list any benefit or issue more than once:
   i. How the earnings goal will affect Social Security cash benefits (this includes SSI, Title II disability benefits, auxiliary benefits, etc.);
   ii. How the earnings goal will affect health insurance (Medicaid, Medicare, Medicare Savings Programs (MSPs), Part D Low-income Subsidy (LIS), VA healthcare benefits, etc.);
   iii. How the earnings goal will affect any other federal, state or local benefits (SNAP, federal rental subsidies, Worker’s Compensation, Unemployment Insurance, etc.);
   iv. 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);

v. Other topics you want to include based on benefits issues you identified or questions the beneficiary posed about issues like deeming or in-kind support and maintenance (ISM), overpayments, or referrals for other benefits the person may need, etc.; and

vi. Important things for the beneficiary to remember like information about reporting wages, documenting work incentives, 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 specific work incentives you want to discuss, add those in, too. You can use a form called the BS&A Planning Sheet to outline the information you plan to include in the report prior to writing the actual report. This planning tool is a structured outline template that will help you organize the information before you begin writing. You will find the BS&A Planning Sheet on the NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=94).

Avoiding TMI Syndrome – Too Much Information

One of the most difficult aspects of writing BS&A reports is deciding how much information to include in and what to leave out. Well-intended CWICs often discuss every conceivable work incentive that could ever apply in far too much detail.

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 the effect of work on benefits. If, after reviewing the BS&A report, the beneficiary does not clearly understand how work will impact their benefits, they may choose not to work rather than take the risk. This is the worst possible outcome of providing too much information.
When writing BS&A reports, TMI syndrome is characterized by two different mistakes CWICs make. 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. The second mistake is discussing provisions, work incentives or other benefit effects that could happen far out in the future. You should not include information about anything that would occur more than 18 months in the future.

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 beneficiaries achieve their employment goals. Just in time benefits counseling assumes that CWICs have ongoing relationships with high priority beneficiaries and are making multiple contacts over 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, you will make repeated contacts, and you may need to revise the BS&A report as a beneficiary’s circumstances change over time.

How do you know when you have provided enough information and at the right time? There is no simple answer. It all depends on the beneficiary and their unique situation. You can find a useful document entitled **What to Include in a Benefits Summary and Analysis (BS&A) Report and What to Leave Out** on the NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=231) that lists each section of the report and provides specific guidance on what you need to include and what would be considered TMI. Be sure to review that document carefully before you develop any BS&A reports that you submit for grading during the certification process. In addition, during WIPA Initial Training, your instructors will also provide you with several sample BS&A reports that will illustrate what is enough information to cover in various situations.

**Including Attachments with the BS&A Report**

You should include companion documents to support your analysis. SSI Calculation Sheets and TWP/EPE/EXR Tracking Charts can really help
beneficiaries understand their BS&A report. Include examples that illustrate what the beneficiary should anticipate considering his or her situation.

You can find a blank copy of the **SSI Calculation Sheet** on the VCU-NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=255). 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 where the person is in the Trial Work Period, the Extended Period of Eligibility, Expedited Reinstatement, and continuation of Medicare coverage. The **TWP/EPE/EXR Tracking Chart** illustrates the progression of these work incentives phases, so the beneficiary will know when to expect changes in their benefits. You can find the tracking chart on the VCU NTDC website (https://vcu-ntdc.org/resources/viewContent.cfm?contentID=249).

**BS&A Report Quality Considerations**

There are several other quality considerations worth discussion. The most important are:

- Customizing the report to match 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**

High quality work incentives counseling specifically addresses the beneficiary’s primary concern of how will their earnings goal affect their benefits.
When you write BS&A reports, a good rule is to follow any description of a work incentive or policy with a discussion about how this work incentive or policy applies to the beneficiary’s situation. For example, after providing an explanation of the TWP, provide information about the beneficiary’s current work or earnings goal in terms of how it would or would not use TWP months. When you use the BSADocs software to develop BS&A reports, 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.

**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 stop, they 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, be clear, concise, and honest about the effect of work on benefits, but phrase it in a way that leads to understanding, not fear.

Use extra caution when you discuss terminating from benefits. While it may not be in the best interest of some beneficiaries to terminate from benefits due to work, this is certainly not the case for all beneficiaries. Do not 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 replace all benefits. Remember, the intent of WIPA services is to promote employment and improve financial stability. 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, a good rule is to 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).

Another 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 cannot work above a very limited level, you should not assume that is always the case. A low earnings goal may indicate that the person is afraid of benefits loss. We do not want beneficiaries to choose low employment goals if they have the capacity to earn more but are afraid of how it would affect benefits. Do not 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 report 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 is not 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. Our goal is to help beneficiaries improve their financial security by working. Employment situations that could cause a beneficiary to have less disposable income are likely to fail. You have a duty to warn the beneficiary when this potential exists. Possible examples of this include:

- A Title II beneficiary receives monthly SSDI benefits that are $400 more than the current SGA level. He is considering a job offer resulting in gross wages that are approximately $200 more than the current SGA level. Once he has used his TWP and Grace Period, Social Security would consider this level of wages SGA and stop paying benefits. The beneficiary’s net wages after all payroll deductions would be over $200 less than the amount of the SSDI cash payment. Therefore, this
would represent a loss of disposable income to the beneficiary.

- 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 $400 more than the current SGA level in SSDI benefits and add the receipt of half that benefit amount in child’s benefits provided to his young daughter. If he accepted a job paying gross wages of $200 more than the current SGA level, which would probably be considered SGA, it would likely cause the eventual loss of both his benefit and his daughter's benefit. It is very important that you help beneficiaries determine what they would need to earn to at least replace all benefits. 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 them to lose eligibility for Medicaid waiver services with no ability to replace the services through another source.

When an earnings goal potentially would cause financial harm to 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. Instead, 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 and can decide about how to move forward.
Quality Control for BS&A Reports

Before releasing the BS&A report to a beneficiary, check your work to make sure you are presenting a high-quality report. Watch for the following things:

- Does the BS&A report capture all of the relevant work incentives that would apply to the beneficiary and provide clear explanations of them? It is 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.

- Does the BS&A report provide work incentives information tailored to the beneficiary’s current or anticipated employment or earnings goal?

- Does the BS&A report address any benefit problems and provide specific advice about how to resolve them?

- Does the BS&A report address upcoming events such as marriage, establishing insured status for Title II benefits, etc. and their effect on payments?

- Does the BS&A report offer referrals to additional services or programs that would help the beneficiary?

- Is the information in the BS&A report well organized, clear, concise, and presented in a logical order?

- Is the BS&A report well written with complete paragraphs and sentences, correct grammar and punctuation? Be sure to double check for misspelled words and typographical errors.

Reviewing BS&A Reports with Beneficiaries

Always provide the beneficiary with a copy of the BS&A report and schedule time to review the contents. Remember, the heart of WIPA services is not the BS&A report, 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 report 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
will need a signed consent form from the beneficiary in order to share the report with anyone else other than the beneficiary. When you are 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 report with other members of the employment support team for feedback, if the beneficiary desires.
- Be sensitive to the beneficiary’s level of comprehension and adjust your explanations to fit the beneficiary’s communication needs.
- Allow sufficient time for the meeting as you may need to review certain concepts multiple times.
- Do not send copies of the BS&A report to others working with the beneficiary without the beneficiary’s prior authorization and signed releases.
- As stated earlier, you will need to update the BS&A report and review any new options as the beneficiary moves forward in achieving his or her employment goals. The BS&A will be one of your main tools to frame counseling sessions.

Next Steps

Developing high quality BS&A reports is one of the most challenging aspects of a CWIC’s job. Do not be concerned if you finish initial training and worry that you will not master this task. The more you work with beneficiaries, the more comfortable you will become with performing benefits analysis. The benefits analysis is what drives the content of the BS&A report. CWICs who achieve full certification will
receive training on using BSADocs and using that software will make it much easier for you to generate consistent and complete BS&A reports. In the meantime, here are some things you can do to build skill.

1. As you begin to develop BS&A reports, but sure to review the sample BS&A reports your instructors provided in initial training and study the handout about what to include in the report and what to leave out. If you model your work on the examples you are given, you will be on the right track.

2. As you begin developing BS&A reports with beneficiaries, ask for feedback from experienced peers or your WIPA Program Director. Having other people review your work before you share it with a beneficiary will help you identify where you need to improve.

3. You can also ask your VCU Technical Assistance (TA) Liaison to review your BS&A reports. This is particularly helpful before you start submitting BS&A reports for review as part of the Part II certification activities. Keep in mind that you may not send a BS&A to your TA Liaison for review and comment if you plan to submit it for grading.
Part II Chapter 14 – Supporting Beneficiaries to Manage Benefits
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Chapter 14 – Supporting Beneficiaries to Manage Benefits

Learning Objectives

After you have read this chapter and completed the associated lectures and activities during WIPA Initial Training, you should be able to:

1. Describe the four major functions CWICs perform to help beneficiaries develop benefits literacy.

2. Identify and describe what information Social Security requires Title II beneficiaries to report and the reporting options available to Title II disability beneficiaries.

3. Identify and describe what information Social Security requires SSI recipients to report and the reporting options available to SSI recipients.

4. Describe the specific tasks CWICs should perform to support beneficiaries with wage reporting.

5. Describe the CWIC’s role in supporting beneficiaries to manage work incentives.

6. Describe the CWIC’s role in helping beneficiaries with benefits problems unrelated to working.

List of Acronyms

- BPQY – Benefits Planning Query
- BS&A – Benefits Summary and Analysis
- BWE – Blind Work Expenses
- CDR – Continuing Disability Review
- EIE – Earned Income Exclusion
- EPE – Extended Period of Eligibility
- GIE – General Income Exclusion
- IDA – Individual Development Accounts
- IRWE – Impairment Related Work Expenses
- myWR – My Wage Report
- PASS – Plan to Achieve Self-Support
- SEIE – Student Earned Income Exclusion
- SGA – Substantial Gainful Activity
- SSITWR – SSI Telephone Wage Report
- TWP – Trial Work Period

**Benefits Literacy**

The phrase “benefits literacy” means acquiring an understanding of public income maintenance programs such as Social Security disability benefits, Supplemental Security Income, Medicaid or Medicare, SNAP, federal rental assistance, or any other income support a beneficiary receives. Far too often, beneficiaries are unaware of the rules for these programs.

Social Security disability beneficiaries need assistance from CWICs to understand their public benefits. This is one of the most important roles CWICs perform. The process of improving benefits literacy consists of the following steps:

1. Helping beneficiaries understand the eligibility requirements for their benefits. When beneficiaries understand the eligibility requirements they can understand when and why earnings can cause loss of essential cash payments and health insurance.

2. Actively teaching beneficiaries about the effect of earned income on benefits. This includes providing information on work incentives built into many benefit programs. When beneficiaries understand how wages affect benefits, they can plan and prepare for these changes.

3. Perhaps the most important part of benefits literacy is teaching beneficiaries to know what information beneficiaries must report to the various governmental agencies, and providing support in the process. Beneficiaries who do not report critical information in a timely fashion often experience an overpayment in benefits or other problems. In the WIPA program, there is no more important form of prevention than supporting beneficiaries to report information to Social Security on time using correct procedures.
4. Even with reporting, some benefit problems will occur. Another aspect of benefits literacy is teaching beneficiaries to recognize when problems occur and how to resolve common problems. In some cases, a beneficiary may need a CWIC to resolve a benefits issue, but CWICs can also empower individuals to take active control of their benefits by giving them the tools they need to identify problems and resolve them successfully.

Supporting Beneficiaries to Report Work

Teaching beneficiaries how to correctly report to Social Security and other agencies that administer benefits is an important part of a CWIC’s job. Beneficiaries may not understand the reporting requirements. For example, some beneficiaries may think that since Social Security is withholding deductions from their paychecks, Social Security is aware that they are working and have the required wage data. SSI recipients may not understand that changes in living arrangement and marital status can cause changes in benefits – including ineligibility for cash payments and health insurance. Understanding what to report, when to report, and how to report can prevent potential benefit problems. Let’s take a closer look at reporting strategies for both the Title II disability programs and the SSI program.

Reporting within the Title II Disability Program

The only types of income that can affect Title II benefits are Worker’s Compensation/Public Disability Benefits and work income. Also, resources do not affect benefits in the Title II program: CDB, SSDI, or DWB. Most beneficiaries do not need to report unearned income, however beneficiaries must tell Social Security right away if:

- Work starts or stops; or
- Duties, hours, or pay changes; or
- They start or stop paying for items or services they need for work due to the disability (e.g., Impairment Related Work Expenses or IRWEs); or
- They start or stop getting help from their employer or others to perform their job duties (e.g., Subsidy/Special Conditions).
Note: There are other situations that beneficiaries must report to Social Security, such as receiving a Worker’s Compensation benefit, changes in address, etc. The above list is especially important for working beneficiaries to avoid or reduce overpayments or underpayments related to work activity.

CWICs should encourage beneficiaries to report any of the changes listed above in writing or in person to the local field office. By reporting in writing, beneficiaries have documentation that they did make a report in case there are questions later. Beneficiaries may simply write a letter describing the employment status change. In some cases, the beneficiary may need to fill out a Work Activity Report form (SSA-821). The SSA-821 gathers additional details about the employment status change, potential work incentives, as well as recent and current earnings information for the beneficiary. The Claims Technician at Social Security uses this information to make decisions about how the change will affect the benefit. When beneficiaries promptly report changes in work activity, Claims Technicians are better able to determine when to request an SSA-821 to help them make these important decisions.

Title II beneficiaries must make the initial report of work to SSA by mail, on the phone or in person. After the initial report, they should report any change in work activity or a significant change in gross income. SSDI beneficiaries may report their wages monthly to establish a record of the earnings and receive a receipt for the report, however Social Security will not make a decision about those wages until a technician conducts a work Continuing Disability Review. Beneficiaries have several options for submitting this information, but Social Security prefers that beneficiaries report by using an online wage reporting application behind the “my Social Security” portal called "my Wage Report" (myWR). By using this option, disability beneficiaries and their representative payees can avoid visiting a field office to report their wages in person. 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. Social Security must obtain an Employer Identification Number or EIN before a beneficiary can report earnings via myWR. CWICs should counsel beneficiaries to ask for this EIN from an employer and encourage beneficiaries to provide this, if able, when reporting new employment. After beneficiaries report their wages online, they can save or print a copy of their receipt. You can

Beneficiaries who are unable to use the myWR option can report wages by mailing or bringing pay stubs to their local Social Security office. Beneficiaries can find the nearest office by visiting the Social Security office locator (https://www.ssa.gov/locator). When beneficiaries report their earnings by mail, they may want to use "certified" mail to protect the security of their information and ensure that it arrives at Social Security. Social Security is required to provide beneficiaries with receipts to document all wage reports. CWICs should encourage beneficiaries to ask for a receipt when reporting. Beneficiaries should keep a notebook describing when and to whom they reported work, a copy of any written information they provide to Social Security as well as any receipts they receive.

**Reporting in the SSI Program**

SSI requires different reporting protocols than the Title II disability program. Social Security needs wage and work incentive information as soon as possible to ensure the payment is accurate. Social Security requires SSI beneficiaries to report any changes that could affect their SSI benefit, including, but not limited to, the following:

- Unearned income, including payments like Unemployment Insurance, child support, or any other cash they receive.
- Earned income such as monthly gross wages or self-employment income. This also includes any in-kind items a beneficiary receives in-lieu of wages (like room and board).
- Changes in living arrangements including anyone moving into or out of the beneficiary’s household.
- Any help a beneficiary receives with living expenses like rent, groceries, or utility bills.
- Changes in marital status such as getting married, separating from a spouse, or getting divorced.
- Resources or assets a beneficiary receives such as stocks, bonds, a second car, a second house, or other property.
Beneficiaries should report a change as soon as possible, but no later than ten days after the end of the month in which the change occurred. SSI beneficiaries who are working should report the gross amount of wages by the sixth day of the next month. For example, if an individual receives wages in July, they should report the total gross amount within the first six days of August.

These reporting requirements apply not only to the SSI beneficiary, but also to a spouse living with the beneficiary and parents of beneficiaries under age 18.

SSI beneficiaries have several options for reporting information to Social Security. SSI beneficiaries may report any of the changes listed above in writing or in person at the local field office. For changes in earnings status, as well as non-employment related changes, beneficiaries may use the **Statement of Claimant or Other Person, SSA—795** form (https://www.ssa.gov/forms/ssa-795.pdf). On this form, beneficiaries explain the change in their status and the date the change occurred, and mail or deliver it to the local field office. You can find the address of the local Social Security offices by using the **online locator** (https://secure.ssa.gov/ICON/main.jsp). Beneficiaries should keep a copy of any written information they provide to Social Security as well as any receipts they get after reporting.

Another reporting option available to SSI beneficiaries is the online wage-reporting tool "myWageReport" (myWR). In addition, SSI beneficiaries have several other automated reporting options that are unavailable to Title II disability beneficiaries. The first is the SSI Telephone Wage Reporting system (SSITWR), which permits beneficiaries or their representatives to call a toll-free number (1-866-772-0953) to report the prior month’s gross wages. The second option 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 beneficiaries should report wages during the first six days of the month to prevent improper payments. Regardless of which automated method a beneficiary chooses to report wages, they can **sign up online to receive a monthly e-mail or text message wage-reporting reminder** (https://www.ssa.gov/ssi/wage-reporting.html).
Using one of the automated reporting systems is somewhat limited because they do not permit deductions for most work incentives that beneficiaries may access. If a beneficiary does not have work incentive deductions, these systems are a valuable and convenient tool. The individual will be required to authenticate their Social Security number, name, and date of birth. The system will mail a wage receipt to the beneficiary or their representative payee. CWICs should encourage beneficiaries and their representative payees to keep these receipts. The automated wage reporting systems work well for:

- Parents or spouses who are not disabled and need to report income that will be deemed to the beneficiary; and
- SSI beneficiaries with no work incentive deductions other than the Student Earned Income Exclusion (SEIE).

Wage reports made via the SSITWR and SSIMWR applications only apply to SSI. While concurrent beneficiaries can use these options to report wages for SSI, the information does not automatically transfer to the SSDI program and a separate report is necessary. The best option for concurrent beneficiaries is MyWR, as the one report will update both programs. People receiving only SSDI benefits cannot use the SSITWR or SSIMWR applications.

Those who may not use the automated wage reporting systems include individuals who:

- Have Impairment Related Work Expenses (IRWE);
- Meet the definition of statutory blindness and have Blind Work Expenses (BWE);
- Have a Plan to Achieve Self-Support (PASS);
- Have deemed income;
- Receive wages from more than one employer in a month; and
- Have Net Earnings from Self Employment (NESE).
The CWIC’s Role in Supporting Beneficiaries with Reporting

The current WIPA Terms and Conditions clearly indicates that Social Security expects CWICs to assume an active role in helping beneficiaries to report wage information. This document states the following:

“99% of engaged beneficiaries should receive information about reporting wages. BS&As developed for engaged beneficiaries must include information about reporting earnings. For statistical purposes, assisting with wage reports extends beyond instructing the beneficiary when and how to report. Instead, “Assisting” requires additional effort, such as completing forms with the beneficiary, going to the local Social Security office, or creating calendars and reminders, etc.”

There are four separate areas in which CWICs should help with wage reporting. Let’s take a look at your responsibilities in each of these areas.

Provide Written Information about Reporting Responsibilities and Reporting Strategies

- Provide all engaged beneficiaries with written information about reporting responsibilities and methods. We recommend using the following Social Security publications entitled (add title to SSA document) It is not enough to simply mail or email these resource materials to beneficiaries. You must review these handouts with beneficiaries to make certain they understand their reporting responsibilities and are clear about how to report information correctly within specific timelines. During this discussion, you should provide information about how to report income to other agencies besides Social Security, including addresses of agencies or online information or portals for agencies that administer other benefits.

- Include handouts on reporting responsibilities and methods as attachments to all Benefits Summary and Analysis (BS&A) reports. You should discuss these materials with beneficiaries as part of the BS&A review process and answer any questions beneficiaries pose. The BS&A report should also include
specific instruction on reporting wages to other applicable agencies, including addresses for local offices.

- When you discover that a beneficiary has started working at some point after engagement and BS&A development, you should contact the beneficiary to discuss reporting responsibilities. The more times you present information about reporting, the better.

**Provide Assistance with Initial Work Reports**

- When you become aware that a beneficiary has started working, you should inform them that they should make initial work reports in writing, or in person by visiting the local field office. You should also instruct beneficiaries to keep copies of all wage information, letters used to report changes, and receipts Social Security issues after reporting. During this discussion, remind beneficiaries to submit a written report of employment to any other agencies that administer benefits affected by paid employment and provide addresses of these agencies, if applicable.

- Always ask beneficiaries if they need help with initial employment reporting and offer assistance as needed. The level of support you provide will vary based on the beneficiary’s need. Make sure beneficiaries have the address of the correct field office to which to send (or take) correspondence. In some cases, the CWIC may need to make a report for the beneficiary. When a beneficiary is unable to report their wages be sure to coordinate with their support team to help support the beneficiary with reporting requirements.

- Make sure beneficiaries are aware of other agencies to which they need to report employment information. Ask beneficiaries if they need help with reporting to other agencies and provide any necessary assistance. This may include helping write a letter, completing forms, copying correspondence, or providing self-addressed stamped envelopes.
Provide Assistance with Ongoing Wage Reporting

- After beneficiaries make their first wage report, review options for ongoing wage reporting. CWICs should review the options available and help beneficiaries select the best option based on the person’s circumstances and preferences.

- Provide instruction on correct use of whatever reporting option beneficiaries choose. For beneficiaries who choose to report using a “my Social Security” account, you may need to help the beneficiary with setting up the account online. For SSI recipients who choose to use one of the automated wage reporting options, you may need to help the beneficiary set up the wage reporting application or figure out the monthly gross wages needed to report using the SSITWR system. CWICs should make sure beneficiaries know to contact them whenever they have questions about how or when to report.

- It is a good idea to contact newly employed beneficiaries on a monthly basis for at least the first three months to confirm that they have successfully completed all wage reporting tasks. This may include phone calls or email messages. After this point, you should initiate contact with beneficiaries at critical touch points at which benefits could change and always check on how wage reporting is going.

- Counsel beneficiaries on the importance of retaining wage information and receipts and offer advice about good ways to keep it organized. This may be as simple as putting paycheck stubs into a shoebox, or as complex as using specially designed Work and Wage Calendars. Take the time to teach beneficiaries to use whatever organizational systems best work for them, and make periodic checks to ensure that they are keeping the records they need.

Provide Assistance with Reporting Employment Changes Over Time

- Remind beneficiaries to notify Social Security and other agencies that administer benefits of any significant change in employment as soon as they occur. This includes job loss, a
raise in hourly wages, or other job changes such as a significant change in hours the beneficiary worked.

- You should recommend that beneficiaries report these changes in writing or submit them in person to the local Field Office whenever possible. Help beneficiaries use Social Security forms to report this information as needed. Remind beneficiaries to keep a copy of all correspondence.

**Supporting Beneficiaries to Use Work Incentives**

Assisting beneficiaries to use work incentives to further their vocational goals is another important function CWICs perform. Using available work incentives allows beneficiaries to experience a smooth transition from dependence on disability benefits through paid employment. Facilitating the use of work incentives requires significant expertise and this service is often unavailable elsewhere. This is a critical part of a CWICs job.

Your role in facilitating work incentives begins with your ability to recognize which work incentives might apply. Social Security applies some work incentives automatically when they evaluate a beneficiary’s wages. For example, in the Title II disability program, this typically includes the Trial Work Period (TWP) and the Extended Period of Eligibility (EPE). In the SSI program, this includes applying the General Income Exclusion (GIE), the Earned Income Exclusion (EIE) and the ½ disregard. Other work incentives only apply under certain circumstances. Social Security staff may identify these work incentives when they evaluate a beneficiary’s work. However, in some cases, beneficiaries may need to take the initiative by providing information about possible work incentive eligibility to Social Security. CWICs facilitate this process in five ways:

**1. Identifying beneficiaries who are good candidates for using specific work incentives.**

Beneficiaries may be unaware that Social Security regulations include special work incentives that help certain individuals achieve their employment goals and ease the transition toward greater financial
independence through work. In the Title II disability program, these work incentives include Unsuccessful Work Attempt (UWA), Impairment Related Work Expenses (IRWEs) and Subsidy/Special Conditions. In the SSI program, special work incentives include the Student Earned Income Exclusion (SEIE), IRWEs, Blind Work Expenses (BWE), and Plans to Achieve Self-Support (PASS). These work incentives only apply under certain circumstances and not all beneficiaries can use them. CWICs should spot indicators that a beneficiary might be a good candidate for using a work incentive. CWICs who conduct thorough information gathering during the intake interview ask questions that help identify potential work incentives. Your ability to recognize when an individual could benefit from using special work incentives is important. Without your assistance, some beneficiaries may miss using valuable work supports.

2. Explaining to beneficiaries how work incentives can increase financial independence.

Work incentives in both of Social Security’s disability benefit programs are complex. CWICs provide counseling to help beneficiaries understand when they are good candidates for work incentives and offer accurate, easy-to-understand, information about how Social Security applies work incentives when they evaluate a beneficiary’s work. For example, CWICs illustrate how IRWEs help SSI beneficiaries keep more of their SSI by using the SSI calculation sheet to compare the SSI cash payment with and without applying the IRWE. For Title II beneficiaries, CWICs would show beneficiaries how Social Security applies IRWEs to reduce countable earned income during work CDRs when they are making SGA determinations. This counseling includes showing beneficiaries the difference that applying work incentives makes in how earnings affect benefits as compared to the effect without applying work incentives. Providing customized information based upon a beneficiary’s circumstances helps them understand how work incentives can help them with their initial or return to work efforts. CWICs reinforce this counseling with individualized work incentives information in BS&A reports and providing additional factsheets about various work incentives to supplement this information. CWICs should continue to look for indicators of potential work incentives during follow-up services as a beneficiary’s situation may change.
3. Helping beneficiaries provide the information Social Security needs to apply work incentives.

Most work incentives require that beneficiaries supply documentation to Social Security in order for the agency to decide if the work incentive applies to them. For example, beneficiaries with expenses they believe qualify as IRWEs or BWEs must provide information to Social Security describing what the expenses are, including an estimate of how much the expenses would be in a typical month. CWICs can help beneficiaries provide this information to Social Security in an organized fashion by using the Social Security form SSA-795.

In order for a Title II disability beneficiary to have subsidy or special conditions approved, Social Security needs information about special assistance the beneficiary is getting on the job from the employer (or other third party) as well as the estimated value of this assistance. You can help with this task by supporting the beneficiary to compile this information. In addition, when an employer subsidy is in evidence, Social Security will send the employer or other knowledgeable source a **Work Activity Questionnaire (SSA-3033)** to complete (https://www.ssa.gov/forms/ssa-3033.pdf). CWICs can provide a valuable service to the beneficiary and the employer by explaining what the form is and what information Social Security needs.

The most underused work incentive CWICs help with is a Plan to Achieve Self-Support. In order for Social Security to approve a PASS, beneficiaries must have a goal that is likely to reduce or eliminate benefits and must have expenses for goods or services they need to meet that goal. Social Security will exclude income or resources the person has and will replace all or part of the income or resources with SSI benefits (up to the Federal Benefit Rate). Beneficiaries use the **SSA-545 Plan to Achieve Self-Support** to outline their goal, the steps, the expenses, and the income they want to exclude (https://www.ssa.gov/forms/ssa-545.html). PASS requires a timeline for completing tasks that lead to the goal. CWICs help beneficiaries understand what information they need to gather to complete the PASS and support beneficiaries to develop the plan. CWICs can find helpful resources in the **PASS Resources** section of the VCU NTDC website (https://vcu-ntdc.org/resources/resourceDetail_search.cfm?id=3#PASSResources).
4. Supporting beneficiaries to use work incentives over time.

Work incentives such as IRWEs, BWEs and PASS require beneficiaries to provide proof to Social Security that they paid for the expenses in order for them to be deducted from earned income. CWICs provide a valuable service by explaining what documentation beneficiaries need to retain. CWICs also need to explain how local Social Security staff want beneficiaries to submit work incentives documentation and how often to submit it. Part of supporting beneficiaries with this task involves offering advice about ways to file information so it is available when needed. CWICs should also follow-up on a regular basis to make sure that beneficiaries submit required information to Social Security in a timely fashion. As part of this process, CWICs need to explain to beneficiaries what to expect in terms of benefit changes. That way, beneficiaries can alert CWICs when expected changes do or do not occur.

5. Helping beneficiaries resolve problems that arise related to using work incentives.

To manage work incentives involves lots of communication between the beneficiary, the CWIC, and Social Security. There are many opportunities for something to go wrong. For example, in the Title II program, Social Security may not recognize that a beneficiary got vacation or sick pay that they should have deducted when determining countable wages during a Substantial Gainful Activity (SGA) determination. Another example would be that Social Security did not conduct a work Continuing Disability Review (CDR) promptly after the end of the TWP for a beneficiary who is engaging in SGA and should have benefits suspended. In the SSI program, a beneficiary may not have communicated that they were in school so Social Security did not know to apply the SEIE. An experienced CWIC can quickly spot a problem and take steps to support the beneficiary to correct it. However, new CWICs may need support from their TA Liaison in order to identify benefits issues. During this process, CWICs teach beneficiaries how to communicate with Social Security to resolve problems.
Helping Beneficiaries with Benefits Issues Unrelated to Work

Although your primary function as a CWIC is to help beneficiaries understand the effect of work on benefits and to support access to work incentives, other events indirectly related to employment may require your help. Beneficiaries often seek assistance from CWICs on a wide range of benefit issues, regardless of whether they are related to work. To avoid becoming overwhelmed, you must learn when to assist with these issues and how far to go in providing help. The following events are common requests for assistance:

- Notices of overpayment that are not related to work incentives
- Medical CDRs
- Entitlement to other Social Security benefits
- Factors affecting eligibility for SSI or payment amount such as excess unearned income, excess resources, changes in in-kind support and maintenance (ISM), or changes in marital status.

For all of these non-employment related issues, your role consists of three parts:

1. First, you should explain the problem to the beneficiary and help them understand how the problem occurred. It is important for beneficiaries to understand how problems occurred to avoid repeating them in the future.

2. Second, you should provide specific step-by-step information about how to resolve the problem using Social Security’s procedures. If there are different options available, explain the advantages or disadvantage of each. For example, regarding overpayments, you should explain how to request a reconsideration if the beneficiary disagrees that an overpayment occurred or disagrees with the overpayment amount. If the beneficiary agrees they were overpaid, you would provide information about how to request a waiver of overpayment. As part of this educational process, you should provide written information such as Social Security brochures and any relevant forms beneficiaries may need to complete.
3. Third, you should follow-up within an appropriate time period to see if the beneficiary was successful in resolving the problem, or requires additional information and support. Remember that your role in resolving non-employment related problems is limited, so be careful not to overstep your bounds. Your goal is to develop benefits literacy by teaching beneficiaries how to resolve common problems themselves - not to resolve them yourself. If the beneficiary encounters problems trying to resolve the issue, your job is to figure out what happened and review alternatives for moving ahead.

**Limits on Helping with Issues Unrelated to Employment**

In the current WIPA Terms and Conditions document, Social Security states that WIPA program staff must not represent beneficiaries in appeals. Instead, CWICs may inform beneficiaries of their right to appeal and help them understand options to mitigate or respond to overpayments (e.g., requesting appeals, waivers, or payment plans). If needed, WIPA program staff may assist beneficiaries to complete required forms.

**Next Steps**

There is a great deal that CWICs need to learn to support beneficiaries to manage their own benefits. This chapter has provided an introduction to this topic. In order to develop expertise in this area, you will need to participate in additional training and seek out technical support from your [NTDC Technical Assistance Liaison](https://vcu-ntdc.org/aboutus/liaisons.cfm).

- To learn more about wage reporting and your role in supporting beneficiaries with this task, start by reviewing the reporting resources available on the NTDC website (https://vcu-ntdc.org/resources/resourceDetail_search.cfm?id=3). You may also participate in an archived supplemental training that covers the [CWICs role in helping beneficiaries with](https://vcu-ntdc.org/aboutus/liaisons.cfm)
**reporting** found on the NTDC website (https://vcu-ntdc.org/training-supplemental/archives.cfm).

- As a new CWIC, you will require a lot of support when it comes to your role in facilitating the use of complex work incentives such as IRWE, Subsidy/Special Conditions, BWEs and PASS. Until you gain experience in this area, you will need to work with your WIPA program director and your TA Liaison as you identify beneficiaries who are good candidates for special work incentives. Your WIPA director and TA Liaison will provide you with specific instruction about your role in facilitating each work incentive, and also help you resolve problems that beneficiaries may encounter with using work incentives.
Part II Chapter 15 – Providing Follow-up Services in the WIPA Program
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Chapter 15 – Providing Follow-up Services in the WIPA Program

Learning Objectives

After you have read this chapter and completed the associated lectures and activities during WIPA Initial Training, you should be able to:

1. Describe which beneficiaries require follow-up services in the WIPA program.

2. Describe proactive follow-up services and identify points in time CWICs would provide proactive follow-up.

3. Identify critical touch points that indicate a need for proactive follow-up for Title II disability beneficiaries and SSI recipients.

4. Describe the steps CWICs should take when a beneficiary experiences an unexpected benefits problem.

5. Describe strategies for developing follow-up plans.

6. Describe when follow-up services end in the WIPA program.

List of Acronyms

- BEP – Break-Even Point
- BPQY – Benefits Planning Query
- BS&A – Benefits Summary and Analysis
- BWE – Blind Work Expenses
- CDR – Continuing Disability Review
- EIE – Earned Income Disregard
- EPE – Extended Period of Eligibility
- EPMC – Extended Period of Medicare Coverage
- EXR – Expedited Reinstatement
- GIE – General Income Exclusion
- IRWE – Impairment Related Work Expenses
- MQP – Medicare Qualifying Period
- PASS – Plan to Achieve Self-Support
- SEIE – Student Earned Income Exclusion
- SGA – Substantial Gainful Activity
Introduction

WIPA services do not stop once you develop the Benefits Summary & Analysis (BS&A) report and counsel the beneficiary. Services you deliver from this point forward include helping the beneficiary report wages, use applicable work incentives, resolve benefits issues, and successfully manage benefits over time. By conducting timely follow-up services, you help beneficiaries achieve their employment goals and avoid benefit problems related to working.

Determining Who Receives Follow-up Services and for How Long

Not all beneficiaries who receive WIPA services will want or need ongoing follow-up services. The WIPA Terms and Conditions Document states that all beneficiaries receiving a BS&A report should also receive an offer of follow-up services, including re-contact at critical touch-points. The CWIC will need to explain what follow-up services entail based on the beneficiaries unique situation, as well as the benefits of accessing additional support overtime. When the beneficiary agrees to follow-up services, the CWIC will work with the beneficiary to develop a plan, and then provide follow-up according to the plan.

In the WIPA program, following up with employed beneficiaries and beneficiaries about to begin a job is often useful. A primary purpose of following-up with this group is to confirm they are successfully fulfilling their reporting responsibilities, or are prepared to begin reporting once employment begins. A second purpose is to help prepare the beneficiary for the effect of paid employment on their benefits. When conducting follow-up with employed beneficiaries, CWICs check to make sure that applicable work incentives are applied properly so that beneficiaries avoid potential benefits problems related to work. For example, when working with Title II disability beneficiaries, CWICs follow-up to make sure Trial Work Period (TWP) months are tracked correctly and that Social Security knows about Impairment Related Work Expenses (IRWEs) or Subsidy when Social Security conducts work Continuing Disability Reviews (CDRs).
and makes Substantial Gainful Activity (SGA) determinations. When CWICs work with SSI beneficiaries, they follow-up to make sure the SSI cash payment is reduced on time, and that work incentives such as IRWEs, Blind Work Expenses (BWEs) or Student Earned Income Exclusion (SEIE) are applied to reduce countable earned income.

CWICs also provide follow-up services for certain individuals who are not yet employed, but who have completed the BS&A report process and have unmet needs related to benefits. For Title II disability beneficiaries, this may include undeveloped past work that the CWIC needs to help the beneficiary report. For an SSI beneficiary, the CWIC may need to help with reporting a change in marital status or change in living arrangement that would affect the SSI cash payment. The CWIC would identify these issues during intake services. The BS&A report would describe the potential problem and give recommendations about how to resolve it. The CWIC follows-up with the beneficiary to see if the recommended actions described in the BS&A report have been completed, or if additional assistance is needed.

Not everyone who gets individualized services and a BS&A report will require follow-up contact. Individuals who do not have identified benefits issues or unmet needs and who are not employed or on the brink of employment typically do not require proactive follow-up services. CWICs should still offer follow-up services to the beneficiary. The follow-up services may be a periodic check-in to determine if any changes have occurred or if there is a presenting need for more individualized services.

Base your plan for follow-up on each individual’s circumstances. As you plan for follow-up, you should outline the length of time you plan to spend working with a beneficiary and the supports the person will require moving forward. Action steps you detail in the BS&A report 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 is no minimum or maximum timeframe 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 involve proactive contact with the beneficiary. By conducting proactive follow-up, CWICs are able to identify
potential problems and prevent them from occurring. Proactive follow-up has the following characteristics:

- You and the beneficiary agree on contact occurring at scheduled intervals;
- You describe planned interaction between you and the beneficiary, or other key stakeholders in the BS&A report;
- Interaction provides an opportunity to reassess the individual’s employment and benefit status; and
- Follow-up helps the beneficiary anticipate benefit changes and reduces the likelihood that problems will occur, or that they will be a surprise if they do occur.

You should do the following to provide proactive follow-up:

- Conducting periodic “wellness” checks with employed beneficiaries to determine if the beneficiary is progressing without problems. Although not required, we recommend reaching out to beneficiaries on a monthly basis for at least the first three months of employment. By making these proactive contacts, you can check to see if beneficiaries are reporting wages and work incentives information properly, and answer questions the beneficiary might have.

- Initiating contact with beneficiaries 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. CWICs identify critical transition points in the BS&A report and address them when they become relevant to the beneficiary.

- Making routine contact with beneficiaries 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 they are to ask questions or provide status updates. Only do this with the beneficiaries’ consent.

- Encouraging beneficiaries to contact you whenever they receive correspondence from Social Security, experience any changes in benefits or employment situation, or have questions. Be sure to return phone calls and emails from beneficiaries promptly. It is
important that beneficiaries know you are available to provide information and assistance whenever the need arises.

Critical Touch Points

Critical touch-points might involve a change in benefits. You need to explain the potential change to the beneficiary and to make sure the change occurs as expected. There are different critical touch points depending on which type of benefit an individual receives.

Common critical touch-points for Title II beneficiaries:

- Beginning a new job or an increase in earnings
- Beginning and end of the TWP
- Beginning and end of the Extended Period of Eligibility (EPE)
- Completing the Medicare Qualifying Period (MQP)
- Identifying and using work incentives such as IRWE or Subsidy/Special Conditions, or Unsuccessful Work Attempts (UWA)
- Work CDRs and SGA determinations
- Beginning and end of the Extended Period of Medicare Coverage (EPMC)
- Attainment of dual entitlement
- Transition to retirement benefits at Full Retirement Age

Common critical touch-points for SSI beneficiaries:

- Changes in earned or unearned income
- Reaching the level of earnings that would cause cash payments to cease and the beneficiary should transition to 1619(b)
- Identification and use of IRWEs or BWEs
- Changes in student status or attainment of age 22 for SEIE
- Approval of a Plan to Achieve Self-Support (PASS) and subsequent review points
- Attainment of age 18
• Reaching insured status for Title II benefits or reaching age 62 with prior insured status
• Changes in living arrangement, marital status, or resources

Common critical touch-points that affect both SSI and Title II beneficiaries:
• Changes in earnings status including start or end of employment and changes in amount of earned income
• Cessation of benefits due to medical improvement
• Expedited Reinstatement (EXR) eligibility

Reactive Follow-Up

CWICs can predict when some critical touch-points will occur because they are based on specific timeframes or circumstances. For example, once a beneficiary starts working, CWICs should be able to predict when wages will trigger the start of the TWP. The CWIC may not be able to predict other touch points in advance. For example, when an SSI beneficiary’s father passes away, that person may become eligible for Childhood Disability Benefits (CDB), which will in turn affect SSI eligibility or payment amount. This would be a very important critical touch point, but not something a CWIC can foresee.

Reactive follow-up occurs when CWICs discover that an unforeseen event has happened that would affect benefits. Sometimes this happens when the beneficiary reaches out to the CWIC after receiving correspondence from Social Security. For example, an SSI beneficiary may receive a letter from Social Security saying that benefits will stop and an overpayment has occurred due to excess resources the agency discovered during a periodic redetermination. Other times, CWICs discover that a critical touch point has happened during a routine check-in with the beneficiary. For example, an employed individual who receives CDB tells the CWIC that he recently got married to someone who is not a beneficiary.

When CWICs discover that something unexpected occurs that could change an individual’s benefits, their responsibilities include the following:
• Investigate the situation thoroughly, using all available information sources.
• Explain to the beneficiary what caused the current situation or problem and how benefits are likely to change.

• Identify options for resolving the problem or minimizing its effects, and explain the pros and cons of each option.

• Support the beneficiary to develop a plan to resolve the problem. The plan should clearly describe what actions the beneficiary, the CWIC, and any other concerned parties would take.

• Check-in with the beneficiary within appropriate timeframes to make sure things are progressing as planned. Be sure to answer any questions the beneficiary has and offer additional support as needed moving forward.

No matter how diligent CWICs are in performing proactive follow-up, there will be instances when unexpected events result in benefit changes. To minimize reactive follow-up, the CWIC needs to teach beneficiaries to recognize possible benefit touch points and encourage them to initiate contact with the CWIC and make required reports to Social Security.

**Providing Effective Follow-up Services**

Effective follow-up services support beneficiaries to achieve their employment goals while preventing unexpected benefit problems related to work. This section describes common characteristics of successful WIPA follow-up services.

**Follow-up Services Are Planned**

As described above, the most effective follow-up services are proactive. When CWICs deliver follow-up services in the right way at the right time, they serve as a powerful tool to prevent benefit problems from happening. That means CWICs need to think about when each employed beneficiary will need follow-up in the future and develop a clear plan for when and how follow-up will occur. While there is no standard required follow-up planning format or template, during initial training your instructors will review several options WIPA programs may use. Quite simply, the plan needs to list points in time that the CWIC will initiate contact with the beneficiary, and clearly describe events that should prompt the beneficiary to reach out to the CWIC. These points in time will include the critical transition points that apply to the beneficiary, but may also include regularly scheduled check-up contacts. Whatever follow-up planning
format you use should be simple, straightforward and easy for the beneficiary to understand. It may be as simple as an itemized “to-do” list included at the end of the BS&A report, or a separate planning document that lists action steps with timeframes for completion. No matter what approach you use, the main objective is to ensure that beneficiaries understand when to expect contact from you, have a firm grasp on action steps to take to avoid problems, and know when to contact you.

Think about the Future

As a CWIC, you may be tempted to address all questions or concerns a beneficiary presents when they initially contact you. The problem with this approach is that the beneficiary’s initial questions or concerns are often just the surface of their overall benefit situation and need for information. In order to be truly effective, you must provide services thinking about future possible events. This means educating beneficiaries on the options that might be available in the future, such as possible eligibility for IRWEs or use of a PASS. Thinking ahead is especially critical when you are counseling younger beneficiaries, such as those transitioning from school to adult life.

Thinking ahead has 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. Best practice is to address only issues that have a high probability of occurring. Keep discussions of those issues within the relative near future (one year to 18 months). If you are maintaining ongoing contact with the beneficiary, there is no need to cover every issue in one or two phone calls. The advantage of ongoing follow-up is that it provides you with opportunities to explain important issues as they appear on the horizon.

Using a Customized Approach

When providing follow-up, remember that every person you serve has a unique set of circumstances and needs. The duration of follow-along planning and assistance services will not 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 is important that WIPA services remain flexible and allow beneficiaries to access additional information and supports as needed.

**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. You should regularly communicate with other partners in the beneficiary’s network. Each update and revision of the BS&A report 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. Members of the employment support team may include:

- Representative payees, authorized representatives, family members, other caregivers;
- Case Managers or Service Coordinators from either the mental health or the Developmental Disabilities systems;
- Vocational Rehabilitation Counselors or Employment Network personnel;
- 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 BS&A report. This is an efficient way for you to oversee follow-up services.

**Sharing Responsibility with the Beneficiary**

Beneficiaries should be responsible for their own plan and take initiative to complete action steps. Rather than foster dependency by doing everything yourself, you should encourage and support the beneficiary to complete necessary tasks, such as initiating contact with employment
support team members, whenever possible. Be clear about action steps and expectations, and then check in with beneficiaries who miss due dates or have not provided updates.

**When Follow-up Services End**

WIPA services do not include any required time limits. Social Security does not encourage WIPA programs to terminate beneficiaries from the program unless an individual becomes ineligible, passes away, moves out of the program’s service area, or asks that services stop. CWICs may continue to provide follow-up contact and assistance to beneficiaries as long as they remain eligible for WIPA services, need them, and desire them.

The duration and intensity of individualized services varies significantly from one beneficiary to another. For example, you may provide in-depth benefits analysis to someone who subsequently decides they are no longer interested in pursuing employment. In that situation, you don’t have to follow-up, but you should encourage the beneficiary to contact you if they change their mind or have questions about benefits and work. You should keep the person’s file just in case they decide to re-contact you. On the other end of the spectrum, you will serve some beneficiaries who have a series of jobs over a period of years and personal circumstances that require you to make frequent on-going contact. Most of the beneficiaries you serve will be somewhere in between these two extremes. The point is to think about what each individual needs from you in terms of follow-up and provide the level of support the person needs without taking on supports outside the benefits counseling role.

**Next Steps**

As you begin to provide services after achieving provisional certification, be sure to meet with your WIPA Program Director to find out what follow-up protocols are in place at your agency. You should provide services that are consistent with your colleagues. You also should ask your agency has a standard follow-up planning tool or template that CWICs in your program use.

Reach out to your TA Liaison when you have questions about follow-up. Your TA Liaison can help you decide which beneficiaries would benefit
from follow-up and help you develop an effective follow-up plan. Your TA Liaison can also review follow-up plans and provide feedback for improvement.