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.
Benefits Planning, Assistance and Outreach

Chapter 21

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>
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<table>
<thead>
<tr>
<th>Desired Outcomes</th>
<th>Resources Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Quality Indicators of Success:

2004 Can be reproduced with permission.
**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>

**Desired Outcomes**

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.

**Resources Needed**

- 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.

**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.

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.¹

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).² 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.

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 will be implemented in three phases. The table below outlines the three phases and States and territories impacted.

<table>
<thead>
<tr>
<th>Phase I – January 2002</th>
<th>Phase II – Calendar Year 2002</th>
<th>Phase III – Calendar Year 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delaware, Florida,</td>
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<tr>
<td>Illinois, Iowa,</td>
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<tr>
<td>Massachusetts, New York, Oklahoma, Oregon, South Carolina, Vermont and Wisconsin</td>
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</table>

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.”
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 (25 – 36 ticket 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 (37 – 48 ticket 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 (49 and + ticket 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 IWPs; reviewing amendments to IWPs; 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 organizes 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

State Vocational Rehabilitation Agencies

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The Individualized Work Plan

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.
Benefits Planning, Assistance and Outreach

Employment Network Payment Systems

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.

Election of an EN Payment System

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.

Payments Under the Two EN Payment Systems

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 – 2004**

During calendar years 2002 through 2004, the following payment calculation bases (PCB) apply:

<table>
<thead>
<tr>
<th></th>
<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 2004, 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>$336.00</td>
<td>$199.00</td>
</tr>
<tr>
<td><strong>Outcome-Milestone Payment System</strong></td>
<td>Milestone #1</td>
<td>40%</td>
<td>$286.00</td>
<td>$169.00</td>
</tr>
<tr>
<td></td>
<td>Milestone #2</td>
<td>68%</td>
<td>$572.00</td>
<td>$339.00</td>
</tr>
<tr>
<td></td>
<td>Milestone #3</td>
<td>136%</td>
<td>$1,143.00</td>
<td>$678.00</td>
</tr>
<tr>
<td></td>
<td>Milestone #4</td>
<td>170%</td>
<td>$1,429.00</td>
<td>$847.00</td>
</tr>
<tr>
<td></td>
<td>Outcome-Milestone Payment</td>
<td>34%</td>
<td>$286.00</td>
<td>$169.00</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.

Dispute Resolution

Disputes Between Beneficiaries and State VR Agencies

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.
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.

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.

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 workplace 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.

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<th>Potential Needs for Support:</th>
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<tr>
<td>Activity / Goal</td>
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<td>Desired Outcome</td>
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Quality Indicators of Success:
An individual’s success in realizing their employment, financial and life goals will ultimately depend on effective management of their benefit programs. As addressed earlier, changes at any time, with any number of variables (including an individual’s employment, financial resources, living arrangements and work incentive utilization) may result in a significant impact on their benefit eligibility and payment status, and their health care coverage. Given these potential impacts, ensuring an overall positive change in a person’s financial and life situation necessitates continuous and effective monitoring and management of their benefit status.

Benefits assistance is about designing, implementing, monitoring, and evaluating the outcome of a long-term benefits support plan. Benefits assistance services usually build on the earlier efforts of the benefits specialist to establish a complete and accurate benefits profile, to analyze and provide advice on potential benefit paths, and, finally, to assist the individual in establishing a long-term benefits management plan based on their informed choice of action. The goals and objectives of this plan serve as a critical guide to the delivery and evaluation of benefit assistance services.

It is important for the benefits specialist to clarify for both the funder of benefits planning and assistance, and the consumer, the point at which benefits planning is shifting into benefits assistance. Planning is focused on analysis and counsel, while assistance deals more with providing long-term supports to oversee and proactively monitor an individual’s benefit status and financial well-being.

Effective benefits assistance services are characterized by the delivery of supports that are individualized, comprehensive, proactive, and available on a continuous basis.

Individualized supports:

The benefit assistance supports required vary significantly from person to person depending on a number of factors. The factors include:

- The array of benefits received;
- The nature and degree of interplay between benefit programs;
- The existence of benefit complications or problems;
- The level of anticipated change in the person’s benefits, employment and life situation;
- The individual’s knowledge regarding their benefit programs and ability to advocate for themselves;
- The existence of other programs or naturally occurring supports in the person’s life that can address support needs.
As these factors will vary widely in each case, benefits assistance plans must be developed on a person-by-person basis. The initial benefits assistance planning process provides a critical opportunity for assessing what type of support needs exist, the intensity of the supports needed, and the benefit specialist’s role in delivering or arranging for them.

**Comprehensive services:**

When discussing benefits assistance, the term “comprehensive” will be defined based on the support needs of each beneficiary or recipient. At one end of the spectrum, comprehensive services for one individual may consist of monthly or bi-monthly meetings to update employment and benefit information, help with reporting income to SSA, provide regular assistance with managing work incentives, and advocating on behalf of the person with other agencies. At the other end, an individual’s benefits assistance services may simply consist of periodic reassessment of benefit status and education concerning benefit issues as they arise.

In a broader sense, the term comprehensive addresses the needed for an agency to ensure that an array of benefit assistance support services and access to information on all possible federal, state, and local benefits are made available to individuals. A comprehensive program of benefit assistance services includes the following key service components:

- Data collection, profiling and analysis
- Advisement and counsel
- Information and referral
- Counseling
- Support planning
- Long-term intervention
- Problem solving and advocacy

For benefits assistance programs limited in the array of services offered and/or scope of information provided, a strong information and referral component will be critical to the overall success of the individual. Efforts must be made to establish and maintain a network of community resources to ensure that all support needs are met, from benefits profiling and advisement to benefits management.

**Proactive services:**

To ensure that smooth benefit transitions are experienced that result in an overall positive impact; it is critical that benefits assistance services be provided on a scheduled, continuous basis. Proactive benefits assistance is characterized by planning for, and providing, supports at regular checkpoints, as well as at critical transition points in an individual’s benefit, employment and overall situation. These regular, intermittent checkpoints, or wellness visits, reduce the likelihood and negative impacts of benefit complications by providing for:
consistent communication with the individual;
• the opportunity to reassess the benefit situation as it currently exists;
• an opportunity to identify needs for benefit decisions and actions, as well as additional services, such as information and referral, problem solving and advocacy, and crisis management.

Long-Term Services:

Effective benefits assistance services involve the provision of supports to beneficiaries and recipients over time. Generally, long-term benefits assistance will involve the need for communication between adviser and consumer over a period of one to three years. In some cases, however, the adviser will retain an open case file and provide services for longer than three years, as individual circumstances dictate. It could extend for more than 36 months, for example, if the benefits specialist will be monitoring a consumer’s activity during the entire trial work period and extended period of eligibility. Similarly, benefits assistance may extend beyond 36 months if a benefits specialist is monitoring an approved PASS through the full period of the consumer’s undergraduate program.

As with the types and intensity of services needed, the duration of follow-along benefits assistance services will not only vary from person to person, but may also vary for a particular individual over time. For example, an individual whose case file was closed after several months of assistance regarding a work/benefit transition may identify the need for support in developing a PASS, or responding to a CDR notice, at a later point in time. Flexibility of the program that allows beneficiaries and recipients to move in and out of active case service status, as well as the overall accessibility and responsiveness of the benefits specialist, are key to effective support.

The following are just a few examples of situations where long-term benefits management is appropriate:

• The consumer is an SSI recipient who is expected to have significant variations in earned income (i.e., wages) from month to month.
• The consumer is an SSI recipient who is expected to have significant variations in the amount of exclusions from income from month to month. These exclusions could include, for example, IRWE, BWE, or the student-earned income exclusion.
• The consumer is an SSDI beneficiary who will need to monitor progress through a trial work period and/or extended period of eligibility.
• The consumer is eligible for both SSI and SSDI. Since the effect of work on benefits will vary greatly for the two programs, it is not likely that a person could provide adequate advisement in just one or two sessions with the consumer.
The dynamic interplay between employment, financial status and benefits requires that benefits specialists continually draw on an array of tools throughout the process of supporting benefits management. Analysis of the factors affecting a person’s situation conducted during the initial profiling process will need to be updated regularly as new conditions or factors surface. As a result of each updated analysis, new scenarios or opportunity paths will need to be developed and explored. Education and advisement about new possibilities and choices will likewise be necessary, as well as additional planning for the continued delivery of benefits assistance. The following outlines a number of strategies for the organization and delivery of benefits assistance services.

A primary component of benefits assistance services involves periodic or proactive meetings to ensure that the necessary communication occurs between all parties to move ahead with accomplishing the goals and objectives of the benefits assistance plan. These visits need to be scheduled and held with the beneficiary or recipient on an on-going basis, every three to six months, depending on the individual’s need for support, or when critical transition points are experienced in employment and benefits. Based on benefit management goals and activities laid out in the plan, a timeline or schedule of services may be established to serve as a tickler for contact points.

The long-term benefits plan can simultaneously serve as an agreement between the service provider and the individual, as well as a focal point for the on-going meetings and communication regarding the delivery of service. For individuals with relatively straightforward and consistent benefit and employment situations, the initial plan may serve to guide the delivery of benefits management services over an extended period of time. In most cases, however, the plan will serve as an evolving tool for the benefits counselor and the individual, and will be reviewed and built upon over time as the individual’s situation changes or unanticipated issues arise.

While the periodic, on-going meetings with beneficiaries and recipients will need to be tailored to address the specific needs of the person, the following areas of discussion are suggested as a guide:

- Update of extensive personal, financial, and work-related information originally gathered in the benefits profile;
- Review of benefits management goals and objectives, including an update on progress made, issues or problems raised, and an evaluation of outcomes;
- Identification, analysis and advisement regarding new variables affecting the benefits monitoring and management process. This may require revising existing goals and objectives and/or adding new ones.
Chapter 22 Benefits Planning, Assistance and Outreach

- Review and update of benefits assistance service and support needs based on new information/changes in situation;
- Informal education and resource information related to specific benefit and work incentive provisions;
- Direct problem-solving and advocacy for the issues identified;
- Information and referral to community resources to address needs.

The benefits specialist will need to work with the consumer to identify other relevant individuals involved in the person’s benefit management process. To the extent possible, these individuals should be included in the periodic update meetings, as specific needs for their expertise, services, and supports are identified. This may include individuals from other agencies providing services or benefits to the individual, as well as family, friends and others involved in providing supports. Such an inclusive approach will provide greater assurance that the benefits management plan is built on complete and accurate information and that the needs/supports identified will leverage and build upon natural supports and resources currently available.

While the benefits management update meetings serve as the backbone of the follow-along services, they will in most instances need to be supplemented by periodic telephone or written communication with the beneficiary or recipient and other significant individuals involved. As mentioned earlier, all information gathered during the course of the benefits management meetings or other communications, and any record of the information and advice given, should be documented in the individual’s case file.

Critical Transition or Touchpoints

To minimize the incidence of benefit complications, the benefits specialist should make every effort to anticipate fluctuations or changes in an individual’s employment and financial situation, as well as other factors that will potentially affect benefits and overall well-being. The events or incidents being explored below are common touchpoints where the benefits specialist will need to plan for and intervene to ensure adequacy of safety nets and smooth benefits transitions.

SSI Touchpoints

Event – Increase or decrease in earnings from employment

An increase or decrease in a person’s earnings from employment will result in a change in their monthly SSI cash benefit. Changes in earnings may be caused by the fluctuations in the individuals work hours, pay rate, a change in pay dates, or termination of employment.
Benefits Planning, Assistance and Outreach

Overview – The SSI program is funded by the general revenues of the Federal Treasury and is intended to provide a minimum level of monthly income to persons who are aged, disabled, or blind and demonstrate economic need (i.e., have little or no income or resources). Individuals who are eligible for SSI receive a monthly cash benefit and will usually qualify for health care coverage under Medicaid as well. The SSI monthly benefit is intended to serve as a financial safety net for recipients during periods of time when they are not able to work at a substantial level, as well as during the process of working towards an employment goal.

As SSI is an economic need-based program, it is intended to supplement any income or resources an individual already has to ensure that they have a minimum level of income each month to meet their basic food and shelter needs. Therefore, the dollar amount of SSI benefit received by an individual in a given month depends on the dollar amount of other income they have for that particular month, as well as their resources, living arrangement, and use of work incentives.

In January of each year, Congress establishes the Federal Benefit Rate (FBR), which is the maximum dollar amount that an individual or couple can receive in SSI cash benefit on a monthly basis. The recipient’s monthly earnings from employment affects how much of the FBR is actually received. Generally, the more an individual has in earnings, the less they receive in SSI.

Not all of the person’s earnings, however, are counted in determining the amount of their monthly SSI benefit. There are several income exclusions that are available to all SSI recipients.

First, a $20 general exclusion is subtracted from a person’s income from any source. The general exclusion is applied first to any unearned income the person has. If the individual has no unearned income, then the general exclusion is subtracted from their earnings.

Secondly, a $65 earned income exclusion is subtracted from the person’s earnings. Finally, the SSA excludes one-half of the amounts of earnings after the $20 and $65 exclusions are applied. So, in other words, the SSI check is reduced $1 for every $2 earned after the other exclusions.

Event: Increase or decrease in unearned income

Examples of unearned income include SSDI, veterans’ benefit, civil service annuity, or monetary support received from another person. Deemed income is another type of unearned income that is counted for individuals who are married or under the age of 18. Deemed income refers to the amount of the parent or spouse’s income that is considered to be available to the recipient. A formula is used by the SSA to determine the amount of the parent’s income and resources that are deemed to be available to the child, taking into consideration the amount of income and number of parents and children in the house.
Background: As with earnings, the more unearned income a person has, the less they will receive in their monthly SSI cash benefit. The $20 general exclusion referenced above is subtracted from the recipient’s unearned income. The remaining unearned income, or countable unearned income, will reduce the person’s SSI cash benefit dollar for dollar.

In particular, benefit specialists should watch for changes in unearned income as a result of the following situations:

- An SSI recipient becomes eligible for an SSDI benefit, because of working and earning enough quarters for coverage on his or her own record.
- An SSI recipient with parental deemed income experiences a change in the number of parents/children living in the household.
- An SSI recipient reaches 18 years of age, at which point parental income is no longer deemed.
- An SSI recipient who is 18 years or age or older is determined eligible for SSDAC as a result of being a dependent of an insured worker who retires, becomes disabled, or dies.

Event: Change in resources

To meet initial as well as continuing eligibility for SSI, an individual must meet a resource test. Resource limitations are established under the Social Security Act and include countable real or personal property that cannot exceed $2,000 for an individual or $3,000 for a couple. If a person has resources in excess of the allowable limits at the beginning of a month, it renders them ineligible for an SSI cash benefit in that month and in future months, until their resources are again below the established limits.

A listing of resources counted can be obtained from your local SSA Office.

Event: Changes in living arrangement

Background: In-kind support and maintenance is considered to be unearned income in the form of food, clothing, or shelter that is given to an individual by someone else. If a person is 18 years of age or older, and receives food, clothing or shelter from a third party, they will be determined to be receiving in-kind support and this will result in their SSI check being reduced by 1/3 of the amount of the federal benefit rate. If an individual is able to pay within $5 of their fair share of the household expenses they’ll be determined not to be receiving in-kind support and will avoid this reduction in their benefit.
Event: Change in Marital Status

Background: Two SSI recipients who are married are subject to the couples Federal Benefit Rate. This will result in a decrease in the amount of SSI received by each recipient. Additionally, when an SSI recipient marries an individual who does not receive SSI, a portion of the spouse’s income may be counted as deemed income, resulting in a decrease in SSI cash benefit. SSI recipients who end a marriage relationship will conversely experience an increase in SSI.

Event: Attainment of Age 18

Background: Upon reaching age 18, SSI recipients will be subject to a re-determination process to determine their continued eligibility for SSI under the adult disability criteria. If determined eligible, SSI cash benefits will continue. There will, however, be a difference in the calculation of the monthly cash benefit they are eligible to receive because parental deemed income will no longer apply and living arrangement and in-kind support rules will apply.

Event: Movement into 1619(a) status

Background: Section 1619(a) basically provides a safety net that enables individuals who continue to be disabled to receive special SSI cash benefits in place of their regular SSI benefits, when earnings exceed the SGA level. To be eligible for 1619(a) benefits, individuals must continue to have the original disabling impairment under which eligibility for SSI was initially determined, and currently meet all other eligibility rules, including the income and resource test.

If all eligibility requirements continue to be met, when earnings increase to greater than the SGA level but remain lower than the break-even point, SSI recipients will automatically move into 1619(a) status. There are no observable differences in the SSI checks indicating the change from regular SSI benefits to a 1619(a) special benefit. Individuals will only receive notice regarding the reduction in their checks when their increased earnings place them over the SGA level. Eligibility for a 1619(a) cash benefits will continue until earnings fall below SGA, at which point individuals will automatically move back into regular status and receive regular checks; or earnings exceed the break-even point (BEP), at which time their cash benefits will cease.

Event: Movement into 1619(b) status

Background: Section 1619(b) of the 1987 legislation provides for continued Medicaid eligibility for individuals whose incomes are too high to qualify for an SSI cash benefits, but are not high enough to offset the loss of Medicaid or publicly funded attendant care. Individuals will be eligible only for the 1619(b) protected Medicaid status if the sole causes for SSI benefits cessation are increased earnings over the break-even point. If cash benefits cessation is a result of a determination of medical recovery or are due to resources and/or unearned income in excess of the statutory limits, individuals will not be eligible for 1619(b).
A second criterion for 1619(b) status requires that individuals’ gross earnings fall below certain limits, called threshold amounts. The thresholds are used as an administrative convenience to determine if “sufficiency of earnings” is met rather than performance case-by-case computations. The law does not mention thresholds. Earnings at or above the threshold amounts are considered to be sufficient to replace the cost of Medicaid coverage. Threshold amounts vary from state to state as a result of variations in the cost of medical services. Individualized thresholds can be computed if individuals have unusually high medical costs, work expenses, or a Plan for Achieving Self-Support (PASS). Individuals are ineligible for 1619(b) if their earnings exceed the threshold amount. They may qualify for this provision at a later date if their earnings fall below the threshold amount within 12 months and all other eligibility requirements continue to be met.

A final criterion for 1619(b) is that individuals must need Medicaid in order to work. Compliance with this criteria is established through statements by the individuals to the SSA regarding the use of Medicaid in the last 12 months, expected use within the next 12 months, or need for Medicaid if individuals become injured or ill within the next 12 months. To qualify for 1619(b) Medicaid status, individuals must:

- Have a disabling condition or continue to be blind;
- Need Medicaid in order to work;
- Be unable to afford benefits equivalent to those received if not working; and/or
- Meet all other requirements for SSI payments other than earnings.

At the time that SSI cash benefits cease as a result of the formula explained above, the SSA computer would automatically determine eligibility for 1619(b). The field office will confirm 1619(b) eligibility at the next determination.

Advocates and family members should monitor earnings monthly and contact the SSA as soon as SSI cash benefits cease, to ensure that the 1619(b) determination is made.

Medicaid can be administered by the SSA or by another state agency, but this varies from state to state. In 32 states, eligibility for SSI brings automatic entitlement to Medicaid.

Individuals who begin working under the SSDI program are provided with several opportunities under the Act to try their hand at work. However, if an SSDI beneficiary medically recovers from their originating disability under which eligibility was established, these provisions of the law do not apply. It is critically important to stay abreast of the individual’s work status as is noted below.
Event: Participation in/Completion of Trial Work Period

**Background:** SSDI beneficiaries not recovering from their medically determined disability are entitled to a nine-month trial work period (TWP). The TWP will begin the first month an individual is entitled to Title II benefits or files an application for disability benefits. The TWP ends only if individuals perform nine months (not necessarily consecutively) of trial work within a rolling period of 60 consecutive months. TWP months must be carefully tracked, because a 36-month extended period of eligibility (EPE) begins immediately following the nine-month TWP.

Event: Participation in/Completion of Extended Period of Eligibility

**Background:** If a beneficiary has not medically recovered at the conclusion of the nine-month TWP, the individual will immediately enter into a 36-month Extended Period of Eligibility (EPE). This period begins the month following the ninth TWP month and is a minimum of 36 consecutive months. At the conclusion of the TWP and during the EPE if it is determined that a beneficiary is working at an SGA level, they will receive their full benefit check for the month in which SGA was determined, plus the following two months. This is known as a “grace period” to allow the beneficiary a period of time to adjust to the fact that they will not receive a SSDI check in the months following the conclusion of the grace period in months which their earnings exceed SGA. During the EPE, it is not necessary to file a new application for benefits to resume. Following the grace period, Title II cash benefits are received only during the remaining EPE months in which gross earnings are below the SGA level.

It is important to note that for individuals who are self-employed, individual determinations of what quantifies SGA during EPE will be established. The claims representatives will make this individualized determination by looking at: how many hours of work were performed; who performed the services; net and gross earnings; subsidies; and other particulars.

Consistency and accuracy in reporting monthly fluctuations in earnings between SGA and non-SGA levels is critical in avoiding overpayment or underpayment of Title II benefits during this period. The EPE ends the first month following the 36th month that individuals engage in SGA. For example: Individuals could earn below SGA in the 37th, 38th, and 39th months and continue to be in the EPE. If they earn SGA in the 40th month, the EPE ends. After the EPE has ended, if they decrease earned income due to medical impairment, a new application for Title II must be filed. Currently, within 12 months they can be reinstated.
Event: Extended Medicare Coverage

Background: Title II beneficiaries who lose benefit entitlement due to performance of SGA, but continue to be disabled, are eligible for extended Medicare coverage. The extended coverage is for a minimum of at least 93 months. In addition, it is possible for individuals with disabilities to buy into the Medicare program once the extended Medicare coverage is exhausted and Medicaid may possibly assist in paying the premium, which is over $300 a month.

Event: Use of Work Incentives

Background: The use of work incentive provisions can help beneficiaries and recipients in two significant ways. They can help individuals to pay for services or items that they need in order to work, and to maintain or even increase their cash benefits until they are stable in employment. In addition to the 1619(a) and 1619(b) work incentives, the PASS, IRWE, and BWE are incentives that enable people with disabilities to recover expenses they incur while working towards greater economic self-sufficiency. The goals of the work incentive programs are to assist individuals to achieve gainful employment, increase independence, facilitate empowerment, and acquire self-support.

In some cases, the work incentives can be used during the initial SGA test to assist individuals who may be working and earning at or above SGA level to establish eligibility. The dollar amount of impairment related work expenses (IRWE) and subsidies are subtracted from the gross monthly wages before the SGA determination is made. Individuals may be earning over the SGA level and still meet the disability criteria if the dollar amount of their IRWEs and/or subsidies is significant enough to reduce their gross monthly earnings below the SGA level. Earnings set aside under a Plan for Achieving Self-Support (PASS) cannot be deducted from gross monthly wages to meet the SGA criteria. However, if individuals are using wages under a PASS to pay for impairment-related work expenses, the PASS expense can simultaneously be computed as an IRWE to reduce wages for the SGA disability determination.

Regardless of whether the work incentive is used during the initial eligibility process or once benefits are established, a decision by a beneficiary or recipient to work and use the work incentives available to them should involve thorough up-front evaluation and planning to ensure an overall positive impact. First, projections should be made on the immediate effect of the earnings and the work incentive plan on cash benefits and the overall financial situation. Second, the long-term impact of changes in both earnings and work incentive utilization must be investigated. Some of the very basic questions that the benefits specialist will want to assist the individual in addressing include the following:
• What happens if earnings increase or decrease?
• If the vocational goal is reached, will benefits cease all together?
• What will be the impact on medical coverage?
• If a work incentive will be used to pay for a work expense that the individual has as a result of their disability, will the IRWE or PASS be more financially advantageous?
• Will the work incentive allow for funding of a needed service on a long-term basis, or will it be necessary to explore other funding options?
• If money or resources are accumulated under a PASS and the plan is interrupted, how will continuing eligibility for SSI be affected?
• How will resources, money accumulated under a PASS affect the individual’s eligibility for other benefits they may be receiving, such as housing?

Successful utilization of the work incentives and smooth benefit transitions ultimately depend on a cooperative effort between beneficiaries and recipients, families, advocates and the SSA. Proactive communication with the SSA will help to ensure that decisions made regarding employment and work incentive use are based on sound, accurate information and projections.

Event: SSI Age-18 Redeterminations

Background: As previously discussed, a redetermination review will be conducted for all individuals when they reach their 18th birthday. The purpose of the age-18 redetermination is to ensure that the individual meets the disability eligibility criteria for adults receiving SSI. The local SSA office will contact the recipient to initiate the process.

The potential loss of SSI as a result of the age-18 redetermination process holds significant implications for young adults and their efforts to become successfully employed. Consequently, strong justification is provided for benefits specialists, school, and rehabilitation professionals to take an early and active role in working with youth, their families, and the Disability Determination Service towards an accurate determination of SSI eligibility for the adult program. The following are suggested guidelines for the involvement of benefits specialists and other school and rehabilitation professionals in this process:

• **Provide information** on the age 18 redetermination requirement to individuals on the childhood SSI roles and their families. Discussions regarding SSI and the requirement that all youth must be redetermined for the adult SSI program should happen early in the transition process. Information shared should include both a discussion of the redetermination process as well as information regarding how input will be gathered and used in the work evaluation component of the process. The role of the individual, family, school professionals, and others in the process should likewise be addressed.
• **Gather and provide documentation** to the Disability Determination Service necessary to support an accurate determination of eligibility. It is critical to keep in mind that the documentation provided by teachers and rehabilitation professionals is used in the redetermination process to evaluate a young adult’s residual functional capacity and related ability to perform substantial work. In light of this, it is extremely important that the information provided give an accurate and comprehensive representation of the individual’s performance, including functional work limitations and information on the supports that are necessary to enable the work activity. In some instances, the forms used by DDS to gather input contain only questions related to the student’s performance in the classroom and other school settings. If a student has engaged in community-based work experience, documentation of performance and necessary supports should be included as supplemental information.

Requests for information on age-18 redeterminations will include questions related to assessing the potential for fraud and abuse. In responding to these questions, it is critical that teachers and others consider carefully both the purpose of the questions as well as the observations and information on which their responses are based.

• **Plan early** for the possible implications of benefit cessation with the individual and their family. Young adults who are utilizing and relying on their SSI for access to critical work supports will need to consider possible alternatives to maintain these supports should benefit eligibility cease. If not already established, efforts should be made to assist the individual in establishing eligibility and access to services under the State Vocational Rehabilitation Agency prior to the age-18 redetermination process. Other community agencies and resources should be investigated as well. Involving vocational rehabilitation and other agencies early in the transition planning process will reduce the likelihood that gaps in services will occur and enhance the overall supports available to the student.

• **Encourage and support** students and their families to appeal benefit cessations that result from age-18 redeterminations. A multi-step appeals process is available to all individuals who do not agree with a determination by DDS that they are not disabled. The first step of the appeals process involves a reconsideration of the initial determination at the state DDS level. If a favorable decision is not reached at the reconsideration level, the determination can be appealed through an Administrative Law Judge Hearing. The final steps may include an Appeals Council Review, followed by civil action in a U.S. District Court.
In a perfect world, the benefits specialist would be able to operate proactively at all times, planning for all benefit events and transitions before they occur and taking action to ensure smooth benefit progress. Unfortunately, not all benefit events or decisions can be anticipated! In some instances, the beneficiary/recipient will receive notice of actions that will need to be handled on a reactive basis.

Change in Benefit Status

SSA will provide written notice to beneficiaries/recipients of all decisions it makes and actions it plans to take. The notice will include an outline of information or factors on which they are basing their decision/action. Individuals receiving benefits have the right to appeal any decision made if they disagree with it or think that it is a mistake. The documents that SSA sends regarding the decision are critical to keep on hand as they will assist in responding to or appealing the decision.

There are timelines that must be adhered to for a beneficiary/recipient to exercise their right to appeal. All decisions must be appealed within 60 days. In the case of some disability decisions, if the appeal is initiated within 10 days, the individual may be able to continue receiving their cash benefit while they appeal. Keep in mind that if they are once again determined not disabled as a result of the appeal, they may have to pay the money back.

Overpayment/Underpayment

Overpayments and underpayments in SSI and SSDI benefits are commonly experienced, and can have significant impact on an individual’s financial well-being. An overpayment exists when the individual receives more in their cash benefit than they were eligible to receive during a specified period of time. Overpayments may occur for a number of reasons, including, but not limited to:

- An SSI recipient had resources exceeding the allowable limits for a cash benefit during the period of time;
- An SSI recipient had additional earned or unearned income that was not reported/counted by SSA in determining the cash benefit during a specific period of time;
- An SSDI beneficiary received cash benefits after the trial work period and a SGA determination was made;
- SSI or SSDI cash benefits were paid during a period of time that the individual was not eligible due to medical recovery;
- An SSI or SSDI cash benefit was paid during a period of time when any number of other eligibility requirements were not met.
The notice of overpayment sent to the beneficiary or recipient will include information on the time period of the overpayment, reason for it, and amount of overpayment. A request for reconsideration of the overpayment can be filed within 60 days of receiving the notice. This 60-day period may be extended if there is “good cause.” The beneficiary/recipient may also file for a waiver of SSA’s right to recover the overpayment if an argument can be made that the individual was not at fault. This would include situations where the individual was unaware of overpayment or told by SSA that it was not an overpayment, among other things. A waiver may be requested at any time.

If it is determined that SSA will move forward with recovery of an overpayment, the beneficiary or recipient will experience a decrease in their monthly cash benefit.

**Benefit Cessation**

For both the SSI and SSDI programs, benefits can be stopped at any point in time that an individual fails to meet any of the disability and/or non-disability requirements for the program. Again, appeals of the decision must be filed within the established timeframes.

It is critical for the benefit specialist to consider the opportunities for the individual to continue benefits while appealing. Additionally, individuals who are determined medically recovered as a result of any of the CDR processes outlined previously, may be eligible for continued cash benefits under Section 301. This provision allows for the continued payment of monthly cash benefits to individuals determined to be medically recovered if they are under an approved vocational rehabilitation plan. The plan must be in place before the CDR process was initiated, and there must be a good likelihood that providing benefits while the person completes the plan will result in self-sufficiency and their ultimate removal from the benefit roles.

Information and referral services will be a key component of the services that a benefits specialist provides in assisting a person with managing their benefits over time. The benefits specialist will frequently find himself or herself in the position of identifying needs for services that are beyond the purview of their program to provide, such as support in the area of employment development and supports and assistive technology. This is where the development and maintenance of a network of community providers discussed in Unit II becomes critical. As with all other services provided, the level of support in information and referral must be customized to individual needs.
While the onus may be on the benefits specialist to be as proactive in monitoring an individual’s benefit status and as knowledgeable regarding SSA’s policy and regulations as they can be, inevitably, situations will arise that require problem solving and crisis management. It is important in these situations to understand that the benefits planning and assistance arena is comprised of an array of human interactions during which, at any point, error or assumptions can be made that inadvertently result in problems/crisis. There are some important elements to consider:

- Is this really a problem or crisis situation?
- Is the nature of the situation based on financial, social, medical, or vocational factors?
- Are others affected by this situation?
- Is this a safety net issue?
- Does this situation involve other individuals?
- Is expertise needed outside of benefits planning and assistance?
- Who is available to network with on this issue?

Keep in mind that some individuals may need extensive support in resolving a problem while others may be capable of solving problems on their own. While the tendency may be to resolve the situation on their behalf, it is important to use the opportunity as a “teachable moment.” Keep in mind the multiple steps associated with problem solving and gauge where the individual you are working with may need some skill building support.

| Step One: Recognize that there is a problem |
| Step Two: Understand the breadth and depth of the problem |
| Step Three: Generate potential solutions to the problem |
| Step Four: Evaluate and analyze solutions generate projected outcomes and consequences of each |
| Step Five: Select a solution |
| Step Six: Implement the solution |
| Step Seven: Evaluate outcomes and consequences |

If desired outcome not achieved:

<p>| Step Eight: Identify factors contributing to lack of desired outcomes |
| Step Nine: Evaluate and analyze other solutions generated to project potential for success |
| Step Ten: Return to Step Five |</p>
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<thead>
<tr>
<th>Do’s</th>
<th>Don’ts</th>
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<tr>
<td>1. Try to buy time in order to investigate the situation.</td>
<td>1. Abandon the person requesting your support if they request your immediate attention.</td>
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<td>2. Be sensitive to the individual’s problem and “legitimize” the complaint.</td>
<td>2. Accept the individual’s perceptions of the situation at face value without investigation.</td>
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<td>3. Assure the individual that you will take steps to work with them to solve the problem. You are the “expert” — inspire confidence in your ability.</td>
<td>3. Evade the situation, come across “wishy-washy,” sound unsure of your ability, or make excuses.</td>
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<td>4. Investigate the situation thoroughly, utilizing all available information services.</td>
<td>4. Assume you know how to handle the situation without investigation or commit yourself to a specific plan of action without gathering information.</td>
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<td>5. Develop and implement an intervention plan that treats root causes of the crisis.</td>
<td>5. Attempt to solve major problems by treating symptoms of a more pervasive underlying cause.</td>
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<td>6. Use the least intrusive method of intervention, then move up the hierarchy.</td>
<td>6. Jump in with the most intrusive intervention strategy.</td>
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<td>7. Utilize existing supporters and stakeholders in intervention plan to maximize involvement.</td>
<td>7. Try to solve the crisis all by yourself without investing others in the solution.</td>
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<tr>
<td>8. Be creative and have back-up plans prepared.</td>
<td>8. Assume that your first plan will always be successful.</td>
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Crisis Intervention Plan

Individual: ___________________________ Date: __________________

Issue (problem): ________________________________________________

The problem could have been avoided if:
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

Others to invest in plan:

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<th>NAME</th>
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<th>Goal</th>
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<th>Person(s) Responsible</th>
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Future safety nets to be considered:
Case Study 1:

Chris is an SSDI beneficiary who tells you that he has been working part-time for the past four years. He has been getting help with his taxes from a volunteer tax preparer who is collecting Social Security retirement benefits. As he describes his work activity during the past four years, it becomes clear to you that he has been receiving benefits for some time that were not due him, under the SGA rule. [The tax preparer incorrectly advised him that his earnings, which were over $8,000 in 1997 and 1998, and over $9,000 in 1999 and 2000, would not affect his SSDI benefits. You know differently, and warn him that he has probably been overpaid.] He has never talked directly to an SSDI Claims Representative. Instead, he reported his earnings by calling the toll-free number.

You contact the SSA at his request, and are told that the beneficiary is overpaid by almost $22,000. He is also considered to have completed his TWP and EPE. His benefits terminate immediately.

This news throws Chris into a deep depression. Each time you talk to him, he suggests that suicide is a solution to his problem. His emotional status deteriorates so quickly that he has to quit his job.

What do you do?

Case Study 2

In another scenario, you are meeting for the first time with a young man named Jake. Jake recently graduated from high school and his mother comes to the appointment with him. He proudly tells you he has been working for two months, earning $450 a month. You have to ask if he has reported this work activity to the SSA. His mother says they were not aware that they were required to report. You explain how earned income reduces the SSI payment, and that he has been overpaid.

Both the young man and his mother become very agitated when you explain that his SSI payment will be reduced not only by the “countable” portion of his wages but by the amount that is withheld monthly to recover the overpayment. The mother says her son should quit working rather than lose part of his SSI payment. This would leave him with no activity at all during the day since he is no longer in school and he lives with his mother, who works full-time.

What is the best way to approach this situation?
Case Study 3

Mary is a woman who is receiving SSDI due to a severe medical condition that is now under control with treatment. Her benefit picture is complicated by the fact that she has three minor children, and each of them gets a monthly benefit because she has a disability. The family’s total income (her benefits combined with the children’s) is over $1100 per month. This individual was very successfully employed prior to her disability, and, having a strong work ethic, she wants to return to work. However, she can’t return to her previous occupation, and she has been advised by her physician not to work full-time.

Through your analysis, she learns that if her earnings are above the SGA level, not only may her cash benefits be terminated eventually; her children’s benefits may stop as well. Her projected earnings do not replace the $1,100 she loses, particularly when you consider the net income after taxes. In addition, as a part-time employee, she is not likely to qualify for employer-sponsored health insurance. Currently, her children are eligible for a special health care benefit for families with income below the poverty level. This coverage will be lost if her SSDI benefit terminates.

When you pause during your report to ask if she has any questions, she suddenly bursts into tears. She admits that she is embarrassed at having to live off the government. She wants to be able to give her children the things they need, and she wants to be a good role model by demonstrating the importance of work. She says that she does not understand all of this work incentive information, and she just wants to forget the whole thing.

What do you do?

Case Study 4

You are explaining a benefit analysis to a man named Bill when, suddenly, he becomes angry and begins to escalate talking about how the government is trying to steal his money. He does not overtly threaten you, but his anger continues to grow and he is not making any motions to leave your office.

What would you do in this situation?

Benefits specialists supporting a caseload of individuals in managing their benefits will need to be effective organizers and time managers. It will be difficult, if not impossible, to remain proactive if you are always finding yourself “behind the eight ball!” The following are some tools and suggestions to consider.
The benefits assistance process involves long-term service to the consumer over a period that will usually be 12 months or longer. It immediately follows the completion of the screening and profiling process, and the presentation of a detailed report to the consumer. The period for benefits assistance will usually vary between 12 and 36 months, depending on individual circumstances. It could extend for more than 36 months; for example, if the benefits specialist will be monitoring a consumer’s activity during the entire trial work period and extended period of eligibility. Similarly, benefits assistance may extend beyond 36 months if a benefits specialist is monitoring an approved PASS through the full period of the consumers undergraduate program.

An individualized timeline should be prepared for each individual, which incorporates not only the planned timeframe for wellness visits and telephone/contact letters, but the specific touchpoints that will apply to their situation as well. Examples of other items to be incorporated into the schedule are contacts concerning the trial work period, extended period of eligibility, transition to 1619(b), work incentive milestone dates, and CDRs.

Additionally, the benefits specialist may chose to establish a tickler file that lists by month all contacts and benefits assistance activities to be carried out for all consumers they are supporting in their caseload.

Main Case Record Elements

Maintaining comprehensive records of all data gathered, reports developed, and interactions with the beneficiary/recipient and other parties is critical to good planning and management of benefits over time. The following is suggested as a format for organizing information specific to an individual’s case in a case file:

- Section 1 — Data collection instruments such as an Interview Questionnaire (screening/profiling) and/or Benefits Management Checklist. This is basically the benefits management timeline in a check-off format.

- Section 2 — Correspondence with, and on behalf of, beneficiary/recipient. This section includes the initial report to the consumer developed during the process of providing benefits advisement, reports from intermittent visits, and correspondence with other agencies and members of the individual’s support network.

- Section 3 — Case logs or a record of contacts with the individual whether they are in person, by telephone, or letter, etc. The case log should include documentation of issues discussed and actions taken, as well as provide dates.
• Section 4 — Financial records and other reports or notices regarding benefits received. This section may also include SSI budget worksheets, a month-by-month listing of income, pay stubs, and so forth.

• Section 5 — Information on work incentive programs, including PASS documentation, letters and documentation submitted on IRWEs, BWEs and so on. Any correspondence with SSA regarding work incentives would be maintained in this section.

• Section 6 — Agency referral and intake forms and documents, release forms, SSA Appointment of Representative Form (SSA 1696).

Effective benefits management will ultimately depend on good communication with the Social Security Administration. A key component of this communication is reporting information to the SSA that will impact continued eligibility and benefit amounts. The benefits specialist should take the time to meet with local SSA staff to discuss reporting procedures, timelines and content. The following are some additional strategies to ensure information is reported appropriately to the SSA:

• Encourage beneficiaries/recipients to develop their own personal Social Security notebook, complete with names and contact information, dates that contacts were made and any information obtained. Again, all written notices and letters from SSA should be saved in this notebook, as well as copies of documents submitted to SSA.

• Keep a log of phone calls, office visits, and names of SSA staff members who assisted in any way.

• Know which benefit is received (i.e., SSI and/or SSDI)

• Know who is responsible for reporting information. The beneficiary or recipient is responsible unless they have a representative payee.

• For both SSI and SSDI, report changes in earnings from employment. If the individual receives both benefits, ensure that the correspondence is directed to both the SSI and SSDI divisions. Failure to do so may result in one benefit being adjusted accordingly, while the other is not.

• For SSI, keep SSA informed of any changes in resources, living arrangements, living expenses, student status, and marital status.

• Provide documentation of subsidies the person may be receiving, as well as any work-related expenses they may have as a result of their employment.

• Inform SSA of any change in work incentive utilization.

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