Once an individual has decided to pursue an employment goal, a possible next step for the benefits specialist is to support the person by designing a strategic plan for achieving their goals while also achieving the benefits effects that have been anticipated. Here is where the differences between planning and assistance become evident.

The entire process of decision-making that we are discussing requires the individual to consider more than one option, to weigh these options in relation to themselves and their circumstances and goals, and then to choose one course over the others. This process asks questions such as whether or not to become employed, whether or not (possibly) to ask others to help with benefits management, and whether to continue to use services long-term. If the person is unaccustomed to making these types of decisions or if the person has a representative payee, it is important for the benefits specialist to encourage the individual to enlist the support of someone whose input they trust (many times this is the person who is their rep payee) to be part of these discussions and the decision-making. The benefits advisor should stay in an information-giving capacity, rather than being seduced into over-influencing the decisions or making the decisions for the person.

This portion of the BPA&O process (decision making), is concluded when the individual has and understands the steps that need to occur depending on the decisions they have made. At this point, the individual has decided to manage the process, has secured the assistance of a natural support, has secured the support of an agency (via inclusion of steps into their strategic plan), or has secured your assistance in managing the strategic plan.

Developing an effective model for providing benefits assistance begins with identifying a need for long-term support and services. If goals and objectives are needed to guide delivery of services and supports, they may be integrated into pre-existing service delivery plans. However, if this is not possible or desired, then develop a separate support plan. A sample plan format is outlined on page 341, followed by a completed support plan on page 342.
There are several additional items to keep in mind when developing support plans for individuals with disabilities:

- This is the individual’s support plan, not yours. The plan must be understood, and agreed to, by the consumer who chooses when, how and who will deliver the supports identified.

- As a supporter, it is essential to assess the extent to which the individual can self-manage their own benefit/employment situation. While the individual may not initially demonstrate the ability to self-manage their situation, this could be developed over time. So, make sure plans being developed always push the individual to develop ownership in the process, with a focus on future orientation and capacity building.

- Any good plan requires an array of resources to successfully fulfill the mission of the plan. There is a tendency to stop successful implementation once the funds have been identified. However, we know that there are typically many human resources that are taken for granted and thus not adequately invested in the plan.

- When gauging the timeframe of the plan itself, take into consideration the frequency at which the consumer may need to be reinforced or encouraged. Once crafted, many plans are written to fulfill some reporting requirement and are never revisited, to customize to the individual’s needs, desires, or preferences.

- Never assume that someone else is going to do something just because you talked about it and agreed to it. Safety nets are the essential cornerstone of a good plan. Always identify the safety nets that will ensure the overall success of the plan.

Finally, while there is a natural proclivity to boilerplate plans, each plan crafted should be customized to meet the unique situation of the person being served. Nothing raises questions regarding the quality or comprehensiveness of services and supports delivered by an agency or professional like a “carbon copy” or “cookie cutter” plan.
Comprehensive Benefits Support Plan

Consumer Name: _________________________  SSN: _________________________

Address: ______________________________________________________________________

Phone: ___________________ Fax: _____________________ E-mail: ____________________

Explanation of Need for Support:

<table>
<thead>
<tr>
<th>Activities</th>
<th>Time Frames</th>
<th>Person / Agency Responsible</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Desired Outcomes</th>
<th>Resources Needed</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
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</table>

Quality Indicators of Success:
Completed Comprehensive Benefits Support Plan

Consumer Name: John B.  Recipient____________________  SSN: 000-00-0000
Address: 000 Security Boulevard  Baltimore, Maryland 00000
Phone: (000)-000-0000  Fax: (000)-000-0000  E-mail: B/R000@outlook.com

Explanation of Support Need: John has expressed a need for support in reporting monthly work expenses and earnings on a regular basis. He has received termination notices in the past based on assumptions made on the part of SSA when he did not report his expenses and earnings information in a consistent manner.

<table>
<thead>
<tr>
<th>Activities / Goals</th>
<th>Time Frames</th>
<th>Person / Agency Responsible</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits counseling</td>
<td>Monthly</td>
<td>Peer Advocates R-Us / Joe Kewl</td>
<td>Provide benefits consultation and initially conduct monthly reporting to SSA.</td>
</tr>
<tr>
<td>John will compile and bring expense receipts and pay stubs to monthly counseling sessions.</td>
<td>Weekly / Monthly</td>
<td>John B. Recipient</td>
<td>Assemble Handi-Transport receipts at end of each day in file by door. Put pay stubs in file weekly. Take monthly to counseling session.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Desired Outcomes</th>
<th>Resources Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joe will support John in gradually implementing a self-management strategy for reporting monthly impairment-related work expenses and gross monthly earnings to SSA in a consistent manner John will consistently report expenses and earnings to SSA with only a verbal monthly prompt. Joe will get to a point where he is only initiating follow-up calls to the SSA Claims Rep every other month to check reporting.</td>
<td>- Monthly postage provided by John.  - Reimbursement for counseling sessions provided by State VR Program.  - Buy-in from Claims Rep – Copy of Support Plan provided along with monthly check-ins.</td>
</tr>
</tbody>
</table>

Quality Indicators of Success:
- John will utilize a personal filing system at home
- SSA Claims Rep will support self-management plan
- Peer Advocates R-Us will gradually reduce support while still maintaining oversight of management plan
- John will gradually assume responsibility for consistently reporting weekly expenses and monthly earnings to SSA minimizing the occurrence of potential crisis benefit situations.
Additional Thoughts on Support Planning

Encourage the customer to tell you what they understand about the required action at each action point and how best to carry out that action (i.e., mail, drop-in). You are assessing the person’s need for support in carrying out the plan and the level of detail that needs to be in the plan to assist the person to use it effectively, should he decide to complete the needed activities himself or with the help of family or friends. It is a good idea to suggest organization strategies to the individual, such as writing all the action dates on a calendar once an employment date is known, keeping all papers in a central location, and asking for reminder calls at certain points from a friend, if the person tends to forget dates and obligations frequently.

Introduction to Other Support Systems


Vocational Rehabilitation

VR is a nationwide federal-state program that provides medical, therapeutic, counseling, education, training, work-related placement assistance, and other services, such as programs to enhance services for special populations. VR was established to provide the services and supports that a person might need to overcome a barrier to employment. Specifically, it covers the following services: “The assessment to determine eligibility and needs, including, if appropriate, by 1) someone skilled in rehabilitation technology (i.e., AT); 2) Counseling, guidance and job placement services and, if appropriate, referrals to the services provided by WIA providers; 3) Vocational and other training, including higher education and the purchase of tools, materials and books; 4) Diagnosis and treatment of physical or mental impairments to reduce or eliminate impediments to employment, to the extent financial support is not available from other sources, including health insurance or other comparable benefits; 5) Maintenance for additional costs incurred during rehabilitation; 6) “Transportation, including adequate training in the use of public transportation vehicles and systems, that is provided in connection with the provision of any other service described in this section and needed by the individual to achieve an employment outcome (emphasis added).” Transportation may include vehicle purchase. Under the regulations, transportation is defined as “travel and related expenses that are necessary to enable an applicant or eligible individual to participate in a [VR] service.”; 7) Personal assistance services while receiving VR services; 8) Interpreter services for individual’s, who are deaf, and readers, rehabilitation teaching and orientation and mobility services for individuals who are blind; 9) Occupational licenses, tools, equipment, initial stocks and supplies; 10) Technical assistance for those who are pursuing telecommuting, self-employment or small business operation; 11) Rehabilitation technology (i.e., AT), including vehicular modification, telecommunications, sensory, and other technological aids and devices; 12) Transition services for students with disabilities to facilitate the achievement of the employment outcome identified in the IPE; 13) Supported employment; 14) Services to the family to assist an individual with a disability to achieve an employment outcome; and 15) Post-employment services necessary to assist an individual to retain regain or advance in employment” (Hagar, 1999, pg. 1). Certain services, however, require that the person satisfy a means test.
People enter the VR system in a variety of ways. Some enter the system while they are in school because of their IEP. Others enter because of their participation in other programs (e.g., SSA VR Reimbursement Program). Finally, some enter the program on their own or because of a referral from a stakeholder. VR offices are generally located in close proximity to, or with, other state program offices, such as TANF, and in many states are coordinated with one-stop delivery systems.

To be eligible for state VR services, a participant must meet certain criteria. First, they must have a physical or mental impairment that results in a substantial barrier to employment. The disability does not need to be so severe that it qualifies the person for DI or SSI benefits, however. SSI and DI recipients can receive VR services, assuming they intend to achieve an employment outcome. Second, they must be able to benefit from VR services. Finally, they must eventually be able to achieve an employment outcome. State VR agencies can deny benefits if they can show that a person cannot benefit from the services. To make determinations, state VR agencies use existing data, such as medical reports, SSA records, and education records and, to the extent that existing data is insufficient to determine eligibility, an assessment by the VR agency (Hagar, 1999).

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

For non-SSA (SSI and Disability Insurance recipients) VR participants, the payment method for VR services varies by state. Based on the individual's available financial resources, the state VR agency may require an eligible individual to help pay for services. All eligible VR participants who are accepted, however, have access to the following services at no cost: assessments to determine eligibility and VR needs, vocational counseling, guidance, referral services, and job placement services (American Foundation for the Blind, 1999).

SSA makes special payment provisions to provide VR assistance to participants. SSA provides funds to reimburse VR agencies for costs incurred in successfully rehabilitating SSI recipients. SSA defines a successful rehabilitation as one in which participation in services results in performance of substantial gainful activity, for a continuous period of at least nine months. The TWWIIA will affect this existing vocational rehabilitation reimbursement program as detailed later in this manual.
In addition to the state-federal VR system, private (non-profit and proprietary) rehabilitation services provide services to people with disabilities. The private services are usually reimbursed through private funding sources—typically, insurance carriers or self-insured employers. It is important to note that while youth with disabilities do access the non-profit human service delivery system often as part of their transition planning process, they generally do not encounter the proprietary VR system because the programs target individuals with disabilities originating in adulthood, through an accident or illness covered by some form of insurance (Stapleton, et al, 1999).

**Mental Retardation/Developmental Disabilities (MR/DD)**

Individuals with MR or DD generally enter the state MR/DD system at an early age and stay in this system during their post-school transition. According to Assistant Secretary for Planning and Evaluation (1999), Medicaid funds account for nearly three-quarters of the operating costs of these systems. State MR/DD agencies work cooperatively with local governments, voluntary organizations, service providers, and families to provide necessary services for persons with MR/DD. In most states, MR/DD agencies provide several services, including after-school programs; services for the aged; housing and residential options; counseling; day treatment services; developmental programs; family support services; financial assistance; health care; respite care; transportation; waiver programs; research, prevention and intervention programs; and supported and sheltered employment. While Medicaid historically financed long-term institutional care, there have been recent movements to place persons with MR/DD in community settings. For example, Medicaid Home and Community Based Waiver programs have been effective at reducing institutionalization, but pressure from the federal and state governments to reduce Medicaid spending has led to an interest in managed care alternatives.  

DD definitions vary by state, but, in general, youth under age 22 can qualify for services if they have had mental retardation or a related condition (e.g., cerebral palsy, epilepsy, autism or other neurological conditions). IEPs will likely guide youth with MR/DD to the appropriate state agency for services. In many cases, youth may enter the MR/DD system through early childhood direction agencies or medical practitioner referral.

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1 For example, some individuals in the MR/DD system, who meet Medicaid financial eligibility requirements, might also be eligible for Supported Living Services (SLS). SLS is a Medicaid waiver program, which offers supports in the households of individuals with disabilities and also provides opportunities for adults with disabilities to move into their own homes. Unlike traditional twenty-four hour supervision models, SLS offers an array of supports to choose from to help individuals with disabilities achieve independent living status.  

2 Another commonly referenced definition for a developmental disability is a severe, ongoing, mental and/or physical disability that was present before twenty-two years of age. It is important to note that some states vary age of onset of disability requirements. For example, Arizona requires onset of disability before age 18.
The MR/DD system is guided by a service delivery-planning construct similar to the IEP. The Individual Service Plan (ISP) requires specific services, supports, roles, responsibilities, and timeframes for assisting individuals in meeting their objectives. In most cases, MR/DD practitioners develop ISP with assistance from counselors, case managers, or others with administrative oversight. Regular and intermittent progress reporting and evaluation is required and conducted under specific state law and regulation.

**Mental Health**

People with mental health support needs may access a relatively independent, and loosely coordinated public and private service system—collectively referred to as the “de facto mental health service system” (Surgeon General, 1999). The system is comprised of four major components that include:

- **Specialty mental health sector**: consists of mental health professionals such as psychiatrists, psychologists, psychiatric nurses, and psychiatric social workers trained to treat people with mental disorders. Services provided in this sector are performed mostly in outpatient settings such as private office-based practices or in public or private clinics.

- **General medical/primary care sector**: consists of health care professionals such as general internist, pediatricians, and nurse practitioners. The general medical sector is typically associated with being the first point of contact for adults with mental disorders.

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

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

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the federal agency in charge of the state mental health systems. The Center for Mental Health Services (CMHS), one of the three centers under SAMHSA, awards state grants for providing mental health services to people with mental illnesses. These grants are designed to improve access to community-based health care delivery systems for people with serious mental illnesses who do not have private health insurance (SAMHSA, 2000). CMHS works closely with each state to design a customized service delivery plan that addresses the unique needs of the state’s populations. Each state administers its public mental health budget and authorizes services in several broad areas, including: system leader-
ship for state and local county mental health units; systems oversight, evaluation and monitoring; administration of federal funds; and operation of state mental health programs, hospitals and/or institutions.

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

**Workforce/Development System**

People with disabilities who do access the VR, SSI, or TANF systems might still access work and other support services through the state Workforce Development system. The *Workforce Investment Act of 1998* (WIA) organized federal statutes governing the job training, adult education and literacy, and VR programs into a one-stop delivery system. Under this system, states are required to develop workforce development plans that describe how the state will meet the needs of major customer groups, including individuals with disabilities, and show how the plans will ensure nondiscrimination and equal opportunity. WIA mandates that one-stop systems be readily accessible to all Americans. Some of the partners in this system include employment services, adult education, post-secondary vocational education, VR, Welfare-to-Work, and Community Services Block Grant. All adults are eligible for core services, and youth enrolled in school are eligible for certain services if they meet certain state criteria for employment, income, and/or disability. Each state VR is also required to conduct an assessment of how its state’s workforce investment system is meeting the needs of individuals with disabilities.

**Other**

There are a number of other systems and private organizations that provide school and employment supports to youth during the post-school transition. These programs generally differ in size and scope. In general, these programs provide a wide range of services that support school or employment-related activities.

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3 In general, these criteria are specified in the Diagnostics Statistical Manual-4R
4 WIA replaced the Job Training Partnership Act (JTPA).
One of the other large support programs is the network of School-to-Work programs, created by the *School to Work Opportunities Act of 1994*. The Departments of Education and Labor provide grants for these programs to colleges and universities, state and local education agencies, and other public and private non-profit organizations, to develop innovative strategies to assist youth, including those with disabilities. The majority of school-to-work transition services are funded and administered at the state and school district level. In some cases, these programs provide funding to support services to aid in the youth’s IEP.

There are also several other demonstration projects funded through the Department of Education, Department of Labor, and SSA, which provide employment support. The services provided under these programs can vary significantly across states and target groups. An example of a recent policy change that provides employment supports is the *Assistive Technology Act of 1998*. Specifically, this act provides grants to continue state assistive technology projects. For a detailed list and summary of these other employment supports, see (Stapleton, et al., 1999).

Finally, several non-profit and community-based organizations provide employment, school, and “other” (e.g., psychological) support services. Many of these organizations receive funding from several sources, including charitable donations, public agency grants (e.g., School-to-Work grants) and contracts, foundation grants, and fund-raising activities. In general, these agencies provide a wide range of employment services, from prevocational assessment, to job coaching and post-employment follow-along services (Stapleton, et al, 1999). Some of these organizations, such as The National Multiple Sclerosis Society, provide services to people with specific limitations. Other organizations, such as Goodwill Industries, The Arc, and Easter Seals, provide services to broader populations.

As discussed earlier, Congress has made provisions for the SSA to provide incentives to working for beneficiaries and recipients with disabilities. In addition to the disability programs and work incentive provisions that the SSA oversees, they also administer a vocational rehabilitation (VR) program for providers of VR services to beneficiaries and recipients enrolled within their disability programs.

Prior to 1981, when Congress established the existing program, SSA awarded State VR agencies block grants to work with beneficiaries and recipients. Unfortunately, the State VR agencies did not report use of these funds on a “per case” basis and SSA was unable to document the success of the VR program utilizing the original block grant formula. Inadvertently, this resulted in SSA not knowing if beneficiaries and recipients were in fact going to work and decreasing reliance on monthly cash benefits. To remedy this situation, Congress modified the program to a reimbursement-based, outcome-oriented formula.
The VR Reimbursement Program was intended to help beneficiaries and recipients go to work. Under this program, SSA pays State VR agencies and alternate participants for the costs of VR services and supports provided to beneficiaries and recipients that result in the beneficiary becoming employed under specific criteria. Legislative authority for SSA’s VR Program and reimbursement of costs for the provision of VR services and supports is outlined in Section 222(d) of the Social Security Act for beneficiaries under the Social Security Disability Insurance Program and Section 1615 of the Social Security Act for recipients of the Supplemental Security Income Program. Initial regulations to implement the VR Reimbursement Program and allow payments to State VR agencies were published in 1983. These regulations were amended on March 15, 1994, to allow SSA to pay alternative participants for the costs of their services under the same criteria governing payments to State VR agencies and to improve the administration and costs effectiveness of the program.

State VR agencies (or alternative participants) offering VR services and supports contributing to beneficiaries and recipients working for a period of not less than nine months at the Substantial Gainful Activity (SGA) level are reimbursed the costs for those services and supports if they meet the conditions for reimbursement. Keep in mind that for a case to be considered a successful rehabilitation under the VR Reimbursement Program, a beneficiary or recipient must be employed for a continuous period at the SGA level. This is defined as at least nine months within a consecutive 12-month window. This included: nine consecutive months; nine of ten consecutive months regardless of the reason for the one-month break; or, at least nine months within 12 consecutive months, if the break in SGA was due to circumstances beyond the beneficiary’s or recipient’s control and unrelated to the person’s impairment.

Prior to the implementation of the Ticket to Work and Work Incentives Improvement act of 1999 (Public Law 106-170), SSA referred beneficiaries and recipients for VR services through either State VR agencies established under the Rehabilitation Act of 1973 or through alternative participants who had signed contracts with SSA to provide VR services to beneficiaries and recipients. The regulations in 1994 expanded the reimbursement program by allowing SSA to refer beneficiaries and recipients to alternative public or non-public VR providers (called alternate participants) for VR services on a case-by-case basis if the State VR agency did not serve a referred individual. Prior to these changes, SSA could only refer beneficiaries and recipients to alternative participants if a State VR agency opted to not participate in the VR Reimbursement Program (all State VR units chose to participate) or if they stopped, or limited, their participation to select groups. While these amendments to the VR program provided SSA with much more flexibility in selecting service providers, it still reserved right of first selection to State VR agencies, making alternative participants a secondary service delivery option.
SSA enhanced the availability of VR services and supports to the beneficiaries and recipients through the infrastructure of the VR Reimbursement Program. Savings to the Social Security trust funds and general revenues for SSI are realized by beneficiaries and recipients going back to work and decreasing their reliance on monthly cash benefits.

Over the next few years as the SSA rolls out and implements the Ticket to Work program in States selected by the Commissioner of the SSA under Public Law 106-107, the provisions of the Social Security Act for referring beneficiaries to State VR agencies will cease to be in effect in those states. Additionally, the use of alternative participants under the VR reimbursement programs will be phased out in the States as the Ticket to Work program is implemented. Further, sections 222(b) and 1615(c) of the Social Security Act were also repealed in section 101(b) of the Ticket to Work Act under which the Commissioner of the SSA was authorized to impose sanctions (i.e. make deductions from SSDI benefits or suspend SSI benefits) with respect to any beneficiary who refused, without good cause, to accept and participate in VR services made available under the reimbursement program.

The Ticket to Work Program was be implemented in three phases. The table below outlines the three phases and States and territories that were impacted.

<table>
<thead>
<tr>
<th>Phase I – January 2002</th>
<th>Phase II – Calendar Year 2002</th>
<th>Phase III – Calendar Year 2003</th>
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The Ticket to Work and Work Incentives Improvement Act (Public Law 106-170) was signed into law on December 17, 1999. The purpose of Public Law 106-170 is four fold:

- provide health care and employment preparation and placement services to individuals with disabilities that will enable those individuals to reduce their dependence on cash benefit programs;
- encourage States to adopt the option of allowing individuals with disabilities to purchase Medicaid coverage that is necessary to enable such individuals to maintain employment;
- provide individuals with disabilities the option of maintaining Medicare coverage while working; and,
establish a “Ticket to Work and Self-Sufficiency Program” that allows SSDI and SSI beneficiaries to seek employment services, VR services and other support needed to obtain, retain, or maintain employment and reduce their dependence on cash benefit programs.

Public Law 106-170 directed the Commissioner of Social Security to establish a Ticket to Work and Self-Sufficiency program (section 1148), which would expand the universe of service providers available to SSDI and SSI disability beneficiaries and provide them with a ticket they may use to obtain VR services, employment services, and other support services from an employment network of their choice. Under the Ticket to Work program a beneficiary will have the options of deciding when and whether to use his or her Ticket to obtain services from a provider known as an Employment Network (EN), or from the State VR agency. A beneficiary with a Ticket may assign his or her Ticket to the EN of their choosing, or State VR agency, as long as that EN or State VR agency is willing to accept their Ticket. A beneficiary may discuss their employment and rehabilitation plan with as many ENs in their areas as they wish, or the State VR agency, and a list of available providers can be obtained from the Program Manager MAXIMUS, Inc. However, a beneficiary cannot assign their Ticket to more than one EN or the State VR agency at a time. The EN or State VR agency will provide employment services, VR services and other support services to assist the beneficiary in obtaining, regaining and maintaining self-supporting employment as specified in the beneficiary’s Individualized Work Plan (IWP), developed with an EN, or Individualized Plan for Employment (IPE), if developed with the State VR agency. At any time a beneficiary can retract their Ticket from an EN or State VR agency and reassign it to another if they continue to meet the Ticket eligibility requirements.

Ticket Eligibility

To be eligible to receive a Ticket a SSDI and/or SSI beneficiary must meet several criteria:

- be 18 through 64 years of age;
- if an SSI recipient, be eligible for disability payment under the adult disability standard
- be receiving a Federal Social Security and/or SSI cash benefit based on disability;
- have a disabling impairment which is not expected to medically improve or a disabling impairment for which medical improvement is possible but cannot be predicted; or
- have an impairment that is expected to improve but have undergone at least one Continuing Disability Review (CDR).

PLUS not receiving: “301” payments, benefits while appealing a medical cessation; provisional cash benefits while SSA is considering an expedited reinstatement; and, presumptive disability payments. Individuals must also reside in a “Ticket State.”
The Ticket

A Ticket is a document that provides evidence of SSA’s agreement to pay an EN or State VR agency to which a beneficiary’s Ticket is assigned for providing services and supports to the beneficiary under the Ticket to Work program if certain conditions are met. The Ticket is a red, white and blue document approximately 6” by 9” in size. The left side of the document includes the beneficiary’s name, ticket number; claim account number and the date SSA issued the Ticket. The Ticket number is 12 characters and comprises the beneficiary’s own social security number, the letters “TW” and a number 1, 2, etc. A number 1 in the last position would signify that this is the first ticket the beneficiary has received. The right side of the Ticket includes the signature of the Commissioner of SSA and the language below:

Assigning and Re-assigning A Ticket and Extension Periods

A beneficiary can assign a ticket if the Ticket is valid and if the beneficiary is receiving a cash payment. To assign a Ticket a beneficiary must first find an EN or State VR agency that is willing to take their Ticket. Once both parties have agreed, the beneficiary and a representative of the EN must develop and sign an IWP. If the beneficiary elects to work with his/her State VR agency, the beneficiary and representative of the State VR agency must agree to and sign an Individualized Plan for Employment (IPE) and an additional form. The EN will then submit a copy of the signed IWP/IPE along with appropriate forms to the Program Manager. The effective date of the Ticket assignment will be the first day on which these requirements for ticket eligibility are met and the IWP or IPE has been signed.

A beneficiary may take a Ticket out of assignment for any reason. The beneficiary must notify the Program Manager in writing. The Ticket will no longer be assigned to that EN or State VR agency effective with the first day of
the month following the month in which the beneficiary notifies the Program Manager. If an EN goes out of business or is no longer approved to participate as an EN in the Ticket to Work program, the Program Manager will take the beneficiary’s Ticket out of assignment. In addition, if the beneficiary’s EN is no longer able to provide services, or if the State VR agency stops providing services because the beneficiary is determined to be ineligible for services, the EN or State VR agency may ask the Program Manager to take the beneficiary’s Ticket out of assignment. In both of these latter situations, a notice will be sent to the beneficiary informing them of this decision.

A beneficiary may re-assign their Ticket as they deem appropriate and as long as they continue to meet eligibility for participation in the Ticket to Work program. To re-assign a Ticket all of the following requirements must be met:

a. A beneficiary may reassign his/her ticket if he/she meets the criteria for assigning a ticket described above.

b. If the beneficiary does not meet the criteria, he/she may reassign his/her ticket only if he/she:

- Continues to meet the ticket eligibility requirements,
- Has an unassigned ticket,
- Has an EN/State VR agency who is willing to work with him/her and sign a new IWP/IPE.
- If the ticket is not in use, the IWP/IPE must be completed and signed within 30 days of unassignment.

If the ticket is in use, the employment plan must be completed and signed before the end of the extension period.

The reassignment is effective on the first day these requirements are met. If the beneficiary reassigns the ticket to the same EN/State VR Agency that he/she was previously working with, SSA resumes counting the months in the initial 24-month period or the 12-month progress review period.

If the beneficiary reassigns the ticket to a new EN/State VR Agency, the 24-month period starts over. However, if the reassignment occurs in a 12-month progress review period, SSA resumes counting the months rather than starting over.

**Extension Period**

As stated above, the beneficiary or EN/State VR Agency may unassign the ticket. The “extension period” is the 3-month time frame after unassignment that the beneficiary who is using a ticket has to select an EN/State VR Agency. If the beneficiary does not reassign the ticket during the extension period, it is considered not in use at the end of the extension period. The extension period does not count in determining whether the beneficiary is making timely progress toward his/her work goals.
Inactive Status

During the initial 24-month period after ticket assignment, the beneficiary can make a written request to the PM to place his/her ticket in inactive status due to possible relapses in health condition or emergency situations. Months in inactive status do not count in deciding whether the beneficiary is making timely progress toward his/her work goals, as discussed later. The ticket is not in use when inactive. The beneficiary can make another written request to the PM to reinstate ticket use. While the ticket is in inactive status, SSA may initiate a medical CDR.

A medical CDR is the review conducted by SSA to determine whether or not a beneficiary continues to meet SSA’s disability standard. SSA will not conduct a medical CDR when the beneficiary is using the ticket. However this protection does not apply to work reviews that SSA may conduct to determine whether or not a beneficiary is engaging in substantial gainful work.

“Using A Ticket”

To be considered “using a ticket” a beneficiary must assign his/her Ticket to an EN. SSA defines “using a ticket” as a specified period of time during which the beneficiary is actively following his/her approved plan to become self-supporting. The EN monitors the beneficiary’s progress with the plan, but the PM actually decides if the beneficiary is “using” the ticket. SSA cannot initiate a medical CDR while the beneficiary is using the Ticket. If a Ticket has been assigned after a medical CDR has been initiated, SSA will complete that CDR. If, during that CDR, SSA decides that the beneficiary has medically recovered, usually benefits will be terminated. However, in some circumstances, SSA may continue benefits if the ticket assignment was made prior to the medical CDR decision.

Active Participation

The initial 24-month period begins the month following the month in which a beneficiary’s Ticket is considered to be assigned. During the initial 24-month period a beneficiary must be actively participating in his/her employment plan. This means that the beneficiary is engaging in activities outlined in the employment plan on a regular basis and within the approximate timeframes. During the initial 24-month period, SSA does not count any month in which the Ticket is in an extended period or in inactive status in deciding whether the beneficiary is making timely progress toward self supporting employment.

The EN will notify the PM if the beneficiary is not following the plan. Also, the PM will conduct a progress review at specified intervals. If the beneficiary fails to successfully complete the review, he/she has the choice of either having SSA review the PM’s decision or re-entering in use status. Even if it has been determined by the program manager that a beneficiary is not making timely progress toward self-supporting employment he/she may continue to participate in the Ticket to Work Program. However, he/she will no longer be provided medical CDR protection.
Once the beneficiary successfully completes the initial 24-month period progress review, he/she will then be required to perform work activity for a prescribed amount of time within the next 12-month period and have earnings at a specified level.

The chart below shows the guidelines that the PM uses when conducting a progress review.

NOTE: The non-blind SGA amount is the annual SGA amount for disability beneficiaries who are not blind. The gross non-blind SGA amount represents the SGA earnings amount before any work incentive exclusions are applies.

<table>
<thead>
<tr>
<th>Review Period</th>
<th>Participation Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial 24-months</td>
<td>Beneficiary following signed employment plan</td>
</tr>
<tr>
<td>First 12-months</td>
<td>Work at least 3 months at gross non-blind SGA level with ticket in use (may include work months in initial 24-month period)</td>
</tr>
<tr>
<td>Second 12-months</td>
<td>Work at least 6 months at gross non-blind SGA level with ticket in use</td>
</tr>
<tr>
<td>Third and subsequent 12-months</td>
<td>Worked 6 of 12 months and SSDI and/or Federal SSI benefits not payable because earnings or NESE too high (after work incentives applied)</td>
</tr>
</tbody>
</table>

**Progress Reviews**

As stated above, progress reviews will be conducted at 24-months and subsequently every 12 months following the initial 24-month progress review. These reviews will be conducted by the Program Manager, Maximus.

**24-Month Progress Review**

At the completion of the first 24 months during which a beneficiary used their Ticket, the Program Manager will conduct a Progress Review. During this review the Program Manager will answer three questions as per the final Ticket regulations:

1. Is the beneficiary actively participating in their employment plan? Simply, is the Beneficiary engaging in activities outlined in their employment plan on a regular basis and in the approximate time frames specified in the plan. These activities may include employment, if agreed to in the employment plan.
2. Does the beneficiary’s employment plan have a goal of at least three months of work by the time of the beneficiary’s first 12-month progress review?
3. Given the beneficiary’s current progress in their employment plan, can the individual be expected to reach this goal of at least three months of work at the time of their first 12-month progress review?

It is important to note that if a beneficiary engages in one or more months of employment during their initial 24-month period, these months can count toward the three months of employment required as part of the criteria for the first 12-month progress review that follows the 24-month progress review. If during the 24-month progress review the program manager is able to answer yes to all three questions then the beneficiary will be found to be making timely progress toward self-supporting employment until the first 12-month progress review. If the answer to any of these questions is no that the program manager will find that the beneficiary is not making timely progress and send a written notice of the decision to the beneficiary at their last known address. The notice will explain the program managers reasoning and inform the beneficiary of the right to ask for a review of the decision. The decision will be effective 30 days after the date on which the program manager sends the notice of the decision to the beneficiary unless a request for review is made.

12-Month Progress Reviews
The 12-Month Progress Review is a two-step process that involves a retrospective review and anticipated work level. During step one the program manager will check to see if the beneficiary completed the work requirements in the completed 12-month progress review period. If they have completed the work requirements the program manager will go to step two. If not, the program manager will make a determination that the beneficiary is not making timely progress toward self-supporting employment.

During the first 12-Month Progress Review the beneficiary must work for at least three of the 12 months at the SGA level for non-blind beneficiaries prior to income exclusions. These three months do not need to be consecutive. During the second 12-Month Progress Review period, and in later 12-Month Progress Review periods, the beneficiary must work at least six of 12 months at the SGA level for non-blind beneficiaries prior to income exclusions. For subsequent 12-Month Progress Review periods the beneficiary must work for six of 12 months with earnings substantial enough to eliminate SSI and SSDI cash payment for those six months worked.

Appealing Timely Progress Review Decisions

If a beneficiary disagrees with a decision made at the conclusion of a Timely Progress Review, that beneficiary can request a review of the decision made before the 30th day after the date on which the Program Manager sends the notice of decision. SSA will consider the beneficiary to be making timely progress until they make a decision. SSA will send a written notice of their final decision to the beneficiary at their last known address. If they decide that the beneficiary is no longer making timely progress, their decision will be effective on the date on which they send the notice of decision to the beneficiary.
When “Using A Ticket” Ends

The period of using a Ticket ends with the earliest of the following:

- The 60th month for which an outcome payment is made to an EN/State VR agency;
- For State VR agencies that chose the cost reimbursement method, the 60th month for which an outcome payment would have ended;
- The beneficiary is no longer meeting timely progress requirements;
- The beneficiary fails to reassign the ticket my the end of the 3-month extension period; or
- Entitlement to Social Security disability benefits or eligibility for Supplemental Security Income cash benefits based on disability ends.

Ticket Termination

A beneficiary’s Ticket will terminate if and when they are no longer eligible to participate in the Ticket to Work program. If a Ticket is terminated a beneficiary will no longer be able to assign it and an EN or State VR agency will not receive milestone or outcome payments achieved in or after the month in which the Ticket was terminated. A beneficiary’s eligibility to participate in the Ticket to Work program will end, and Ticket will terminate, in the earliest of the following months:

1. The month in which entitlement to SSDI benefits based on disability ends for reasons other than work activity or earnings, or the months in which eligibility for SSI benefits based on disability or blindness terminates for reasons other than work activity or earnings, whichever is later;
2. If the beneficiary is entitled to widow’s or widower’s insurance benefits based on disability, the month in which the beneficiary turns age 65; or,
3. If the beneficiary is eligible for SSI benefits based on disability or blindness, the month following the month in which they turn age 65.

Program Manager

On September 29, 2001 SSA competitively awarded a 5-year contract to MAXIMUS, Inc. of McLean, Virginia to provide program manager services to assist SSA in the administration of the Ticket to Work and Self Sufficiency Program. The responsibilities of the contractor include:

- Recruiting, recommending, and monitoring of ENs
- facilitating access by beneficiaries to ENs
- facilitating payments to ENs
- performing administrative duties such as reviewing IWP; reviewing amendments to IWP; ensuring that ENs only refer to a State VR agency for services pursuant to an agreement regarding the conditions under which such services will be provided; and resolving disputes between ENs and State VR agencies with respect to agreements; resolving disputes between a beneficiary and an EN which cannot be resolved by the EN’s internal grievance procedures; and referring disputes between beneficiaries and ENs to SSA for a final decision if this is requested by either of the parties.
SSA will periodically evaluate the Program Manager. This evaluation will include, but not be limited to, an assessment examining the following areas:

1. Quality of services;
2. Cost control;
3. Timeliness of performance;
4. Business relations; and
5. Customer satisfaction.

MAXIMUS, Inc. can be reached at:

Ticket to Work Program
Toll-free line: 1-866-968-7842
Toll-free TDD line for Hearing and Speech Impaired: 1-866-833-2967

**EN Qualifications**

An EN is any qualified entity that has entered into an agreement with the SSA to function as an EN under the Ticket to Work Program. To serve as an EN an entity must meet and maintain compliance with both general and specific selection criteria. General criteria include: having systems in place to protect the confidentiality of personal information about beneficiaries seeking or receiving services; being both physically and programmatically accessible; not discriminating in the provision of services based on a beneficiary’s age, gender, race, color, creed, or national origin; having adequate resources to perform the activities required under the agreement with SSA or the ability to obtain them; and, implementing accounting procedures and control operations necessary to carry out the Ticket to Work Program. The specific criteria that an entity must meet to qualify as an EN include: using staff who are qualified under applicable certification, licensing or registration standards that apply to their profession including certification or accreditation by national accrediting or certifying organizations; using staff that are otherwise qualified based on education or experience, such as by using staff with experience or a college degree in a field related to the services the EN wants to provide such as vocational counseling, human relations, teaching, or psychology; and taking reasonable steps to assure that if any medical and related health services are provided, such medical and health-related services are provided under the formal supervision of persons licensed to prescribe or supervise the provision of these services in the State in which the services are performed. Any entity must have applicable certificates, licenses, or other credentials if such documentation is required by State law to provide VR services, employment services or other support services.

**EN Responsibilities**

The EN assumes responsibility for the coordination and delivery of employment services, vocational rehabilitation services or other support services to beneficiaries who have assigned their Ticket to that EN. An EN may consist of a one-stop delivery system established under the Work Investment Act of 1998.
or either a single provider of such services or a group of providers organized to combine their resources into a single entity. An EN provides services either directly or by entering into agreements with other providers, which can furnish appropriate services and serves prescribed service areas and takes measures to ensure that services provided under the Program meet the requirements of individual work plans. An EN must develop and implement individual work plans in partnership with each beneficiary they have agreed to provide services to in a manner that affords the beneficiary the opportunity to exercise informed choice in selecting an employment goal and specific services needed to achieve that employment goal. Each IWP must meet the requirements detailed in the section below.

Finally, the EN must report to the Program Manager each time it accepts a Ticket for assignment; submit a copy of each signed IWP to the Program Manager; submit to the Program Manager copies of amendments to a beneficiary’s IWP; submit to the Program Manager a copy of any agreement the EN has established with a State VR agency; submit information to assist the Program Manager conducting the reviews necessary to assess a beneficiary’s timely progress; report to the Program Manager the specific outcomes achieved with respect to specific services the EN provided or secured on behalf of the beneficiary; provide a copy of its most recent annual report on outcomes to each beneficiary considering assigning a ticket to it; meet all financial reporting requirements; collect and record such data as SSA requires; and, adhere to all requirements specified in the agreement with SSA.

SSA will periodically evaluate an EN’s performance to ensure effective quality assurance in the provision of services by ENs. SSA will solicit and consider the views of the individuals the EN serves and the Program Manager monitoring the EN. ENs must make the results of these periodic reviews available to beneficiaries to assist them in choosing among available ENs.

Every State agency administering or supervising the administration of the State plan approved under Title I of the Rehabilitation Act of 1973, as amended, must participate in the Ticket to Work program if it wishes to receive payments from SSA for serving beneficiaries who are issued a Ticket. The Ticket to Work program does provide different payment options that are available to a State vocational rehabilitation agency for provided services. A State vocational rehabilitation agency participates in the program in one of two ways when providing services to a particular beneficiary under the program. On a case-by-case basis the State agency may participate either as an EN or under the cost reimbursement payment system. When the State agency serves a beneficiary with a Ticket as an EN, the agency will use the EN payment system it has elected for this purpose, either the outcome or outcome-milestone payment system. The State vocational rehabilitation agency will have periodic opportunities to change the payment system it uses when serving as an EN. When serving a beneficiary who does not have a Ticket, the State vocational rehabilitation agency may seek payment only under the cost reimbursement payment system. A State vocational rehabilitation agency participates in the program in one of two ways when providing services to a particular beneficiary under the program.
A rehabilitation agency can choose to function as an EN or to receive payment under the cost reimbursement payment system each time that a Ticket is assigned or reassigned to it if payment has not previously been made with respect to that Ticket. If payment has previously been made with respect to that Ticket, the State agency can receive payment only under the payment system under which the earlier payment was made.

An EN may refer a beneficiary it is serving to a State vocational rehabilitation agency for services if the State vocational rehabilitation agency and EN have an agreement that specified the conditions under which services will be provided by the State agency. This agreement must be in writing and signed by both parties prior to the EN referring any beneficiary to the State agency for services.

An IWP is a required written document signed by an EN and a beneficiary, or a representative of a beneficiary, with a Ticket. It is developed and implemented in partnership when a beneficiary and EN have come to a mutual understanding to work together to pursue the beneficiary’s employment goal. The purpose of the IWP is to outline the specific employment services, vocational services and other support services that the EN and beneficiary have determined are necessary to achieve the beneficiary’s stated employment goal. The beneficiary and EN share the responsibility for determining the employment goal and the specific services needed to achieve that goal. At a minimum the IWP must include:

- a statement of the vocational goal including, as appropriate, goals for earnings and job advancement;
- a statement of the services and supports necessary for the beneficiary to accomplish that goal;
- a statement of any terms and conditions related to the provision of these services and supports;
- a statement that the EN may not request or receive any compensation for the costs of services and supports from the beneficiary;
- a statement of the conditions under which an EN may amend the IWP or terminate the relationship;
- a statement of the beneficiary’s rights under the Program, including the right to retrieve a Ticket at any time if the beneficiary is dissatisfied with the services being provided by the EN;
- a statement of the remedies available to the beneficiary, including information on the availability of advocacy services and assistance in resolving disputes through the State P&A System;
- a statement of the beneficiary’s right to privacy and confidentiality regarding personal information, including information about the beneficiary’s disability;
- a statement of the beneficiary’s right to seek to amend the IWP; and,
- a statement of the beneficiary’s right to have a copy of the IWP made available to the beneficiary, including in an accessible format chosen by the beneficiary.

The EN is responsible for ensuring that each IWP contains this information.
The underlying premise of the Ticket to Work program is to pay ENs based on the satisfactory employment (or self-employment) outcomes of the SSDI or SSI beneficiary. With the exception of four milestone payments available under the Outcome-Milestone Payment System, and the separate option for State VR Agencies to be paid under the longstanding cost reimbursement payment system, all payments to an EN occur based on work activity that results in the beneficiary’s loss of SSDI benefits and disability-based Federal cash SSI benefits.

ENs may elect to be paid under one of two EN payment systems – the Outcome Payment System or the Outcome-Milestone Payment System. Payments under the new EN payment systems differ depending on the option chosen and the types of benefits received by the beneficiary. The pace of payments to an EN will also depend on how quickly the beneficiary achieves the required work outcomes.

An EN elects one of the two payment systems when it enters into an agreement with SSA to serve as an EN. After first electing a payment system, the EN can then make one change in its chosen payment system at any time during the first 12 months after the month it becomes an EN, or within 12 months after the month the Ticket program starts in its state, whichever occurs later. Additionally, at least every 18 months SSA will offer each EN the opportunity to change its elected payment system.

Each calendar year SSA bases the payments for both EN payment systems, described below, on something called the Payment Calculation Base. One of two Payment Calculation Bases is used, depending on whether the individual served is an SSDI or SSI beneficiary. For SSDI beneficiaries (including concurrent SSDI/SSI beneficiaries), the Payment Calculation Base will be the average monthly disability insurance benefit payable for the months during the preceding calendar year to all disabled worker beneficiaries who are in current pay status for the month in which the benefit is payable. For SSI beneficiaries (who are not concurrently SSDI beneficiaries), the Payment Calculation Base will be the average monthly Federal SSI payment based on disability payable for the months during the preceding calendar year to all beneficiaries who: i) are have attained age 18 but not age 65; ii) are not concurrent SSDI/SSI beneficiaries; and iii) are in current pay status for the month in which the payment is made.

**Under the Outcome Payment System**, SSA can pay the EN for up to 60 outcome payment months that a beneficiary attains during his/her outcome payment period. A beneficiary attains an outcome payment month when no SSDI or disability-based Federal cash SSI payments are payable because of work or earnings. An EN can be paid for an outcome month only if it is attained after a beneficiary has assigned his or her ticket to the EN and before the individual’s ticket terminates. An outcome payment under this payment system will be equal to 40 percent of the Payment Calculation Base for the calendar year in which the outcome payment month occurs, rounded to the nearest whole dollar.
Under the Outcome Milestone Payment System, SSA can pay the EN for up to four milestones achieved by beneficiary after the ticket is first assigned and the beneficiary begins to work. In addition, SSA can pay the EN for up to 60 outcome payment months that the beneficiary attains for each month that no SSDI or disability-based Federal cash SSI payments are payable because of work or earnings.

The Four Milestones are based on the earnings levels that SSA uses when it considers whether a beneficiary’s work activity is SGA. The requirements for meeting the four milestones are as follows:

- The first milestone is met when the beneficiary has worked for one calendar month and has gross earnings from employment (or net earnings from self employment) for that month that is more than the SGA threshold amount.

- The second milestone is met when the beneficiary has worked for three calendar months within a 12-month period and has gross earnings from employment (or net earnings from self employment) for each of the three months that are more than the SGA threshold amount. The month used to meet the first milestone can be included in the three months used to meet the second milestone.

- The third milestone is met when the beneficiary has worked for seven calendar months within a 12-month period and has gross earnings from employment (or net earnings from self employment) for each of the seven months that are more than the SGA threshold amount. Any months used to meet the first two milestones can be included in the seven months used to meet the third milestone.

- The fourth milestone is met when the beneficiary has worked for 12 calendar months within a 15-month period and has gross earnings from employment (or net earnings from self employment) for each of the 12 months that are more than the SGA threshold. Any months used to meet the first three milestones can be included in the 12 months used to meet the fourth milestone.

An EN can be paid for a milestone only if the milestone is attained:

- after a beneficiary has assigned his or her ticket to the EN,
- before the individual attains the first outcome payment month, and
- before the individual’s ticket terminates.

The payment amounts for the four milestones are each tied to a percentage of the Payment Calculation Base for the calendar year in which the month of attainment of the milestone occurs, rounded to the nearest dollar.
Each of the **60 Outcome Payments** under the Outcome–Milestone Payment System is equal to 34 percent of the Payment Calculation Base for the calendar year in which the outcome payment month occurs, rounded to the nearest whole dollar. If the EN received one or more milestone payments with respect to an individual, each outcome payment made to the EN with respect to the same individual will be reduced by an amount equal to 1/60th of the milestone payments made. For example, if an EN received a total of $900 in milestone payments, each of the 60 outcome payments would be reduced by $15.

Keep in mind that an EN may not receive all four milestones under the outcome-milestone payment system. Once a beneficiary’s earnings meet the criteria for receiving an outcome payment, the EN will begin receiving outcome payments and no further milestone payments will be made. In such a case, the EN does not actually “lose” the milestone amounts. They are part of the outcome payment base and will be paid out over the 60-month outcome payment period.

**Rates for Calendar Years 2002 – 2005**

During calendar years 2002 through 2005, the following payment calculation bases (PCB) apply:

<table>
<thead>
<tr>
<th>SSDI PCB</th>
<th>SSI PCB</th>
</tr>
</thead>
</table>

The following chart summarizes the payment rates under the two EN payment systems for calendar year 2005, based on the type of benefit received. It also provides the percentage of the PCB each payment rate equals.

<table>
<thead>
<tr>
<th>Payment System</th>
<th>Type of Payment</th>
<th>Payment Rate (% of PCB)</th>
<th>SSDI Rate (SSDI and Concurrent)</th>
<th>SSI Rate (SSI Only)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome Payment System</strong></td>
<td>Outcome Payment</td>
<td>40%</td>
<td>$347.00</td>
<td>$204.00</td>
</tr>
<tr>
<td><strong>Outcome-Milestone Payment System</strong></td>
<td>Milestone #1</td>
<td>40%</td>
<td>$295.00</td>
<td>$173.00</td>
</tr>
<tr>
<td></td>
<td>Milestone #2</td>
<td>68%</td>
<td>$590.00</td>
<td>$347.00</td>
</tr>
<tr>
<td></td>
<td>Milestone #3</td>
<td>136%</td>
<td>$1,181.00</td>
<td>$694.00</td>
</tr>
<tr>
<td></td>
<td>Milestone #4</td>
<td>170%</td>
<td>$1,476.00</td>
<td>$867.00</td>
</tr>
<tr>
<td></td>
<td>Outcome-Milestone Payment$5</td>
<td>34%</td>
<td>$295.00</td>
<td>$173.00</td>
</tr>
</tbody>
</table>

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$^{5}$ Under the outcome-milestone payment system, each outcome payment will be reduced by an amount equal to 1/60th of the milestone payments received by an EN with respect to an individual.
A State VR Agency participates in the Ticket program in one of two ways: as an EN, or under the longstanding cost reimbursement payment system that is spelled out in the SSDI and SSI regulations. The State VR Agency, on a beneficiary-by-beneficiary basis, may choose whether it will serve a beneficiary as an EN or under the cost reimbursement program. The choice of payment systems is generally made when the State VR Agency first notifies the Program Manager of its decision to serve the beneficiary. If the beneficiary was already a consumer of the State VR Agency prior to receiving a ticket, the agency notifies the PM of its payment system election at the time the beneficiary decides to assign the ticket to the State VR Agency.

For those beneficiaries it serves under the EN payment system, the State VR Agency has the same option as other ENs to elect either the Outcome Payment System or the Outcome-Milestone Payment System. When the VR agency elects to serve an individual beneficiary as an EN, it will be bound by the EN payment system it elected. Like other ENs, the State VR Agency will periodically have opportunities to change the payment system it uses when serving as an EN.

The cost reimbursement option for payment is described earlier in this chapter. When it is used, the State VR Agency is paid by SSA for all of its qualified rehabilitation expenses with respect to a particular beneficiary. The total payment to the agency under this traditional reimbursement system may, on a case-by-case basis, be more or less than what it would receive for the same beneficiary using one of the EN payment systems.

SSA will pay an EN only for milestones or outcomes achieved after the beneficiary’s ticket was assigned to the EN and before the ticket terminates. In no event, can the EN charge the beneficiary for any services provided by the EN.

Beneficiaries may meet some, but not all of the goals needed to for 60 outcome payment months. Can the EN keep the milestone and outcome payments in such a case? The answer is yes, provided SSA does not subsequently determine that one or more of the payments was made in error. Each milestone or outcome payment to an EN will be paid based on whether the criteria for that payment is met. So, for example, an SSDI only beneficiary who exhausts his or her trial work period, works for 27 months at the SGA level immediately following the trial work period, and then has to quit working, will not achieve all 60 outcome months. In the example, the person would have probably achieved 24 outcome months following the nine-month trial work period and a three-month grace period with continued benefits. In that case, even though the beneficiary can return to SSDI payment status since he/she stopped performing SGA and is within the 36-month extended period of eligibility, the EN can keep the 24 outcome payments due as the result of the 24 months in which the beneficiary was not eligible for an SSDI payment.
There will be some cases in which two or more ENs qualify for payment on the same ticket. This may occur because the beneficiary assigned the ticket to more than one EN at different times and now more than one EN is claiming that their services contributed to the achievement of a milestone or outcome. When that happens, payment will still be limited based on the payment formulas discussed above (i.e., the total payments are not increased because more than one EN is involved) and the milestone or outcome payments will have to be split up. The Program Manager must make an “allocation” recommendation with regard to what percentage of a particular payment will go to each EN. If the beneficiary is served by two ENs that have each selected a different payment option, the Program Manager must recommend a payment allocation and each EN’s payment will be based on the payment option in effect for each EN when the ticket was assigned to each.

This splitting of payments could involve an EN and a State VR agency that serves the beneficiary as an EN. In that case the allocation of payments would be made as described above. However, if the State VR Agency is paid by SSA under the cost reimbursement system with respect to a ticket, such a payment precludes any later payment to an EN, or State VR Agency serving the beneficiary as an EN, under either the Outcome Payment or Outcome-Milestone Payment Systems. Similarly, if either an EN, or a State VR Agency, is paid under one of the EN payment systems, that payment would preclude any subsequent payment to a State VR Agency under the cost reimbursement system, with respect to a ticket.

What if SSA receives a request for payment, with respect to the same ticket, from an EN or State VR Agency that elected payment under an EN payment system, and also receives a request for payment from a State VR Agency that elected payment under the cost reimbursement system? The final regulations provide that: SSA will pay the provider that first meets the requirements for payment under its elected payment system; or, if both providers first meet those requirements in the same month, SSA will pay the claim of the provider to which the beneficiary’s ticket is currently assigned. If the ticket is not currently assigned to either, SSA will pay the claim of the provider to which the ticket was most recently assigned.

The Ticket program offers a dispute resolution system for three types of disputes: those between beneficiaries and State VR Agencies acting as ENs; those between beneficiaries and ENs that are not State VR Agencies; and those between ENs that are not State VR Agencies and Program Managers.

When a State VR Agency serves a beneficiary, the agency is required to comply with all of the provisions under Title I of the Rehabilitation Act of 1973 (29 U.S.C. 720 et seq) and its implementing regulations found in 34 C.F.R. Part 361. One of those requirements is the opportunity to resolve disputes through formal mediation services or an impartial hearing process.
Any individual who is seeking or receiving VR Agency services, who is dissatisfied with a determination made by personnel of the agency, has the right to a timely review of that determination. Each State VR Agency must develop and implement procedures to ensure that an individual may request a timely review, which must include the right to mediation and an administrative hearing before an impartial hearing officer. The VR Agency must notify individuals, in writing, of their right to mediation, an impartial hearing, and the availability of the Client Assistance Program (CAP) to assist them with disputes. This notice must be provided at the following times: at the time the individual applies for VR services; at the time the individual is assigned to a category in the State’s order of selection, if the State VR agency has established an order of selection under section 361.36; at the time the Individual Plan for Employment (IPE) is developed; and upon the reduction, suspension, or cessation of VR services. At an impartial hearing, the individual has the right to be represented by an attorney or other advocate. Both the individual and the agency can present evidence and cross examine witnesses. The hearing decision is final and must be implemented, unless appealed.

The 1998 amendments to the Rehabilitation Act provide that a State VR Agency may establish a procedure for a second level of administrative review. The review officer must be the chief official of the designated State VR Agency or an official from the office of the Governor. If the state does establish a second level of administrative review, either party may appeal within 20 days of the hearing officer’s decision. The review officer cannot overturn a hearing decision unless, based on clear and convincing evidence, the decision is “clearly erroneous” based on an approved State VR Plan, Federal law, Federal Vocational Rehabilitation regulations, or State regulations or policies that are consistent with Federal regulations. The 1998 amendments also add the right for either party (i.e., the consumer or the VR agency) to appeal a final administrative decision to federal court (or to state court if your state provides for court review of administrative decisions).

The administrative hearing required to be offered by State VR Agencies is very similar to the hearing available to SSI and SSDI beneficiaries who are dissatisfied with decisions by SSA affecting their benefits. Unlike the very informal dispute resolution procedures governing ENs that are not State VR Agencies, described below, the VR Agency hearing provides an extensive opportunity to present live testimony and cross examine adverse witnesses. The hearing officer is then required to render a written decision, which must determine if the services in dispute are mandated under the very intricate provisions of Title I and its implementing regulations.

For disputes between beneficiaries and ENs that are not State VR Agencies, the Ticket program offers a three-step dispute resolution process:

1. The beneficiary can file a complaint through the EN’s internal grievance procedures.
2. If the EN’s internal grievance procedures do not result in an agreeable resolution, either the beneficiary or the EN may seek a resolution from the PM.

3. If either the beneficiary or the EN is dissatisfied with the resolution proposed by the PM, either party may request a decision by SSA.

All ENs that are not State VR Agencies must establish written grievance procedures that a beneficiary can use to seek a resolution to a dispute under the Ticket program. The EN must give each beneficiary seeking services a copy of its internal grievance procedures and inform him or her of the right to refer a dispute first to the PM for review, and then to SSA for a decision. The EN is also required to inform each beneficiary of the availability of assistance from the State Protection and Advocacy system.

At a minimum, the EN is required to inform each beneficiary seeking services under the Ticket program of the procedures for resolving disputes when:

- the EN and the beneficiary complete and sign the IWP;
- services in the beneficiary’s IWP are reduced, suspended or terminated; and
- a dispute arises related to the services spelled out in the beneficiary’s IWP or to the beneficiary’s participation in the program.

When the EN’s grievance procedures do not result in a satisfactory resolution, either the beneficiary or the EN may ask the PM to review a disputed issue. The final regulations do not spell out any time limit for requesting this review, but do require the PM to contact the EN to submit all relevant information within 10 working days. The information to be submitted should include:

- a description of the disputed issue(s);
- a summary of the beneficiary’s position, prepared by the beneficiary or a representative of the beneficiary, related to each disputed issue;
- a summary of the EN’s position related to each disputed issue; and
- a description of any solutions proposed by the EN when the beneficiary sought resolution through the EN’s grievance procedures, including the reasons the beneficiary rejected each proposed solution.

The PM has 20 working days to develop a “written recommendation,” that should explain the reasoning for the “proposed resolution.” Upon receiving the PM’s recommendation, either the beneficiary or the EN may request, in writing, a review by SSA. That request for review must be received by the PM within 15 working days of the receipt of the PM’s recommendation. The PM has 10 more working days to refer this request to SSA. The request for SSA review must include: a copy of the beneficiary’s IWP; information and evidence related to the disputed issue(s); and the PM’s conclusion(s) and recommendation(s). SSA’s decision in response to this request is final. No further appeal within SSA is available and the regulations do not provide for any court appeal.
Representation of Beneficiaries in Ticket Disputes

If a beneficiary is using either the appeals system for resolving disputes with State VR Agencies, pursuant to Title I of the Rehabilitation Act, or using the more informal procedures for resolving disputes with ENs, pursuant to the final Ticket regulations, the beneficiary can be represented by an attorney, advocate, or any other person. The two advocacy programs, available in every state and territory to assist beneficiaries with these disputes, are the Client Assistance Program (CAP) and the Protection and Advocacy for Beneficiaries of Social Security (PABSS) program. The CAP was created in the mid 1980s, largely to assist individuals with disabilities in connection with State VR Agency disputes, and may also be available to assist with EN disputes. The PABSS was created as part of TTWWIA and is available to assist beneficiaries with EN disputes, including disputes with State VR Agencies serving as ENs. Some state Protection and Advocacy agencies will provide services under both the CAP and PABSS programs.

Dispute Between ENs and Program Managers

For disputes between ENs that are not State VR Agencies and the PM, that do not involve an EN’s payment request, there is a two-step dispute resolution process:

1. The EN can seek a resolution through the PM’s internal grievance procedures; and
2. If the PM’s internal grievance procedures do not result in a mutually agreeable solution, the PM must refer the dispute to SSA for a decision.

Whenever there is no mutually agreeable solution to the EN’s dispute, the PM has 20 working days to refer the dispute to SSA with all the relevant information. The information should include:

- A description of the disputed issue(s);
- A summary of the EN’s and the PM’s position related to each disputed issue; and
- A description of any solutions proposed by the EN and PM when the EN sought resolution through the PM’s grievance procedures, including the reasons each party rejected each proposed solution.

SSA’s decision in response to this dispute is final. No further appeal within SSA is available and the regulations do not provide for any court appeal.

Questions and Answers on the Ticket to Work

For more information on frequently asked questions pertaining to the Ticket to Work and Work Incentives Improvement Act of 1999, visit SSA’s Office of Employment Support Program’s web site at: http://www.ssa.gov/work

Link to “Legislation” for up-to-date information on legislation and regulations pertaining to the employment supports of individuals with disabilities. Additional information is available on MAXIMUS’ website at: http://www.yourtickettowork.com.
If the individual has another strategic plan in operation, related to his or her life and employment possibilities, it is often best to support the person integrating the action points associated with benefits management into that plan, rather than to create a separate plan (one person, one plan!). Many times, the person may already be enrolled with the state office of Vocational Rehabilitation and may have an IPE either written or in process. By writing down the actions needed to ensure smooth transitions in benefits, the customer can take this to his or her counselor and ask to have it included, as well as ask for assistance in securing the supports needed to carry through, if needed. Other individuals will have a transition plan associated with their school program, if they have not graduated, and this is another place to think about integrating these strategies. Many people with developmental disabilities or mental illnesses have case specialists (or service coordinators) who maintain a plan of support with the person. This is an ideal place to encourage the person to integrate the benefits management steps.

Keep in mind that there are many situations where the person may not have a plan because they are not connected to other support agencies, and may not want to be. In other cases, integrating the action points into another plan may not be good assurance that they will be attended to, as there are some support agencies and personnel that are more thorough than others, and there is certainly a widespread lack of information and skill related to benefits management among the above-mentioned providers of supports. Therefore, the benefits specialist must be sensitive to this, relying on past experiences and the input of the customer to assist them in deciding whether including the action steps into one of the plans will provide enough support to them to ensure a smooth transition with benefits as they begin to pursue an employment goal.

As federally defined, transition planning should begin at age 14, or earlier if deemed appropriate. As mandated in the Individuals with Disabilities Education Act, several transition benchmarks exist: development of a statement of needed transition instruction, development of the IEP, identification of long-term adult outcomes, identification of needed transition services, and finally, development of the coordinated set of activities. While these benchmarks are for the most part static, personnel responsible for each benchmark may not be. This poses a large barrier to coordinating benefits advisement and management support for a student in the transition process. Given actual team members and personnel may vary, we are going to explore the benchmarks by looking at what they specifically entail and the potential advisement roles which should be explored and played.

**Statement of Needed Transition Instruction**

Early on in a student's transition planning process, a “**statement of needed transition instruction**” must be incorporated into the student's IEP. This is the first benchmark, or step, on the road of transition planning. Depending on the state and district of the student, this statement may be obtained using one or more different approaches.
For example, in New York State, districts must complete what is called a Level One Vocational Assessment by age 12. This assessment is comprised of several pieces of information aimed at identifying a student's vocational interests and preferences, basic skills, past successes, and long-term adult outcomes. Other states and districts use instruments like Transition Planning Inventories and other tools to baseline where a student is, and to project where they want to go. Whatever the tool, it assists the user in formulating long-term adult outcome statements in the student’s own words which leads them to formulate a statement of needed instruction that will either move the student toward, or refine, their projected adult outcomes.

This is an important benchmark for beginning to consider how disability benefits planning and assistance and use of work incentives might be incorporated into the transition planning process and IEP. At this juncture, several questions should be answered as part of the base line assessment process or annual planning:

- Does the student currently receive SSI?
- If so, to what extent?
- If not, is there economic need evident that might lead you to advise the family to apply for benefits? If the student has benefits, is there a benefits management / advisement plan in place?
- If working are they currently reporting their earnings?
- If yes, are they using work incentives?
- Have they used work incentives in the past?
- If the student does not get benefits but is possibly eligible, does the student or family need support in making application and pulling information together?
- Does the student and/or family know of community agencies that can provide support and assistance as they seek to maneuver the SSA system?
- Does the student have a prior work history?

These questions begin to frame very clearly the specific transition-support needs a student might have that should be incorporated into a student's statement of needed transition instruction.

For example, if a student is receiving benefits, working, not reporting earnings, and doesn't understand the impact of work on their check, then this student's needed transition instruction could include: benefits advisement and counsel; training and/or coursework concerning consumer economics or specifically, SSA disability and work incentive programs; or functional activities of daily living instruction focused on money management and consumer awareness.

As questions are answered, statements of needed transition instruction can be formulated and roles needing to be played become increasingly evident.
Developing the IEP

Following formulation of needed transition instruction is the development of the student’s IEP. Each year as part of the student’s education program, the long-term adult outcomes are revisited and modified annually, to assist the student in moving toward or refining their long-term adult outcomes with the goal to assist the student in achieving higher academic standards. At this point, similar questions continue to be asked. However, questions are also asked that move the student toward adult living, learning and earning outcomes. Leading questions dictating level of benefits advisement and support needed should focus first on whether or not the student desires to work or to go on to postsecondary education. For students thinking about employment, clarification is needed and additional information must be collected, such as:

- What are quality indicators of employment for this student?
- Are the student’s preferred outcomes viable, and do they have a feasible plan for attainment?
- If not, how will we support them in identifying more viable and feasible outcomes?
- What supports might this student need to work toward this outcome?
- What are the current resources and supports we can build a plan upon?
- Where can additional resources and supports be secured?
- Is the student planning on working this year?
- If so, is a benefits advisement / management plan in place?
- Will the student use work incentives other than the Student-Earned Income Exclusion?
- Are personnel responsible for student progress documentation aware of performance/capacity reporting implications?
- What level of earnings/income will the student need, to generate support for their learning and living adult outcomes?

For students considering postsecondary education, it is also important to clarify whether or not they will be working at the same time. These individuals in particular might benefit a great deal from active benefits advisement and full use of the work incentive provisions. When thinking of supporting students in moving toward full community living, it is important to break this large area down into smaller components, specifically: recreation/leisure; residential; financial; medical/health; transportation; and legal/advocacy. As community living is broken down into these smaller areas, the implications each holds for a transition-aged student who receives SSI are recognized.

Inevitably, where and with whom the student lives, and how old they are, is going to affect the amount of the Federal Benefit Rate used, or income of a parent or guardian that may be deemed toward a student under 18.

When examining the medical/health arena, the issue of ongoing health insurance must be faced. While 1619(b) provides for ongoing Medicaid coverage for those who maintain eligibility for this status, if a student turns 18 and is moved into the SSDI program (either as a DAC or through their own insured coverage)
Medicare does not have a 1619(b) provision. To receive Medicare insurance, an individual must complete a 24-month waiting period following eligibility determination for Title II benefits. This could potentially pose a particular dilemma for transition-aged youth moved from the SSI to the SSDI program, who will have a two-year period without healthcare coverage. However, youth who received SSI and had Medicaid coverage prior to their age 18 re-determination are ensured ongoing Medicaid coverage under the Pickle Amendment.

The effective transition planner or benefits advisor will assist a student in understanding the complexity of legal/advocacy-related need areas. These areas specifically relate to knowledge, skills, capacities or supports that must be in place if the student is to make a successful transition to adulthood. Some areas for consideration include: knowledge of civil rights legislation; understanding of complexity of individual support and advocacy needs; ability of the student to self-advocate, monitor, and manage their own benefits situation; and long-term legal planning supports, should a student ever need to file an appeal with SSA.

Responses to the questions identified earlier begin to highlight specific activities and possible goals and objectives that will need to be formulated to support the student’s educational program. Some possible activities might include:

- Ongoing investigation of current benefit status
- Exploration of possible effect of future/current earnings on benefit
- Exchange of benefit and work-related information with the student, family, educators and involved community agencies
- Appropriate and relevant documentation of work-related activities, progress, and ongoing support needs
- Accurate and timely reporting of earnings and other pertinent information to SSA
- Application of work incentive provisions
- Continued career exploration
- Development of a benefit advisement plan
- Development of a work incentive management plan (e.g. how a PASS will be managed, etc.)

Coordinated Set of Activities

The final benchmark of transition to consider when supporting a transition-aged youth is the Coordinated Set of Activities. The coordinated set of activities has been interpreted in several different ways. The coordinated set of activities should be seen as an opportunity for us to ensure that a quality IEP has been crafted that incorporates all of the elements discussed. It provides a chance to assess and document the extent of employment / post-school activities incorporated into a student’s IEP that move them toward, or refine, their long-term adult outcomes based on their identified support needs. It also provides a chance to identify and evaluate the quality and quantity of community experiences, instruction, and related services that move the student toward the same. In addition, need for activities of daily living instruction or functional vocational assessment should be assessed, documented and provided, as deemed appropriate.
Do not forget the impact that turning 18 holds for transition-aged beneficiaries and recipients. It is important to provide supports and proactively plan for this pivotal point in a child's educational program and benefit status. Some important activities might include:

- Gathering records and data to make a case for continued benefits as an adult;
- Assessing the impact of re-determination on current use of work incentives;
- Keeping abreast of pending re-determination dates;
- Advising students and families as to the impact of being switched from SSI to SSDI/DAC;
- Proactively seeking advocacy and support should an appeal be required.

Continued Payment of Benefits for Children and Those Turning Age 18 Who Are Participating in an Approved Vocational Rehabilitation Program

On August 10, 1999, the Office of Employment Support Programs of the Social Security Administration provided further guidance in field memorandum file number EM-99079, clarifying that the procedure for determining continued payment of benefits under “section 301” of the Social Security Disability Amendments of 1980 applies to all age 18 redetermination and continuing disability review cases. Section 5113 of the Omnibus Budget Reconciliation Act of 1990 extended eligibility for “section 301” payments to individuals whose disability ceased because of medical recovery while participating in an approved non-state “alternative participant” VR program.

The field memorandum clearly articulates that “section 301” does apply to an individual age 18 and older whose impairment is determined to be no longer disabling, as a result of re-determination as an adult, as long as they are participating in an approved VR program.

This further clarification strongly supports the movement and connection of students, prior to school exit, into approved VR programs. Inadvertently, connecting students to VR programs could potentially have two positive outcomes: reducing the numbers of SSI recipients at age 18 not being determined eligible for SSI as an adult, and more transition-aged youth becoming attached to employment.

Pursuant to Title I of the federal Rehabilitation Act, each state will have a state vocational rehabilitation (VR) agency to provide services to individuals with disabilities to assist them in entering the work force. Some states will do this through a single state agency, but the state may designate a second agency to serve individuals who are blind. For example, New York’s two-state VR agencies are the Office of Vocational and Educational Services to Individuals with Disabilities (VESID) and the Commission for the Blind and Visually Handicapped (CBVH).
State VR agencies can fund a wide range of goods and services which are connected to a person’s vocational goal. Congress has stated that VR services are to empower individuals to maximize employability, economic self-sufficiency, independence, and integration into the work place and the community through “comprehensive and coordinated state-of-the-art programs.”

Consistent with these principles, and subject to state-specific financial need guidelines that may be in place, a state VR agency is available to fund items such as vocational training, college tuition, transportation, vehicle modification, assistive technology, and supported employment services.

Each individual who is served by a state VR agency will receive services pursuant to an individualized plan of employment (IPE). This plan had been called the individualized written rehabilitation plan (IWRP). The name was changed to the IPE, pursuant to the Rehabilitation Act amendments of 1998.

Like its counterpart, the IEP for students receiving special education services, the IPE is the blueprint that will identify all services provided by the state VR agency.

Any service provided to meet the employment goal must be specified on the IPE. The IPE should enable the individual to achieve the agreed-upon employment objectives, and must include the following:

- The specific employment outcome, chosen by the individual, consistent with the unique strengths, concerns, abilities and interests of the individual;
- The specific VR services to be provided, in the most integrated setting appropriate to achieve the employment outcome, including appropriate assistive technology and personal assistance services;
- The timeline for initiating services and for achieving the employment outcome;
- The specific entity, chosen by the individual, to provide the VR services, and the method chosen to procure those services;
- The criteria for evaluating progress toward achieving the employment outcome;
- The responsibilities of the VR agency, the individual (to obtain comparable benefits) and any other agencies (to provide comparable benefits);
- In states which have a financial needs test, any costs for which the individual will be responsible;
- For individuals with the most significant disabilities and who are expected to need supported employment, the extended services to be provided; and
- The projected need for post-employment services, if necessary.

The IPE must be reviewed at least annually and, if necessary, amended if there are substantive changes in the employment outcome, the VR services to be provided, or the service providers. Any changes will not take effect until agreed upon by the individual and the VR counselor.
If the person who is served by the state VR agency is a recipient of SSDI or SSI (or is expected to be a recipient upon application), the consumer’s need for benefits planning and assistance should be identified in the IPE. The IPE should identify the entity, which will provide the benefits planning and assistance, and spell out how that service will be funded. (At least two states that we know of, New York and Ohio, are selectively funding the provision of these services. In New York, the VR agency contracts with independent living centers and will soon contract with other agencies as part of a demonstration project; in Ohio the VR agency has a contract with a legal aid office to provide the service.)

Benefits screening, advisement, and management, as described elsewhere in this manual, will often be critical to the successful employment of an individual with a disability. With the new emphasis in the 1998 Rehabilitation Act amendments on consumer involvement in writing the IPE, many consumers, or their advocates, will want to insist that these services be written into the IPE and, if necessary, funded by the state VR agency. (Currently, both the law and regulations governing state VR agencies are silent on whether benefits planning and assistance are required services. It is noteworthy, however, that under the new Ticket to Work and Self Sufficiency provisions, this is one of the specifically enumerated services that Employment Networks can provide to “ticket” holders.)

In addition to the IEP and IPE, there are other service delivery and support planning constructs. Under the Mental Retardation and Developmental Disabilities system, an Individual Service Plan maintains a similar structure to that of the IEP and IPE. (These additional constructs may go by various names, including Individual Habilitation Plan (IHP) and/or an Individual Support Plan (ISP).) Whatever the name, the service delivery and support planning constructs outline specific areas that parallel the IPE and IEP. These include:

- Introduction to the individual planning is being done with;
- Goals;
- Objectives; and,
- Action Strategies;

**Introduction**

This information typically describes the person for whom the planning is being done. This usually entails the person’s present situation cutting across all aspects of their life, which might include present levels of performance, capacities, interests, preferences, support needs, and existing support systems. A general introduction will also provide an outline of the individual’s overall dreams and aspirations, and projecting long-term desired outcomes. This may be framed in the context of “future statements” or “desired states.”

**Goals**

Goals are typically framed within a 1-3 year period, although can as much as 3-5 years. Goals will typically address most life domains including living, loving, learning and earning. While broad in context, they provide the framework upon which objectives are crafted to serve as a stepladder to achieving the overall goal.
Objectives
Objectives are typically written to be achieved within one month to one year. They outline very specific outcomes that must occur, that serve as milestones to reaching the goal established. A given goal may have several objectives that lead to its attainment. Keep in mind, there are primarily two types of objectives, which can be written: learning and service objectives. Learning objectives, as the title suggests, assist the individual being supported in developing or acquiring a specific skill or competency. Service objectives focus on providing help, or supporting an individual in an area where capacities negate independence.

Action Strategies
Action strategies clearly identify several important pieces of information related to the goals and objectives, specifically:

• What needs to be done;
• Who will do it;
• What the timeframes will be;
• How success will be measured; and,
• The frequency at which progress will be measured.

These strategies could be related to who will offer support; who will access other resources; or what the customer will do to achieve learning or service objectives.

Considerations for the Benefit Specialist
If possible, the benefits specialist should consider and attempt to achieve actions that would be in a separate benefits support plan (included in the objectives) and most importantly, in the action strategies of the ISP or related plan. As referenced earlier in the IPE section, there are several touchpoints / support needs which should be considered for inclusion in the ISP, based on an individual’s unique set of needs. These include, but are not limited to:

• Ongoing investigation of current benefit status
• Exploration of possible effect of future/current earnings on benefit
• Exchange of benefit and work-related information with the student, family, educators and involved community agencies
• Appropriate and relevant documentation of work-related activities, progress, and ongoing support needs
• Accurate and timely reporting of earnings and other pertinent information to SSA
• Application of work incentive provisions
• Continued career exploration
• Development of a comprehensive benefit advisement plan
• Development of a work incentive management plan (e.g how a PASS will be managed, etc.)
Support Plan Case Study

Breaking into small groups of 3-5, review the following case study and propose possible support needs and plan accordingly.

John B. Recipient is considering taking a part-time job as a greeter with the local historical society in their museum. The job pays minimum wage to start, although provides incentive raises to promote job longevity, gradually increasing his hourly wage to $10 at the end of two years of employment. John is excited about beginning this job in a month. John recently moved into a supported apartment program and will be living independently. His parents are concerned that he has never taken care of his own finances, although the residential program assures them that a staff person will work with him each week to manage his finances and do his shopping and banking. The residential program has called you because they just lost their benefits specialist and are concerned because John receives both SSI and Social Security and his placement is contingent upon maintaining his health care coverage.

| Potential Needs for Support: |

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<tr>
<th>Activity / Goal</th>
<th>Time-frames</th>
<th>Person(s) Responsible</th>
<th>Role</th>
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</thead>
<tbody>
<tr>
<td>Desired Outcome</td>
<td>Resources Needed</td>
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Quality Indicators of Success: