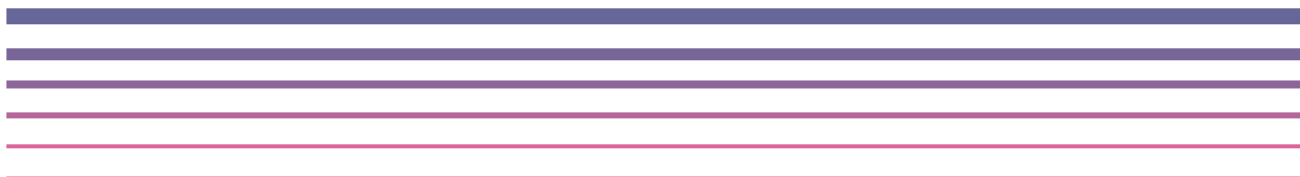
Assessment of Continuum of Care Progress in Assisting Homeless people to Access Mainstream Resources

THE CASES OF MARYLAND, MICHIGAN, AND TENNESSEE



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INTRODUCTION

Background/Purpose

This report examines how Continuums of Care (CoCs) and their grantees in the three sample states of Maryland, Michigan, and Tennessee are successful in assisting people who are homeless to access four mainstream resources (Medicaid, SSA disability benefits, Food Stamps, and Temporary Assistance for Needy Families) and explores related best practices in the field. This assessment is framed within the wider context of eligibility issues and challenges to access for each of these mainstream resources. This is the first of three deliverables produced under contract with the U.S. Department of Housing and Urban Development (HUD). The second report provides case study examples of best practices in the field. The third deliverable is a PowerPoint presentation drawn from the first two reports.

The need for this report stemmed from HUD's interest in understanding the progress of CoCs in accessing SSA disability benefits, Medicaid, Food Stamps, and Temporary Assistance for Needy Families (TANF). Until now, HUD has relied on CoC Annual Progress Reports to assess progress in this area. However, these indicators were considered inadequate by HUD staff and potentially misleading for the purpose of understanding current trends. Furthermore, HUD had no reports on current strategies being tried and the extent to which these were considered successful. Ultimately, HUD desired profiles of best practices in the field that can be shared with CoCs nationwide. In response to this need, the Corporation for Supportive Housing (CSH) – in partnership with Policy Research Associates, Inc. (PRA) and the Technical Assistance Collaborative Inc. (TAC) – formed a research Team and submitted a proposal to HUD in December of 2005, revised and approved in January 2006, to conduct a series of targeted telephone interviews in a sample of three states.

In February 2006, the Team met with HUD staff to select the three states that would serve as the focus of this report. The group chose Michigan for its prominence in HUD data extracted from Exhibit One Applications and Annual Progress Reports. Tennessee was selected for its recent efforts to increase the capacity of homeless service systems to assist constituents with SSA disability benefits. Lastly, the group included Maryland for longer-term efforts to widen access to SSA disability benefits and its more recent gains in expanding Medicaid eligibility. The latter of these advances came about, in part, from the advocacy efforts of homeless service providers trying to improve access to mainstream resources in their state.

Methodology

The Team began this project by reviewing eligibility criteria for each of the mainstream resources. They also studied data from CoC Exhibit One Applications and Annual Progress Reports provided by HUD to identify communities likely to have been successful in accessing mainstream resources. The Team translated these indicators into Chart 1: CoC-State Data on Mainstream Resource Effort (see Appendix A) and added additional variable data pertaining to state level activity in capacity building related to mainstream resources. Each of the sample states, most notably Michigan, stand out on Chart 1 as relatively well engaged in activities that could be expected to increase access to mainstream resources.

With Chart 1 in mind, the Team made initial contact with 5 – 10 selected CoC coordinators in the three sample states and interviewed them about the extent to which the data reflects their

experiences with mainstream resources. Feedback from this initial inquiry, mostly negative concerning the validity of the HUD-derived data in Chart 1, was captured in a Memo to HUD (See Appendix B). The Team then divided up the mainstream resources along lines of expertise with PRA exploring SSA disability benefits, TAC exploring Medicaid and TANF, and CSH exploring Food Stamps. The Team then interviewed approximately 15 – 25 CoC coordinators, grantees, state and local officials, and local experts in each of the sample states to learn more about activities and best practices of their CoCs in accessing each of these four mainstream resources.

These methods produced a number of important insights, challenges and best practices that are described in this report. However, there were some limitations to the approach taken. First, the team interviewed CoC coordinators and grantees in only three states. Second, many CoCs had insufficient direct knowledge of the strategies grantees were trying and the specific challenges they faced. Others were extremely busy and had limited time to respond to questions or needed to be contacted several times before an interview could be carried out. Third, the team had limited success finding examples of CoC and grantee strategies to improve access to Food Stamps and TANF. Despite these limitations, the team believes that this report represents an important first step in understanding the experiences of CoCs and their grantees related to accessing mainstream resources. Future investigations of these issues might include interviews with a larger number of states/CoCs as well as targeted site visits for a more in-depth understanding of the challenges and best practices.

Report Contents

This is the first of two reports on access to mainstream resources by CoCs. It presents background and field research into the access challenges and solutions being tried in the sample states. The second report contains more concise descriptions of best practices in the field that are drawn from a wider array of states. It is intended to inspire an audience of CoCs to take action by applying some of the new best practices described. The final product is a companion to the second report. It is a PowerPoint presentation highlighting several particularly noteworthy and replicable best practices. This slide presentation is designed to be used by CoC coordinators in meetings held with groups of grantees.

This first report is divided into four sections devoted to each of the mainstream resources researched. Each subsection provides a general introduction to the mainstream resource highlighting its role in helping end homelessness and its general eligibility issues relevant to people who are homeless. The introduction also reviews some of the complexities associated with each resource that contribute to the challenges that homeless people and CoCs face.

Findings are presented under the subheading, *Investigation of Access in Sample States*. This section begins with an overview of general accessibility of each mainstream resource as reported by CoC contacts. More specific findings follow and are presented in detail first by the *Problem,* or challenge experienced, and followed with *Solutions Being Tried* by CoCs, grantees, and state agency staff.

MEDICAID

Introduction to the Mainstream Resource

Medicaid's Relevance/Eligibility for Homeless people

Medicaid is a means-tested, federal-state entitlement program that covers basic health and long-term care for certain categories of low-income Americans. Medicaid is available to individuals and families who can demonstrate need as established through income and asset standards. Recipients must also be a child, have dependent children, be pregnant, blind, disabled, or age 65 or older. For homeless people who participate in McKinney/Vento-funded housing and service programs, Medicaid is a vital resource that can transform lives by paying for and providing many services that treat the underlying causes of homelessness. These include mental health services, prescription drugs, medical services, addiction treatment, and case management. It also pays for primary and preventive care, which reduces expensive specialty and hospital-based services. Furthermore, Medicaid improves access to the kinds of secondary care that people who are homeless need. This care is essential to helping homeless people manage disabling conditions that often prolong homelessness.

Despite the important role of Medicaid in ending homelessness, approximately 70 percent of homeless service recipients in a national survey were not receiving it.[1] Some among this group are simply not eligible. However, of the portion of those homeless people presumed eligible for Medicaid, as many as 50 percent are not receiving it.[2] Furthermore, those who are enrolled often lose their Medicaid coverage due to the upheaval associated with homelessness itself, the symptoms of their chronic disease, or other characteristics of their lives on the margins of society. The reasons for the overall inadequacy of Medicaid coverage for people who are homeless are multiple. The most significant factor is the fact that most states do not cover able bodied, working age adults unless they are pregnant. Exaggerating this limitation are widespread misconceptions, held by those who work with people who are homeless, concerning who can and cannot be determined disabled. In fact, many people who are homeless have conditions that are not immediately recognizable as disabilities that would, in fact, trigger their eligibility. For those who do qualify for Medicaid, there are significant problems of access and improper disenrollment. Differences in Medicaid programs from state to state mean that the relative weight and details of each of these challenges vary according to region. Not surprisingly, the number of homeless people enrolled in Medicaid varies from state to state.

National Medicaid Program Complexity

The Medicaid program is noted for its complexity. At the heart of this complexity is the fact that Medicaid is jointly administered by federal and state governments whereby the federal government pays for half or more of the cost of care. There are both financial (income/ resources) and non-financial (categorical, immigration status) requirements to qualify for this

[1] Burt, M. et al. Homelessness: Programs and the People They Serve- Findings of the National Survey of Homeless Assistance Providers and Clients. Washington, D.C.: The Urban Institute, December, 1999, p.1.
[2] Post, P. Casualties of Complexity: Why Eligible Homeless People are Not Enrolled in Medicaid. Nashville, TN : National Health Care for the Homeless, , 2001, p. 22.

mainstream resource. Yet beyond these mandatory categorical requirements, states have considerable discretion about who they cover and the levels and kinds of coverage they extend to beneficiaries. All of this variation and frequent changes that result from state legislatures implementing cost containment measures translates into a sea of ever-changing confusion for people who are homeless and local CoCs. Not surprisingly, Medicaid is perceived by many in the homeless service arena as a "complicated program" with convoluted application and recertification processes.

Another aspect of Medicaid's complexity is its relationship to other mainstream resources. For homeless families, for example, Medicaid is tied but not officially linked to TANF eligibility. This means families can apply for both at the same time and are likely to be eligible for Medicaid if they qualify for TANF. In many states, SSI eligibility equates with Medicaid eligibility, and the two programs are applied for at once. However, there are 11 states where criteria for Medicaid differ from SSI and yet another group of 7 states where criteria are the same but the applications are made separately (See Appendix C for lists of these states). For CoCs, these program linkages mean that, in many cases, homeless people who have been successful in obtaining SSI or TANF will automatically receive Medicaid. Nevertheless, in certain states, other homeless people who do not qualify for SSI or TANF may, in fact, qualify for Medicaid. Therefore, CoCs and their grantees must not only understand when Medicaid overlaps with other entitlements but also what homeless groups are likely be covered by their state's Medicaid program above and beyond determinations for other mainstream resources.

CoC's confusion about Medicaid is perhaps most pronounced when the issue of state waivers is introduced. Some states have exercised options, made possible through federally approved waivers, which loosen up basic categorical eligibility requirements. The new requirements are typically more inclusive of broader categories of homeless individuals. Confusingly, other specifics of each state's waiver program are distinct. In states that operate Medicaid in the absence of such waivers, CoCs face the limitations, noted earlier, of the basic federal eligibility rules. For CoCs, these variations in the existence and nature of state waivers mean that it is hard for them to learn from their successful peers in other states about how to operate within Medicaid systems and improve their homeless constituents' access.

There are still other policy-level variations in state Medicaid programs that have an effect on a CoC's likelihood of success with access. These include whether or not a state has taken the initiative to increase access to Medicaid and minimize disenrollment for the most fragile and disenfranchised groups. Examples are the use of out-stationed Medicaid eligibility workers in places where disenfranchised people go, reductions in documentation requirements, allowances for "remote applications," and streamlined access to Medicaid when a beneficiary enters and leaves jail or prison. Another significant variable is whether a state allows Medicaid to pay for medical services during an interim period while an SSI application is pending. This practice – allowed in only a few states, such as the sample state of Michigan – allows homeless individuals to receive Medicaid while collecting the more comprehensive documentation required for SSI.

Investigation of Access in Sample States

Overview

Prior to even talking directly to CoC contacts for this report, each of the sample states emerged from policy reports and interviews with Medicaid experts as noteworthy in their own respective ways for both "top-down" efforts, led by the state Medicaid agencies, and "bottom-up" efforts, led by CoCs, underway to improve homeless people access to Medicaid. Tennessee, for one, is acknowledged for being one of the first states to expand eligibility rules to better capture some demographic groups to which homeless people typically belong. This state is also noted for setting up a program for educating shelter providers about Medicaid, offering expedited enrollment for homeless children, and convening workgroups to address access challenges.[3] Michigan, in turn, appears to be having notable success in securing Medicaid for its CoCs' program participants as evidenced in CoC Annual Progress Reports from this state. Maryland's recognition is for its top-down efforts to tailor its Medicaid program and procedures to better meet the needs of homeless people. Specifically, this state now has a policy whereby people who are homeless are singled out as one of seven special needs populations for which the managed care organizations that implement Maryland's Medicaid program must meet certain standards for engagement.

Taken together, these three sample states seem to offer a range of examples of how Medicaid access may be incrementally improved within the broad context of limited eligibility for homeless demographic groups and significant enrollment and retention challenges. Beyond the scope of this report is analysis of the extent to which these states' Medicaid programs are improving or worsening with respect to the quality of care extended to people who are homeless. The remainder of this report more fully describes specific challenges as they are experienced by CoCs in each of the sample states and presents examples of top-down and bottom-up solutions to these problems that are currently being tried.

Perceived Eligibility Challenges

The Problem

As noted, many CoC contacts in the sample states perceive that most demographic groups within their homeless populations seemingly do not qualify for Medicaid. This perception is based on the national rule that any adult who is not pregnant, not elderly, not disabled according to SSI standards, nor has dependent children is excluded. This leads many CoC grantees to believe, often erroneously, that the large number of single adults under age 65 who fill the nation's homeless shelters and have no other disability other than substance abuse cannot qualify. As an example, a CoC in Maryland interviewed for this report perceived that as many as 70 percent of her community's homeless single population fits this demographic and therefore has no Medicaid. Several other CoCs interviewed for this report echoed this sentiment, and it seems to be a unanimous frustration.

Medicaid experts, however, believe that more than half of such individuals probably could, in fact, qualify for Medicaid based on hidden disabilities that commonly co-occur with addiction

[3] Post, Causalities of Complexity, p.29.

such as liver disease, clinical depression, and mobility impairments.[4] This suggests that the CoCs interviewed for this report may be overemphasizing, to some degree, the eligibility challenges in Medicaid and underestimating other challenges related to qualifying substance abusers with subtle secondary disabilities. Therefore, it seems that it is not only the eligibility rules but also the CoCs' interpretation of them that can limit homeless substance abusers' access to Medicaid.

Interviews with CoC contacts for this report revealed that their perception of limited categorical eligibility for Medicaid extends to other discreet homeless groups such as those with asymptomatic HIV. One such contact, who works in an urban area, argued that all of the seemingly excluded profiles, such as the groups who have no disability other than substance abuse and the asymptomatic HIV population, correlate most directly with the demographics of chronically homeless people. This urban CoC finds that there is generally more limited access to Medicaid among the chronically homeless in general. For homeless people who, in fact, might be eligible, CoCs in Michigan and Tennessee explain that SSI is frequently the only door to Medicaid for their constituency and it is open to a small minority. Yet, where this door is open, obtaining SSI is reported by these CoC contacts to be, in itself, a rigorous, prolonged, multi-step process which limits homeless people' access in numerous ways further discussed in other sections of this report.

Solutions Being Tried

A significant development in the realm of top-down initiatives to increase Medicaid access are the Medicaid waivers referred to earlier in this report. Known as 1115 waivers, they are now implemented in over 10 states. These states now offer expanded Medicaid eligibility for impoverished adults under age 65 without children regardless of disability. Two of the sample states, Tennessee and Maryland, now have such waivers.[5] While not specifically targeting people who are homeless, these states are now technically extending coverage to previously ineligible homeless demographic groups such as single adults with only substance abuse as a disability or no disability at all.

At its outset in 1994, Tennessee's 1115 waiver was hailed by homeless advocates for its success in improving coverage for homeless people with very limited access to private insurance.[6] For a period of years thereafter, homeless people and other "uninsurables" enjoyed better coverage by health insurance than ever before and the state was held up as a national model. More recently, the program was curtailed to restrict eligibility and benefits to the point where the positive impact for homeless people is reported to be virtually lost altogether.[7] The future outlook for restoring the short-lived advances in Tennessee is now unclear. In Maryland, an 1115 waiver was implemented as recently as July 1, 2006. A Maryland based CoC contact interviewed for this report was hopeful that the program designed from the waiver could significantly improve Medicaid access for a wide swath of the state's homeless populations. Importantly, applications can be made by mail, the application itself is succinct, and one need not apply through SSA offices. However, Maryland's CoCs and other homeless advocates in the state worry that

[4] Day, S. Technical Assistance Collaborative Inc. Interview, June 2006.
[5] Robert Wood Johnson Foundation, web-based State Coverage Initiatives, 2005, www.statecoverage.net/matrix.
[6] Conover C. and Davies H., The Role of TennCare in health policy for low-income people in Tennessee, The Urban Institute, 2000, p.8.
[7] Post, P. Program Changes in TennCare, Tennessee's Medicaid Program, National Health Care for the Homeless Council, 2005, p.3.

inadequate design of the program will limit both its accessibility and its ultimate benefits for people who are homeless. A CoC coordinator interviewed for this report complained that, one month into the waiver's implementation, her CoC and grantees had yet to learn where to send people who are homeless to apply.

At the CoC level, representatives from some homeless service networks are engaged in local systems change activities, such as advocacy and constituency building, to broaden Medicaid eligibility. For example, across Maryland, CoCs have engaged in some dialogue with state representatives to help make the state's 1115 waiver accessible specifically to homeless demographic groups. Through participation in homeless constituency organizations, they have worked with policy experts to engage state government officials. To date, the impact of this activity has been limited. In Michigan, key leaders among the larger CoCs have participated in state sponsored systems change processes that have addressed mainstream resource access for homeless people. However, given that Medicaid has a decentralized service delivery model in Michigan, as is the case in Maryland, it has been less accessible to this kind of intervention according to one CoC contact there.

Lack of Enrollment of Eligible Persons

The Problem

Several subgroups of homeless people are under-enrolled in Medicaid despite being categorically eligible. Perhaps the most sizable of this group is disabled individuals who cannot surmount the obstacles of the rigorous and prolonged SSI application process to attain their SSI and Medicaid benefits, which are frequently linked together. Other qualified groups who are often missed by the Medicaid system are youth aging out of foster care, families not on TANF, and immigrant children born in the United States.

The CoCs interviewed for this report highlighted, first and foremost, obstacles faced by disabled individuals who likely qualify but ultimately do not get Medicaid. Reportedly, homeless people with mental illness more than any other qualified group cannot sustain their engagement through the long enrollment process even with the assistance CoCs are able to offer. CoCs in Michigan, where the application/appeal process is described as longer now than in recent years, recounted numerous examples of such persons who could not stay stable long enough to learn the outcome of a joint SSI/Medicaid application. Some CoCs interviewed also indicated that homeless families seeking TANF and Medicaid together were at times diverted by TANF employees to work related requirements. When such requirements were not fulfilled, these families failed to get Medicaid. In Maryland, CoCs report that, from their perspective, Medicaid is operated as so separate from other mainstream resources that it increases the challenge of simply identifying who, in fact, might qualify.

Solutions Being Tried

At the CoC level, considerable work is in evidence in all the sample states in the realm of educating CoCs about the importance of increasing Medicaid enrollment for eligible homeless people. In fact, most CoCs interviewed for this report made a point of acknowledging their grantees' increased awareness of the role of all mainstream resources, Medicaid among them, and commitment to facilitating higher levels of enrollment. In Tennessee, a CoC contact

described his grantees as "well aware of the importance of accessing mainstream resources" and HUD's related expectation. A CoC in Maryland commended his grantees for stronger general effort in accessing Medicaid and other mainstream resources through establishing links with local representatives of these programs. Across Maryland, in fact, it appears that regular capacity buildings meetings of CoC grantees are addressing access issues for all mainstream resources. Michigan and Tennessee CoCs also offer examples of regular forums and meetings whereby CoC grantees gather to strategize their role in facilitating such linkages. In Tennessee, three access trainings have been offered by state officials specifically for HUD grantees. Overall, the CoCs interviewed for this analysis report a clear increase in grantees' skills resulting from such forums but more uncertain impact with respect to increased Medicaid enrollment.

At the state level, the sample states have varying levels of commitment to increase the number of eligible enrollees in the homeless demographic groups. Michigan stands out for its cross-system efforts to collaborate and problem solve Medicaid access in conjunction with other goals. This state also recently reinforced the message that mainstream resources are important for homeless providers in a Request for Proposal (RFP) issued for state housing money. This RFP required that applicants demonstrate links between people who are homeless and mainstream resources such as Medicaid. All of this effort in Michigan has reportedly produced new collaborations between local Medicaid officials and CoC leaders in some jurisdictions. In several CoCs interviewed from Michigan, local Medicaid officials now participate formally and regularly in CoC planning meetings and even in forums to directly educate CoC grantees and homeless people themselves about Medicaid. For these CoCs, with the notable exception of those based in the Detroit area, there is now a greater sense of increased "shared ownership" of the problem of people who are homeless not getting Medicaid. Whether or not these collaborations are ultimately leading to better Medicaid access seems to be undetermined as yet.

Also noteworthy for this discussion of access is the Michigan State Medicaid Plan's new special provision where the state will allow disabled individuals to be made "presumptively eligible" for Medicaid while their SSI application is pending. This means any person who is likely to qualify for SSI need not wait out the prolonged SSI application process to enroll in Medicaid. According to one CoC in Michigan, homeless people whom they serve are clearly benefiting from this policy. It should be noted that this improvement and other reported improvements in Michigan are perceived unevenly across the state with little to no positive impact reported by the CoCs operating in the Detroit area where the numbers of people who are homeless are highest.

Accidental Disenrollment

The Problem

As noted, Medicaid is an administratively complicated program. Among the challenges created by this complexity is the difficulty many homeless people face in avoiding unintentional disenrollment. Eligibility is redetermined periodically at regular intervals. Many states carry out redeterminations by mail and terminate enrollment if the post office returns the mailed forms. This has high impact on those who are homeless whose inconsistent addresses thwart their ability to receive or respond to recertification documents.[8] Chronically homeless people are perhaps the most challenged by the requirements associated with re-determinations. Symptoms

[8] Eiken, S. and Galantowicz, S. Improving Medicaid for People Experiencing Chronic Homelessness: State Examples, Washington, D.C.: MEDSTAT, 2004, p.5.

of their mental illness and substance abuse often impede their response or survival needs supersede their attention to administrative matters. In addition, documents received in the mail can be incomprehensible and intimidating to any homeless person with low literacy or limited written English comprehension.

For homeless families on TANF, accidental terminations from Medicaid are caused by other factors. Confusion on the part of TANF employees sometimes leads them to erroneously link terminations from TANF with terminations from Medicaid.[9] In addition, in some states, Medicaid is terminated by programmatic association if, and when, a nonpregnant parent fails to fulfill TANF related work requirements. In Tennessee, CoCs report that yet another factor contributes to Medicaid terminations for people who are homeless. Here, the state's Medicaid program created a risk of inadvertent terminations when it expanded its coverage to include working poor demographic groups through the 1115 waiver described earlier. Apparently, working homeless people who qualified under this policy are easily disenrolled due to a provision of the state's Medicaid program that beneficiaries pay premiums and report changes in income. Again, people who are homeless typically fail to meet this requirement due to the lack of a stable address.

Solutions Being Tried

None of the CoCs interviewed for this report commented on efforts to prevent inadvertent termination from Medicaid. However, in the realm of state-initiated efforts, the state of Tennessee has reportedly made some effort to improve both Medicaid access and retention for homeless families. Specifically, the State has an initiative in family shelters, known as the Shelter Enrollment Project, designed to better facilitate enrollment and retention in the Medicaid program of homeless families who are at particular risk for this problem.[10]

Communications Challenges

The Problem

Applications for Medicaid require substantive supportive documentation. Homeless people moving through their local CoCs typically have no such documentation because they have a tendency to lose records. As one CoC in Michigan interviewed for this report pointed out, there is document related assistance available in the appeal phase of joint SSI/Medicaid applications, because community-based legal aid organizations have built in remuneration for successful appeals. However, for the initial application, CoC grantees have only their own limited internal capacity upon which to rely. According to one small CoC in Maryland interviewed for this report, their grantees cannot afford to hire the staff with the level of clinical education needed for this kind of assistance. Also reportedly problematic for all Maryland-based CoCs coping with Medicaid's documentation requirements is the division between SSI and Medicaid, which means its homeless people do not benefit from the efficiency of applying to two programs at once.

[9] Post, Casualties of Complexity, p.18.
[10] Post, Casualties of Complexity, p.29.

Solutions Being Tried

There are several top-down policy changes that state Medicaid programs can implement to reduce obstacles posed by documentation requirements associated with Medicaid. Medicaid regulations do allow states to simplify eligibility determination. One strategy used widely – including in the sample states – is out stationing Medicaid eligibility workers at federally qualified health centers or Health Care for the Homeless sites. Maryland and Tennessee also now allow remote applications. This means people who are homeless can apply via the mail, internet, or telephone. Lastly, a passive renewal policy can be implemented to allow a beneficiary to respond only if there are relevant changes.

At the homeless provider level, few of the CoCs interviewed for this report described carrying out any specific bottom-up initiatives to address document related challenges to Medicaid. However, one CoC in Michigan reported clear success in a strategy that resulted from their designation as an SSA-funded HOPE Program site (See the SSI section of this report for greater detail about the SSA-funded HOPE Program). This CoC has amplified the direct assistance they provide in document assembly for SSI linked Medicaid applications. The grantee staff now works to identify physicians with specific experience treating people who are homeless to complete the examinations determining a disability. They also collaborate with the physicians after the examination to ensure that the letters resulting from such examinations fit Medicaid eligibility standards well. Results suggest that this new "savvy" is having a positive impact for this particular CoC.

Institutionalization Challenges

The Problem

Federal law mandates that incarcerated individuals not receive Medicaid. Given that many homeless people cycle in and out of jail and prison, this law creates significant obstacles to keeping homeless people enrolled in Medicaid. Although a person is theoretically eligible immediately upon release, facilitating this access requires proactive support services that are typically unavailable to people in correctional institutions. Many states actually terminate enrollment upon incarceration and require a reapplication upon release even though this is not a requirement of the federal law. The result is that individuals moving between homelessness and incarceration experience either long gaps in their Medicaid coverage or never regain coverage after losing it. There is a similar scenario for people entering state psychiatric hospitals. Many states handle inpatient stays at such institutions the same many way they do incarceration.

Solutions Being Tried

Few of the CoCs interviewed for this report had direct knowledge or comment about the institution related disruptions to Medicaid. Nevertheless, one state among the sample states, Maryland, has implemented a top-down initiative to address Medicaid disruptions for individuals in correctional institutions with significant potential benefit for homeless people. Specifically, Maryland now maintains incarcerated Medicaid recipients as enrolled in the program even if the person has been incarcerated for more than 30 days.[11] This policy allows a recipient to immediately obtain Medicaid upon release without onerous administrative procedures. Whether

[11] Eiken and Galantowicz, p.10.

or not those formerly incarcerated individuals who become homeless in Maryland upon reentry to mainstream society are seamlessly reengaging with Medicaid and its services was unclear to the CoCs interviewed for this analysis.

TANF

Introduction to the Mainstream Resource

TANF's Relevance/ Eligibility for Homeless people

Temporary Assistance for Needy Families (TANF) provides time-limited cash assistance and work opportunities to needy families with dependent children. The program is designed to help move recipients into work and turn welfare into a program of temporary assistance. Basic eligibility varies from state to state, but in general, a person who is homeless with little or no monthly income (approximately $400 or less), no other appreciable assets, and one or more dependent children will be eligible for TANF. Other relevant national eligibility requirements include the need to be a legal resident of the state where applying, to be a U.S. citizen (any child born in the U.S. is a citizen and is eligible for benefits if the parent is not), and to supply social security numbers

In general, TANF is an essential resource for helping end family homelessness. It serves as a reliable source of modest income typically used by a homeless family to pay for basic necessities such as food, diapers, baby formula, and clothes. While usually insufficient to cover all costs of living, TANF is a "leg up" for homeless families that plays an important role in helping them achieve stability.[12] It is often complimented with other forms of assistance from the state TANF agency and other local homeless continuum programs to resolve homelessness. It is widely assumed that the vast majority of homeless families today are eligible for TANF, and that they make up a significant portion of most state's TANF rolls. According to the U.S. Conference of Mayors, homeless families are, in fact, filling a growing proportion of TANF caseloads nationwide.[13]

Typically, TANF eligible homeless families live in shelters or transitional housing designated specifically for families. Often, they reside there for months at a time given the obstacles to securing permanent affordable housing. Most were likely homeless at least once before.[14] Often they come to a shelter from a shared living arrangement. Also typical is a pattern of shifting from one family shelter to another. While homeless TANF recipients share many characteristics with the general population of TANF recipients, some distinctions exist. For one, homeless TANF recipients have higher rates of mental health problems than their non-homeless counterparts.[15] Their lives are also generally more chaotic, less resourced, and more marked by domestic violence and conflict. These characteristics are significant to this report's analysis because they create challenges for heads-of-household attempting to meet TANF program requirements. These challenges are further outlined later in this report section.

[12] Reeg, G., and Shepard, A. Families on the Edge: Homeless Parents and Their Welfare Experiences, Washington, D.C: Center for Law and Social Policy, obtained 2006. p.1.
[13] National Alliance to End Homelessness: Tools to End Homelessness Among Families. web-based publication, obtained 2006. p.1.
[14] Washington State Department of Social and Health Services, A Study of Families Helped by Shelters and their Use of Welfare and Social Services, Washington. D.C.: obtained 2006, p. 3.
[15] Washington State Department of Social and Health Services, p.5.

When homeless families enter homeless service systems such as shelters, the likelihood of their accessing TANF increases sharply from 33 percent enrollment to between 50 and 75 percent.[16] This enrollment rate is relatively high in comparison with Medicaid and SSI enrollment for people who are homeless. TANF, therefore, is a seeming success story with respect to eligibility and access for people who are homeless. Nevertheless, TANF enrollment among homeless families is somewhat lower than Food Stamp Program enrollment.[17] The remainder of this report section, dedicated to TANF, investigates the extent to which reforms and CoC initiated strategies are needed and being implemented in the sample states to improve upon the existing access rate and to address problems with disenrollment for homeless families.

National TANF Program Complexity

Relative to SSI and Medicaid, the TANF system is reputed to be relatively simple to navigate according to CoC contacts interviewed for this report. That is, the application and approval process is experienced as a generally direct and efficient process even for families that are homeless. Nevertheless, at a regulatory level, TANF does have its own kind of bureaucratic complexity and variation. Specifically, as a block grant, TANF gives states significant responsibility and flexibility to design their own programs. Therefore, it is the states, not the federal government, that decide the design of the TANF program, type and amount of payments, and the rules of eligibility.

Another element of the TANF program's complexity are the variety of "other services" paid for out of an annual cost-sharing requirement referred to as Maintenance of Effort (MOE). Under this requirement, states must spend a certain amount of their own funds to help eligible families in ways consistent with the purpose of TANF. These investments can be shaped to help homeless families with varying degrees of effectiveness. An analysis of the positive impact of these state-tailored programs on homeless families is, as with other issues touched upon in this report, beyond the scope of this report. However, it is worth noting that they are a primary area where some states do continuously modify interventions to improve results for homeless families.

The most significant areas of complexity in TANF were brought about by national policies advanced in the last decade's Welfare Reform era. This period produced new requirements of TANF recipients and limits on their benefits that impact homeless families including the five year limit of eligibility, weekly work participation requirement, and Individual Responsibility Plans. In addition, a recent Welfare Reauthorization, which passed in February 2006, adds yet higher expectations to the work requirement by heightening requirements for workforce participation rates among TANF recipients and limiting the flexibility states previously had with respect to what activities can fulfill the work requirement.

While contacts in the sample states report that the effect of the 2006 reauthorization is not yet clear, it is likely to create challenges for homeless families who require more flexibility than others to meet program expectations. According to a CoC contact in Maryland interviewed for this report, the reauthorization also creates a general sense that TANF policies are in flux which, in turn, leads to confusion and misunderstandings among both the homeless families they serve and the staff assigned the task of helping such families to access and retain TANF.

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[16] Ibid, p.3.
[17] Ibid, p.3.

Investigation of Access in Sample States

Overview

To apply for TANF, applicants in all three of the sample states must go to their local TANF social service office. In all three states, CoC grantees report assisting heads-of-household with transportation and childcare needed to attend these initial appointments. In Michigan, some TANF local offices have stepped outside the restrictions of office-based appointments and accepted applications at CoC sponsored events that brought together homeless applicants and state mainstream resource agencies.

Also relevant to TANF access for homeless families is the cap on the number of days that each state allows itself to determine eligibility. In the sample states, this cap ranges between 30 and 45 days. In general, contacts interviewed for this report all indicated that eligibility was often determined in a shorter timeframe than this official "cap." In Tennessee, CoC grantees reported that the state goes so far as to accelerate the qualification process when it is aware that the applicants are homeless. Thus, the "cap" plays an important role in homeless families' access of TANF. Nonetheless, CoC grantees indicated that, for a homeless family with no income, even 30 to 45 days is a problematically prolonged period to wait.

As none of the state social service agencies in the sample states officially track who among TANF recipients is homeless, there is no concrete data to support the anecdotal evidence from this report's investigation which suggests that TANF access is relatively successful for homeless families. Within this generally positive picture there are, however, some subgroups that do experience challenges to access. Furthermore, retention on TANF for homeless families in the sample states is a much more problematic picture. The remainder of this report section, dedicated to TANF, outlines the few specific problems related to access and the more commonplace problems related to retention that were in evidence in the sample states.

Eligibility Challenges

The Problem

As described earlier, eligibility challenges seem to be a relatively minor problem for the CoCs connecting homeless families with TANF. In fact, CoC contacts interviewed for this report stated that the vast majority of the homeless families they serve are ultimately found eligible for TANF. The primary exception noted by these contacts is the minority of heads of household that become homeless but retain a job with earnings that precludes them from TANF eligibility. Typically, these families earn more money through part-time employment than they would obtain through a TANF grant.

Policy and research literature that examines TANF access for homeless families draws attention to two additional groups that face challenges to eligibility. First are immigrants legally residing in the United States. For this group, national policy imposes restrictions in eligibility or reductions for families where children are United States citizens but parents are not. However, two of the sample states, Maryland and Tennessee, use state funds to help non-citizens who are ineligible under federal TANF assistance. Therefore, Michigan, alone among the sample states, faces this restriction.

Another group noted in the literature as facing restrictions to TANF are families headed by minor heads of household. All states are prohibited from providing TANF to unmarried, custodial, minor parents unless they live with their own parent or in "approved settings." Although this rule may be exempted due to good cause, research suggests that it often intimidates minor parents from applying to TANF if their home life is violent or unwelcoming to them. [18] Therefore, the living arrangement rule may be acting as a barrier to TANF services for some homeless families. In Michigan, an additional special rule is imposed on minor parent eligibility whereby a minor parent cannot head a TANF unit nor receive a benefit check in his/her own name. Despite this finding in the literature, CoC contacts interviewed for this report did not note the rules imposed on minors as a particular barrier. However, as CoC grantees that serve families often do not accept minors as program participants, these subgroups' experiences may be unknown to those contacts interviewed.

Solutions Being Tried

For the few homeless families who do face eligibility challenges to TANF, CoCs interviewed for this report all seem to have strong systems in place for overcoming those that are encountered. Firstly, CoC grantees that serve families typically provide direct assistance through the application process. The grantees generally have designated staff that ensure that homeless families apply for TANF at the outset of their participation in homeless programs. In Tennessee, one CoC grantee described TANF applications as "the very first thing we do." When problems do occur with qualifying applicants, the most effective strategy reported by the CoCs is having a "go to" person in their local TANF office. This is a TANF officer with whom the grantee has a strong relationship but not necessarily an expert in the needs of homeless families. Sometimes such relationships take years to evolve. Of note is the tendency for staff turnover amongst CoC grantee staff, typically the result of low salaried positions, to undermine this relationship building with mainstream resource personnel.

Challenges to Fulfilling Work Requirements

Work requirements are obligations entered into by TANF recipients that must be fulfilled to receive their grants. Each state defines for itself "good cause" reasons that may exempt a head-of-household from work requirements. Nevertheless, in most states homeless families are expected to fulfill these requirements and are sanctioned with partial or full termination of their grants when out of compliance. Sanctioning and disenrollment of homeless families who qualify and begin receiving TANF but fail to meet aspects of these plans are seemingly a common pattern in the sample states. A CoC grantee serving homeless families in Tennessee reported that, even without the work obligations, their homeless families already have many competing demands on their time. They must carry out permanent housing search activities, attend to responsibilities for their children who are often disenrolled from school, and participate in programmatic requirements imposed by the grantee such as regular meetings with a case manager. Homeless families are tasked with attending to these responsibilities while simultaneously meeting the work requirement.

The work requirement nationwide is, specifically, an obligation to engage in at least 20 hours (more when children are over the age of 6 years) a week of educational/vocational training or

[18] Reeg, Grisham, and Shepard, p.3.

employment. One of the sample states, Maryland, raises this expectation further by requiring that the job search commence at the time of application. Regardless of the timing of the work commitment, contacts in the sample states find that many homeless families fail to meet this obligation. In fact, a Tennessee-based contact for this report estimated that as many as 35-40 percent of the homeless families they serve fall out of compliance. As a result, these families are "sanctioned" with reductions to their TANF grants and loss of their state-sponsored childcare. There is also national research with findings that homeless TANF recipients participate in work at significantly lower rates than TANF recipients in general.[19]

In Maryland, a state level contact for this report, involved with policy academies on homelessness, stated that the recent TANF Reauthorization of February 2006 will amplify the existing pattern of sanctioned homeless families. The reauthorization increases expectations for the percentage of TANF recipients that states must have engaged in the workforce and formalizes what activities can qualify as educational or vocational training. As of the reauthorization, states now publish lists of activities that will qualify whereas, in the past, TANF representatives were free to interpret what constituted work. In Maryland, CoCs voiced concern that these changes will lead to higher percentages of homeless families facing sanctions.

Research literature further indicates that the work responsibilities create particular challenges for families where the head of household has a disability. Nationally, this group is overrepresented among those who have been sanctioned by TANF.[20] Researchers believe some may have been sanctioned for behavior symptomatic of their disability or that their disability impedes their ability to meet work expectations. As there are many homeless families with disabled heads of household, this finding points to yet another dimension to the problematic picture of sanctioned homeless families.

Solutions Being Tried

Tennessee contacts for this report indicated that their state offers little in the way of top-down (i.e., led by the TANF agency) strategies for accommodating homeless families who cannot meet work obligations. A Maryland contact, however, indicated that his state is to be commended for showing high levels of flexibility as to what activities could qualify as vocational and educational training hours. This contact described a direct link between this policy and the likelihood that homeless families retain TANF. Unfortunately, changes in the recent TANF reauthorization described previously may constrain Maryland's ability to maintain this level of flexibility.

In the realm of " bottom-up" efforts (i.e., led by the local CoC), one Tennessee grantee uses a strategy of identifying local short-term training programs that offer efficient enrollment processes and will satisfy the TANF work requirement if only temporarily. Connecting homeless families with these programs ensures that the family will receive TANF in the short-term and allows them to begin accumulating modest savings while homeless. Of course, this is only a short-term solution to a family's ongoing problem of meeting work obligations. Yet it suggests that linking CoC programs for homeless families with vocational activity, such that the programs do not compete for participants' time, is needed now more than ever. Other bottom-up strategies

[19] Washington State Department of Social and Health Services, p.4.
[20] National Alliance to End Homelessness, TANF Reauthorization Proposal: Concern for Homeless Advocates, Washington, D.C., web-based publication, obtained 2006, p. 1.

in the sample states generally consisted of efforts to help educate homeless families about the work requirement.

A question that emerges from this analysis is whether CoCs could do more in helping grantees negotiate with their TANF program officers to get exceptions and greater flexibility in their work obligations. To do so, CoC grantees would likely need more training in the subtleties of TANF regulations, state policy, and possible exemptions. Yet another possible strategy would be for homeless service organizations to create housing and job linked programs for homeless families that both meet TANF requirements and suit homeless families.

Bureaucratic and Outreach Challenges

The Problem

Despite the high levels of enrollment of homeless families in TANF, according to CoC contacts, there is evidence of some outreach and bureaucratic challenges that impede certain applicants. In the realm of outreach, research indicates that young minor homeless parents often do not know they might be eligible to receive TANF. [21] It seems that top-down strategies for outreaching to this particular subgroup of TANF eligible families may be lacking in many states.

In the realm of bureaucratic challenges, some homeless families do not have the necessary documentation to complete their TANF applications. According to studies on homeless families, birth certificates, in particular, are commonly missing from homeless families' document collections.[22] CoC contacts interviewed for this report reiterated that birth certificates are sometimes lost or inaccessible for their TANF applicants.

Solutions Being Tried

Solutions related to outreach in all of the sample states generally follow the same model. State TANF agencies in all three states now send local representatives to CoC meetings on a regular basis. In these meetings, CoC grantees interface directly with TANF representatives. Contacts interviewed for this report indicated that these meetings are used as an opportunity for CoC grantees to ask questions and establish working relationships with TANF representatives. However, it does not appear that the TANF representatives are taking a leadership role in the sessions.

The problem of missing birth certificates is generally addressed by bottom-up problem solving by the CoC grantees. Most CoC grantees in the sample states that specialize in serving homeless families offer staff time needed to assist homeless families in garnering duplicate birth certificates. In such relatively simple tasks, it seems that the CoCs are well equipped to overcome relatively minor obstacles to TANF access. However, this effectiveness contrasts with the CoC's more limited capacity to assist these same families with avoiding sanctions related to work requirements associated with TANF. This contrast raises the question as to whether the CoCs and their grantees could offer a yet higher level of expertise needed to help applicants negotiate the kind of exemptions and flexibility that homeless families need to maintain TANF enrollment over the long term.

[21] Reeg, Grisham, and Shepard, p.3.
[22] Washington State Department of Social and Health Services, p.4.

SOCIAL SECURITY DISABILITY PROGRAMS

Introduction to the Mainstream Resource

SSI/SSDI's Relevance/ Eligibility for Homeless people

Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) are federal disability programs with program rules and regulations that do not vary from state to state, but they are sometimes applied differently across jurisdictions. Administered by the Social Security Administration (SSA) these two programs are designed to provide cash benefits for persons who are determined to be disabled. SSI provides benefits to low-income people who are disabled, blind or elderly. To qualify for SSI, an applicant must meet strict income and resource guidelines to establish that he or she has low or no income and minimal resources, and criteria that he or she is aged (age 65 or older), blind, or disabled as defined by SSA. In some states, the SSI benefit is supplemented by the state giving the individual more than the $603 per month allowance provided under the Federal SSI benefit rate.[23]

The relevance of SSI and SSDI to people who are homeless is obvious. With an income of at least $603 per month (the minimum Federal benefit rate for SSI in 2006), people who are homeless can begin to provide for their own basic needs, particularly when these benefits are coupled with subsidized housing and other mainstream programs for low-income persons, such as Food Stamps. In addition, both SSI and SSDI are (in most states and for most people) accompanied by publicly funded health insurance. For people receiving SSDI, most beneficiaries qualify for Medicare 24 months after becoming eligible for benefits.

SSDI provides benefits to disabled or blind individuals who are "insured" based on contributions paid into the Social Security trust fund as authorized by the Federal Insurance Contributions Act (FICA). To qualify for benefits, an individual must have worked long enough and recently enough under Social Security to receive benefits. A person also may qualify as an SSDI beneficiary through their parents or a spouse. Disabled widows/widowers age 50 or older may qualify for benefits on a spouse's earnings. Since the SSDI benefit amount depends on the average earnings of the wage earner, the benefit amount will be different for each beneficiary.

Both SSI and SSDI use the same definition of disability. Disability is based on an inability to work at the level of substantial gainful activity (SGA). SGA is work that involves significant mental and physical activity completed for pay or profit. An individual will be considered disabled by SSA only if he or she cannot do work that was done before and if SSA decides that the individual cannot adjust to other work due to his or her medical condition(s). An individual's disability also must have lasted or be expected to last at least a year or to result in death. Documentation of an individual's disability is required and must meet strict criteria that are determined by SSA. These criteria are know as "The Listings" or the "Blue Book" and can be found on SSA's website at: www.ssa.gov/disability/professionals/bluebook.

[23] $603 is the 2006 monthly SSI Federal benefit rate. This amount is adjusted annually for cost of living changes. A list of states that provide supplementary SSI payments can be viewed at: www.ssa.gov/notices/supplemental-security-income/text-benefits-ussi.htm.

There is tremendous variability in how the rules regarding substance use as it relates to disability are applied. In 1997, Congress required SSA to change its regulations regarding the receipt of SSI by individuals with a diagnosis of drug or alcohol abuse. Regulations do not prohibit current users of drugs or alcohol from receiving SSI.[24] People may receive benefits as long as the substance abuse is not material to the individual's disability.

Medicaid is the health insurance program typically associated with the SSI benefit. In 33 states (see Appendix C), people eligible for SSI are automatically eligible for Medicaid – no separate application is required. In seven additional states, the rules for Medicaid eligibility are the same as SSA uses for SSI, but individuals are required to file a separate application for Medicaid. Eleven states require a separate application and also use their own rules to determine if an individual is eligible for Medicaid. In these states, in particular, people eligible for SSI may have a more difficult time accessing Medicaid benefits.

SSA Disability Programs Complexity

Despite the high levels of disability estimated among people who are homeless, many potentially eligible homeless people never apply for SSA disability benefits.[25] Among those who do apply, the chance of getting an SSI or SSDI application approved – without someone taking an active role to assist with the documentation of their disability – is very low.[26] Once an SSA disability application is denied the appeals process can take years.

The reasons why homeless people face more challenges than other applicants for SSA disability benefits are many and varied. First, they are more likely to have one or more serious mental illnesses alone or in combination with other qualifying disabilities, such as cognitive disorders, chronic physical health conditions, and so on. For example, in Massachusetts where SSA flags applications for homeless people and can, therefore, report separately on these applications, more than 70 percent of successful applicants for SSI are approved on the basis of a mental illness.[27] Disability based on a mental illness or cognitive disorder is more difficult to document than some other disabilities because of the lack of treatment histories, difficulty in finding medical records for people who may have moved about over time, etc. People who are homeless for long periods of time are often poor historians and are not good record keepers. They often do not remember when or where they were hospitalized or for what. Many do not know, do not understand, or are reluctant to admit that they have a mental illness.

Second, many people who are homeless – and their case managers – believe incorrectly that if they have a substance use problem that they are not eligible for SSA disability programs regardless of their other disabling conditions. While it is true that persons disabled solely on the basis of substance use without any other qualifying disabling condition are not eligible for SSA disability programs, many homeless people with substance use disorders have co-occurring conditions that qualify them for these benefits. As a result of this misunderstanding, many people

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[24] Rosen, Hoey and Steed, op cit., 2001.

[25] Rosen, J., Hoey, R., and Steed, T. Food Stamp and SSI Benefits: Removing Access Barriers for Homeless People. *Journal of Poverty Law and Policy,* March-April. General Accounting Office (2000) *Homelessness: Barriers to using Mainstream Programs.* Washington, DC: U.S. GAO, 2001.

[26] In some localities where data is kept on homeless applicants for SSI, the proportion of applications approved range between 10 and 15 percent. With active assistance by case managers or other benefits specialists, this can rise to the national average allowance rate of 37 percent or even higher.

[27] Personal communication, Clare Deucher, Boston Disability Determination Service, 2006.

do not apply or are discouraged from applying. Another common myth heard in many communities across the U.S. is that to receive disability benefits, one must apply at least three times over a period of several years before one can be found eligible. Again, such misinformation and commonly held beliefs are significant factors in discouraging homeless people from applying for benefits. Practically, SSA first evaluates which of the applicant's disabling conditions would remain if he or she stopped using substances. Second, SSA determines whether the applicant's remaining limitations would be disabling. If the answer to this question is "yes" then the applicant is considered disabled, regardless of drug or alcohol use. This applies even if drug or alcohol abuse originally caused the disabling condition (e.g., cirrhosis of the liver). These rules are complex and difficult to apply in addition to being applied differently across jurisdictions. If the CoC has good working relationships with the Disability Determination Service (DDS), the state agency that contracts with SSA to make disability decisions, it can help to understand how they are applied and to work together to be sure that they are being applied fairly and consistently across adjudicators.

Another complexity that affects homeless people more than most is when DDS orders a consultative exam (CE). These examinations are ordered when DDS does not have enough information to make a disability determination – a situation that is very common for people who are homeless because they typically do not have detailed records of their medical history, do not have continuity of care, and/or have been seen in geographically disparate locations. The CE exam is typically conducted by a DDS-contracted physician or psychologist who has never seen the applicant before. This is particularly problematic for persons who may have mental illnesses – where the history of symptoms and treatment is difficult to convey effectively in a brief face-to-face encounter with a stranger. Getting the applicant to this appointment is difficult enough, but those who do keep their CE appointment typically deny their mental illness and the examiner has no choice but to report that no disabling condition was found. If a CE appointment is missed, it may be possible to reschedule at least once, but missing more than one CE appointment may result in a denial on technical grounds. This will mean that a new application will have to be started after some period of time has passed – further delaying the receipt of benefits for the applicant. Avoiding the need for CE's by assuring that applicants have adequate documentation of their disability is a key strategy for increasing access to SSI and SSDI. Another strategy is working with DDS to have these evaluations done by physicians or psychologists who know the applicant – such as a Health Care for the Homeless physician.

Third, most homeless people with disabilities need assistance to apply for SSA benefits in order to be successful. Many, if not most, denials of SSA disability benefits for homeless people are the result of SSA's inability to contact the individual when they need further information in order to process the case, missed appointments for SSA scheduled medical examinations, and, more generally, the lack of adequate documentation to support the case for a finding of disability. When case managers become an applicant's representative (for the purpose of filing an SSA disability application) approval rates for people who are homeless can range from 65 to 95 percent. However, most case managers have neither the time nor an understanding of how to assist applicants effectively. This has been recognized by SSA resulting in the HOPE (Homeless Outreach and Program Evaluation) demonstration program[28] and by the Substance Abuse and Mental Health Services Administration's (SAMHSA's) *Stepping Stones to Recovery* manual and training curriculum for case managers assisting homeless people with SSA disability

[28] www.ssa.gov/HOPE.

applications.[29] Recently, a Federal interagency technical assistance program, known as the SOAR (SSI/SSDI Outreach Access and Recovery), has targeted states participating in the Policy Academies on Homelessness and Continuum of Care in various communities for intensive education and collaborative efforts designed to improve systemic approaches to accessing SSI and SSDI as well as training opportunities for direct service staff from CoC agencies in participating states.[30]

Investigation of Access in Sample States

Overview

Several Continuum of Care coordinators in each of the three states selected for this analysis (Michigan, Maryland and Tennessee) were interviewed by phone to learn more about their challenges and approaches to increasing access to SSI and SSDI for homeless people. In addition, upon the suggestion of CoC coordinators, interviews were also conducted with state and local agency staff. In the next few pages are challenges in accessing SSI and SSDI from the perspectives of CoC coordinators and staff from local CoC agencies. For each challenge, there are strategies and key factors to their success.

Myths about the Application Process

The Problem

The difficulties encountered by people who are homeless with applications for SSA disability benefits have been so severe in parts of the country that some popular and stubborn myths have evolved. Chief among them is that everyone is denied the first time they apply and that one must apply three times over a period of several years before an approval is possible. The result of such beliefs – strongly held by many direct service staff – is a sense of discouragement and disempowerment regarding their ability to help clients with this process. As with most myths, there is a grain of truth. It is a difficult process and one that often does not meet with success – especially for people who are homeless. Nationwide, initial approvals of SSI disability applications – whether the applicant is housed or not – is 37 percent. For people who are homeless, it is much lower. Reports from one CoC in Tennessee are that about 15 percent of applications for people who are homeless are approved on initial application. With few exceptions, most states and localities have no idea what their real rate of approvals are for SSI and SSDI applications from homeless people as these data are not maintained.

The conclusion of many CoC contacts that were interviewed for this report is that homeless people are not disabled enough to qualify for SSI or SSDI. They also conclude that their focus should be on appeals that can take years, rather than on improving the outcomes of initial applications. With appeals as the focus, it is nearly impossible to offer interim housing. Most

[29] Rosen and Perret, *Stepping Stones to Recovery: A Case Manager's Manual for Assisting Adults Who Are Homeless with Social Security Disability and Supplemental Security Income Applications*. Rockville, MD: SAMHSA; Perret and Dennis (2006) *Stepping Stones to Recovery: A Training Curriculum for Case Managers Assisting Adults Who are Homeless with Social Security Disability and Supplemental Security Income Applications.* Rockville, MD: SAMHSA., 2005.

[30] See www.pathprogram.samhsa.gov/soar.

programs support people in housing if they know that they will have an income source in a few months, but the length of the appeals process and the uncertain outcome creates an obstacle to placement.

Another belief is that persons who are abusing substances are not eligible for SSA disability benefits. While there are rules that limit eligibility for these individuals, they often have other conditions that may qualify them for benefits. Acting on misinformation or not having the resources to help their clients document the full extent of their disabilities, direct service staff often discourage many homeless people from applying for benefits.

Solutions Being Tried

Efforts to address long-term homelessness on the part of states and communities have lead to a focus on benefits for homeless people who are disabled. As part of the technical assistance offered to states participating in the Federal interagency Policy Academies on Homelessness, 24 states are participating in the SSI/SSDI Outreach Access and Recovery (SOAR) Technical Assistance Initiative. Two of the states interviewed for this report have recently taken part in the SOAR Initiative. CoC representatives from these states (Tennessee and Maryland) report that they are using information and collaboration (with each other and with SSA and DDS) to combat myths about access disability benefits for people who are homeless. In one state, a CoC contact that was interviewed said that the CoC agencies have good relationships and contact with County agencies, but that there was "hardly any" contact between the local SSA office and the CoC.

CoC Agencies Need Expertise and Resources to Assist Applicants

The Problem

Many of the CoC agency staff understand that their clients, many of whom have mental illnesses and/or cognitive disorders and lack a stable address, cannot access benefits by themselves. They cite a lack of understanding among case managers of their role in assisting people with applications and, a lack of resources to allow case managers the time it takes to provide effective assistance.

Solutions Being Tried

In Maryland, Service Point, the HMIS in place throughout the state (except for Baltimore), has a benefits screening tool that state Department of Social Service workers began using on July 1, 2006 to link people to benefits. While this may be helpful in identifying people in need of benefits, it will require considerably more effort to follow up with and to assist individuals to apply for these benefits.

To address this, Maryland and Michigan are putting benefits specialists in the field. In Maryland, for example, state Department of Social Services staff do outreach in some shelters around the state to assist people with benefits. But the contacts interviewed believe that much more of this needed to be done and that even these staff did not have the time to follow up on gathering the existing medical documentation and presenting it in a cohesive and convincing package. In Michigan, the state Department of Human Services is planning to identify SSI application

experts in regions around the state and make them available to assist applicants and provide training locally.

As part of their SOAR initiative, Nashville is working with the state DDS to designate DDS staff who will identify and process applications from people who are homeless. DDS will track applications from homeless people so that they will know how long it takes to process these applications and what the outcomes are for applications from people who are homeless. They will use this information to understand whether their efforts are resulting in improved results for homeless applicants.

The SSA-funded HOPE program in Michigan has become more skilled with gathering and presenting the documentation that DDS needs to approve more SSI and SSDI applications. Unfortunately, the funding for this SSA demonstration program will end soon and the capacity to assist applicants does not extend beyond the agency that received the grant. The future for this program at the time of this writing is uncertain.

In Maryland, the state is using a $17,000 PATH grant to support a benefits specialist at the Baltimore Health Care for the Homeless program. This person will be responsible for facilitating the application process and working with applicants until they are approved.

Through SOAR, both Tennessee and Maryland will conduct training using SAMHSA's *Stepping Stones to Recovery* curriculum to help case managers better understand the process and the role that they can play to increase access to these benefits. In Tennessee, they also will be using the National Health Care for the Homeless Council's (NHCHC's) *Documenting Disabilities* training curriculum to provide training for physicians who work with the homeless population and on whom DDS relies to provide medical documentation of disability.

As a result of their city's plan to end homelessness, the City of Nashville provided funding to a CoC provider agency to create an SSI outreach project with two full-time staff persons who assist with applications taken directly from the street or shelters. Approvals in the early weeks of this effort have been up dramatically and the time it takes for SSA and DDS to reach a determination has averaged less than three months.

Despite these promising efforts, each of the contacts interviewed were clear that the resources that they had been able to devote to this intensive work were far too few and the overall impact is likely to be limited to particular agencies or areas of the state that have access to the training or staff time to devote to assisting applicants.

Medical Documentation of Disability

The problem

Each of the CoC contacts that were interviewed voiced their frustration with getting the medical documentation that was needed to make the case with the DDS for disability. The reasons cited ranged from clients not remembering where they were treated or for what; to complaints about the SSA consultative exam process; to difficulty getting appropriate medical exams and tests due to the lack of a payer; to physicians seeing it as a conflict of interest to help people obtain benefits that will in turn pay for their services.

The Solution Being Tried

Most contacts that were interviewed had few answers for these problems. While the medical documentation for many clients probably exists, CoC staff does not have the time to locate, much less assemble, this information. Cursory consultative exams by physicians who do not know the patient and patients who forget or forget to mention their mental illness during these exams were frequently mentioned as problems. If a CoC has a Health Care for the Homeless program (or other federally qualified health care facility), they may be able to do some free medical evaluations, but their capacity is limited and their commitment is generally to provide acute care first. Using the NHCHC's training curriculum, *Documenting Disabilities,* may help educate and engage physicians. Nashville and Baltimore's CoC will be conducting this training for physicians in the next year.

Other SSA-Specific Challenges

There are several other issues that affect access to SSI and SSDI. Many of these are challenges specific to some requirement or process that is part of the SSA's routine operations. Three such issues were raised by the CoC contacts that were interviewed for this report.

The Problem

Securing identification for people to enter Federal buildings to apply for the benefits is particularly difficult and a complaint heard frequently.

The Solution Being Tried

In Maryland, the Department of Motor Vehicles provides a state-issued ID and is able to waive the associated fees for people who are homeless.

The Problem

The Disability Determination Service (DDS) often is unable to contact people who are homeless when they need additional information. They need a contact person who can respond on the behalf of the applicant or who knows how to reach the applicant at all times. They also need someone to help insure that if a consultative exam is ordered that the applicant keeps the appointment.

The Solution Being Tried

The Nashville SOAR project is requiring all providers that participate in SOAR to use the SSA 1696 Appointment of Representative form for applicants they assist. Using this form is an important promising practice identified by SAMHSA in their report on promising practices for SSI outreach.[31] By becoming the applicant's representative, the case manager can "stand-in" for the applicant and receive copies of all correspondence that SSA sends to the applicant. Using this form also allows the DDS adjudicator to speak directly to the case manager so that inquiries can be made about the need for additional information, status of the application, coordination of

[31] Policy Research Associates, Inc. op cit. (draft, February 9, 2006)

arrangements for consultative exams, etc. Without this form, many SSI and SSDI applications are denied simply because the SSA or DDS cannot locate the applicant or because they have missed a rescheduled consultative exam.

The Problem

One CoC contact that was interviewed explained that the nearest SSA office was miles outside the downtown area. There was a satellite office in the downtown area, but it recently closed. The new location is accessible to homeless people only by a long bus ride, which makes the office difficult to access.

The Solution Being Tried

There was no solution that this CoC had found to address this issue. Although SSA's increasing reliance on telephone and electronic application filings may help this problem in the long run, it still remains difficult for people who are homeless to access computers or telephones from which to file their applications.

FOOD STAMPS

Introduction to the Mainstream Resource

Food Stamps' Relevance/ Eligibility for Homeless people

The Food Stamp Program is designed to alleviate hunger and malnutrition by permitting low-income individuals and households to obtain a more nutritious diet through normal channels of trade. The program provides low-income individuals with coupons or Electronic Benefits Transfer (EBT) cards that can be used to purchase food. Recipients may use these coupons or cards in authorized retail food stores. In some areas, restaurants can be authorized to accept Food Stamps from homeless, elderly, or disabled people in exchange for low-cost meals. For people who are homeless, Food Stamps are particularly essential given that the task of simply finding food is commonly difficult for those with no permanent home. According to one report, as many as 58 percent of homeless people have one or more food problems within a 30-day period.[32] By accessing and using Food Stamp benefits, homeless people can get the sustenance they need.

Eligibility for the Food Stamp Program is based on financial and non-financial factors. The application process includes completing and filing an application form, being interviewed, and verifying facts crucial to determining eligibility. With certain exceptions, a household that meets the eligibility requirements is qualified to receive benefits. A household is defined as a person or a group of people living together, but not necessarily related, who purchase and prepare food together. Households, except those with elderly or disabled members, must have gross incomes below 130 percent of the poverty line. All households must have net incomes below 100 percent of poverty to be eligible. Most households may have up to $2,000 in countable resources. Households with at least one household member who is disabled or age 60 or older may have up to $3,000 in resources.

There are provisions for receipt of expedited Food Stamps. Recipients can receive Food Stamps within seven days (some states have shorter time frames) if they have less than $150/month in income and no more than $100 in resources.

Legal immigrants who are children or disabled are now eligible to receive Food Stamp benefits, as well as legal immigrants who have legally resided in the United States for at least 5 years. Other legal immigrants and any undocumented immigrants are ineligible for Food Stamps. Also, many able-bodied, childless, unemployed adults between 18 and 59 have time limits on their receipt of Food Stamp benefits. Generally, this group will receive Food Stamps 3 months out of a 36-month period unless they are deferred or participate in at least 20 hours per week of employment-related activities.

National Food Stamps Program Complexity

The Food Stamp Program, while providing benefits to all low-income populations, is often times difficult to access for individuals and families who are homeless. This is primarily due to the somewhat complex procedures involved in applying for assistance and the documentation

[32] Martha R. Burt et al., The Urban Institute, Homelessness: Programs and the People they Serve: Technical Report 7-1 Interagency Council on the Homeless, 1999.

necessary to receive benefits. The program rules, however, do limit this complexity for people who are homeless. This section describes aspects of the Food Stamps' complexity and the extent to which the program minimizes it, as a matter of policy, for people who are homeless.

For one, the Food Stamps Program requires all states to have provisions for receiving expedited or emergency Food Stamp benefits. In order to provide expedited service, the state Food Stamp agency must interview the household within a seven day deadline. If the household fails to complete the application process for expedited service (i.e., complete the application, be interviewed, verify identity) the state agency will be unable to provide expedited service and will process the application within the normal 30 days of the date of application.

In addition, the federal Food Stamp regulations require a Food Stamp caseworker to verify the identity of applicants for Food Stamps. The caseworker must accept either a photo ID issued by a State, or alternatives such as work or school IDs, medical insurance IDs, wage stubs, a birth certificate or a voter registration card. The Food Stamp caseworker can also verify identity by calling a "collateral contact" who can confirm the identity of an individual. Shelter workers and employers are examples of possible collateral contacts. The Food Stamp office cannot require homeless recipients to fill out report forms each month if they are homeless. Social Security Administration offices and state welfare offices can take applications for Food Stamps at the same time that they take applications for SSI and TANF.

Homeless households are not required to verify where they live, but having a written or oral statement from a homeless shelter or a statement from someone who can verify where he or she lives will be sufficient to show proof of homelessness. In addition, to address the challenges of serving homeless recipients, the federal government has provided states the flexibility to choose to develop a homeless household shelter deduction to be used in place of the excess shelter deduction in determining the net income of homeless households. Under the rules set forth by the federal government, state agencies may set the homeless household deduction at any amount up to a maximum of $143 per month.

Homeless people can pay for meals at some soup kitchens and homeless shelters with Food Stamps, but these soup kitchens and shelters must be authorized by the Food and Nutrition Service to accept Food Stamps. A shelter cannot force require guests to use Food Stamps to pay for food at the shelter, and guests must be given the option of eating free, making a monetary donation, or using the Food Stamps to pay for the food. In addition, homeless people may use their Food Stamps at certain restaurants if the restaurants contract with the state to serve meals to homeless people at reduced prices in exchange for Food Stamps.

Investigation of Access in Sample States

Overview

Coordinators from several of CoCs in each of the three sample states were interviewed for this analysis of Food Stamps access in the sample states and solutions that are being tried to address challenges. State agency staff, direct service providers and advocates were also interviewed.

To apply for Food Stamps in each of the three sample states, an individual must complete an application, appear for an interview at the state agency responsible for the Food Stamp Program,

and provide verifications. All three states have a provision for a telephone interview if the individual is unable to go to the office. The main eligibility criteria are identification, income and assets and residence. For able-bodied, childless adults, this group will receive Food Stamps 3 months out of a 36-month period unless they are deferred or participate in at least 20 hours per week of employment-related activities. Many of those interviewed said this was not an issue since the counties in which they worked had a waiver of this provision.

In addition to the initial application requirements laid out above, there are different certification requirements between the sample states. For example, in Tennessee households must be registered for no less than three months but no longer than a year. However, those accessing the TANF program can have an automatic certification period of one year. Those accessing the program after the 15th of the month receive an additional month of certification (four months). Households experiencing changes are recommended to only receive one to two months of certification at any time (to be determined on a case-by-case basis).

The Food Stamp Program in Maryland differs considerably from its counterpart in Tennessee. Those households that contain elderly adults or adults with a disability qualify for 24 months of certification with one contact requirement during this time. Maryland has also created the CARES Program, which is a simplified recertification process within the state. CARES will assign 6-month certification periods to households with exceptions pertaining to the following:

- Single adults without dependents that do not work full-time;
- Migrant farm workers;
- Households with members that are homeless;
- Elderly households without an earned income; and
- Households receiving transitional Food Stamps.

All of these categories that are not eligible for simplified certification status must then be given 1 – 2 month certification status, which is determined on a case-by-case basis by their caseworker. In Michigan, households are certified for a period of 1 – 12 months, depending on their circumstances. Some households qualify for a 24-month benefit period – those in which all group members are seniors and/or disabled, and the group's only source of income is SSI and/or RSDI benefits.

In general, most of those CoC contacts interviewed, with a few exceptions, felt that individuals who are homeless have access to Food Stamp benefits. The challenges to receiving food assistance appear to be the usual challenges faced by homeless people attempting to access mainstream resources generally – it is difficult for people who are homeless to get to eligibility offices, to have the required documentation, and to follow-up for additional information. In the sample states, it seems that Food Stamps, however, are easier to access than SSI, Medicaid and TANF, since there are fewer (relatively speaking) eligibility requirements.

Eligibility Challenges

The Problem

In 1999, The National Law Center on Homelessness and Poverty surveyed 72 direct service organizations around United States that had indicated their clients had encountered difficulties when trying to access Food Stamp benefits. The survey sought to identify the types of challenges

encountered by people who are homeless when they sought to obtain Food Stamps. This survey found that homeless people encounter significant challenges associated with being homeless:

- Approximately 45 percent of all non-profits surveyed reported that their homeless clients were denied Food Stamps sometimes or frequently because their clients had no address.
- Approximately 77 percent reported their clients were sometimes or often denied Food Stamps because their clients did not have proper identification.
- Approximately 23 percent reported their clients were denied Food Stamps often or sometimes because they did not have a cooking facility.
- Thirty-two percent reported that their clients were only sometimes or never allowed to file a Food Stamp application the same day they received it.
- Fifty-eight percent reported that their clients received expedited Food Stamps – benefits that are to be provided within 7 days of application – either sometimes or never.

A more recent report by the National Law Center on Homelessness and Poverty recommended that the Food Stamp eligibility offices work with local restaurants to: encourage more restaurants to accept Food Stamps; send eligibility caseworkers to homeless shelters, food pantries and domestic violence shelters to enroll homeless people in public benefits; and have cities implement the federal child nutrition law, which make homeless children and youth automatically eligible for free school meals.[33]

Most of the CoCs interviewed for this report felt that eligibility for Food Stamps was not a big problem in the sample states. However, because HUD has been emphasizing access to mainstream resources, the CoCs indicated that there has been increased attention to training of homeless providers on public benefits including Food Stamps. The lack of identification was mentioned as an issue for many people who are homeless as well as transportation to the local eligibility offices.

Some CoCs interviewed for this report noted that the eligibility rules for Food Stamps can be complicated – particularly the budgeting and work requirements – and that the administration of the program is affected by the competence of the eligibility workers. A Maryland CoC contact observed that people who are homeless are not well understood by the typical case management workers. She also mentioned that homeless people do not receive the Food Stamp debit card[34] the same day they file their applications, which is problematic for people who have difficulty getting to eligibility offices.

Another Maryland CoC contact felt that there are bureaucratic challenges – "bureaucratic disentitlement" – to helping homeless individuals get Food Stamps. She noted that staff at eligibility offices: frequently do not help people with the written application; display a lack of understanding about those with physical and/or mental disabilities; and have office procedures that discourage people from filling out applications. She also noted: the problem of getting identification; income and residence verification; not enough outreach by eligibility workers to take applications outside the office; inconvenient office hours for people who are working at low

[33] National Law Center on Homelessness and Poverty, Adding Legal Teeth to Plans to End Homelessness, 2006.
[34] The electronic benefit transfer systems (EBT) replaces paper coupons through use of a benefits card, similar to a bank card. The use of Food Stamp "coupons" is no longer the means by which a client receives their benefits.

wage jobs with irregular hours; and the fact that people going into and out of institutional care, such as jails and prisons, have to start over with a new application every time they are released.

One CoC Michigan contact related that they were not seeing the same effective outreach for Food Stamps as in other parts of the state. She also believed that since recertification was required every six months, it was cumbersome for homeless families.

Another difficulty for people who are homeless is the requirement that the state agency has to have an interview with the household before expedited Food Stamps can be issued. Some CoCs in the sample states mentioned that even with the outreach efforts at shelters and soup kitchens, the actual application must still be filed with the state agency and a state employee must interview the applicant. Since simply getting people who are homeless to eligibility offices is challenging, this requirement at time impedes receipt of benefits.

Solutions Being Tried

All three states mentioned that there has been increased attention within the CoCs on training of public benefits, including Food Stamps. There are several such outreach and training programs in Tennessee. For example, in Memphis, the city launched a computer-based screening tool called Earn Benefits, which is programmed with the eligibility requirements of the Food Stamp program and 22 other benefit programs. The tool is provided to community-based organizations, and enables staff to generate and submit online applications for those benefits for which the clients are deemed eligible. The State of Tennessee also recently received funding from the federal government to purchase laptops for a team of State Department of Human Services caseworkers who will go to homeless providers, soup kitchens, and shelters to take applications for Food Stamps and other State benefits.

Notably, Michigan has a Food Stamp Partnership Website to facilitate Food Stamp applications. It includes an online budgeting calculator at: www.foodstamphelp.org. Michigan also developed a pilot program in one county to place Food Stamp Program outreach workers at various food pantry locations throughout the county, at low-income schools, and at businesses where low wage workers were employed. When the state agency was unable to continue mobilizing workers to outlying areas, private funding was secured to hire an outreach worker to process applications and serve as a liaison between Food Stamp applicants and the state agency. In Maryland, a few state agency caseworkers go to homeless shelters to take eligibility applications for public benefits.

Institutionalization Challenges

The Problem

The Food Stamp program stipulates that a person who becomes incarcerated is no longer living in the recipient family's home and is, therefore, ineligible for Food Stamps. The head of household has an obligation to report this change in household composition to the local office and cannot simply wait until recertification. If unreported, benefits paid would constitute an overpayment. Depending on the circumstances, failure to report could lead to the entire household's disqualification from the Food Stamp program. For families that are homeless, chaotic lives make this requirement a challenge to fulfill.

Yet another challenge to receipt of Food Stamps for people who are homeless is the drug felony disqualification. This provision disqualifies people from Food Stamp participation if they have been convicted of a state or federal felony offense involving the use or sale of drugs. State legislatures can opt out of the penalty entirely or choose less severe restrictions. However, 21 states do have a lifetime ban on receipt of Food Stamps following the federal legislation and twenty states have a modified ban. Given the high incidence of drug related felonies in the backgrounds of people who are homeless, this policy presents an obvious challenge to such individuals.

Solutions Being Tried

Among the sample states, Tennessee stands out for taking some initiative to address institutional challenges to Food Stamps access. Specifically, one of the Food Stamp outreach projects in Tennessee, MANNA, based in Nashville, goes to prisons and makes presentations to inmates who are reaching the end of their sentences. When these individuals leave prison, many contact MANNA for assistance with Food Stamp questions and with completing applications assuming they are not prevented from receiving Food Stamps because of a drug conviction.

APPENDICES

APPENDIX A

Chart 1: CoC-State Data on Mainstream Resource Effort

State	C-o-C State Affiliations Scoring in Top Five for 2005 Annual Progress Report Outcomes for % of Participants Exiting with Entitlements											Social Security Homeless Outreach Project (HOPE) Sites	Policy Academy Plans that reference access to SSI/	P.A. Plans that reference "mainstream	SSI/SSDI/ Outreach Access & Reach (SOAR)TA Sites	2001 CMS Real Systems Change Grant includes	2004 CMS Integrating LT Supports with
	SSI	SSDI	Soc Sec	GPA	TANF	SCHIP	Vets Benefits	Unemployment Benefits	Vets Health Care	Medicaid	Food Stamps						
Alabama				7/3			7		1								
Alaska																	
Arizona							2		7			1 site	X		X*		
Arkansas								5					X				
California			7	7	3/7		8		8/10			8 sites			X (LA)		
Colorado												1 site	X				
Connecticut	8	7/9		5/9								1 site		X			
Delaware														X			
Florida	5	5	5/9	1					5			1 site	X		X		
Georgia													X		X		
Guam			2														
Hawaii						7						1 site		X	X		
Illinois										7	6			X			
Indiana												1 site	X				
Kansas					9							1 site	X				
Kentucky													X		X*		
Louisiana	9	4				10					1	1 site	X				
Maine										8			X				
Maryland						8							X				
Massachusetts	7	3	4			9	10	9	6	9	9	4 sites	X				
Michigan			3	8/2	4/5	4	1/4	3/7		1	7	1 site		X			
Minnesota						5						2 sites					
Mississippi													X				
Missouri	2		1										X				

Montana													X		X*		
Nebraska						2/3							X				
Nevada												1 site		X	X		
New Hampshire														X			X
New Jersey	4	1		9/10	2/8					2	2		X				
New Mexico													X				
New York	6			4			3/6		2			5 sites	X				
North Carolina	3											1 site	X				
North Dakota													X				
Ohio												1 site	X		X		
Oklahoma													X		X		
Oregon						1						1 site		X	X*	X	X
Pennsylvania		2/8															
Puerto Rico											8						
Rhode Island													X				
South Carolina								1									
South Dakota														X			
Tennessee		6			1/6	6	9	2	3	3	3/5					X	
Texas			10					8				3 sites	X				
Utah													X		X		
Vermont													X				
Virgin Island													X				
Virginia	1		8					6		4/5	4		X		X*		
Washington								10				1 site		X	X		
West Virginia			6										X				
Wisconsin							5		4			2 sites					
Wyoming													X				

*State's Strategic Plan for SOAR is "done.

APPENDIX B

Memorandum

To: Velma Simpsom, U.S. Department of Housing and Urban Development

From: Kristina Hals, TAC Inc; Kelly Kent, Sue Augustus, Corporation for Supportive Housing Inc.;

Francine Williams, Deborah Dennis, PRA Inc.;

Re: APR Chart on Mainstream Resources

In our preliminary research for the Mainstream Resources TPA, our collaborative team made up of staff from PRA, CSH, and TAC unearthed some feedback from CoC contacts on the *Mainstream Programs and Employment Chart* used in HUD's APR and also employed, in translated form, in the SuperNOFA application. We solicited this feedback as a component of our qualitative interviews to help us answer HUD's inquiry question about the relative merits of this chart and the CoC's own assessments as to whether it accurately represents their performance in mainstream resource access.

We understand that HUD is soon to make revisions to the APR and has contracted with an independent team to carry out this task. For their consideration in making these revisions and for HUD's future interpretation of the *Mainstream Programs and Employment Chart* should it be retained, we are sharing our preliminary findings here on this topic. Please note that this summary represents inquiries in only three sample states: Michigan, Maryland, and Tennessee. Furthermore, within each of these states, we have only interviewed a representative selection of CoC coordinators and key contacts. Nevertheless, some consistent themes have emerged, and they are presented below in order of magnitude as conveyed by our contacts.

1. Our sample CoCs general assessment of the value and validity of the chart is uneven. Many of the more veteran CoC contacts, who have actively engaged with the national policy initiative to emphasize mainstream resources, critique the chart as an invalid/ unfair tool for assessment. Other CoCs are more neutral or point out only its susceptibility to factual inaccuracy.

2. The strongest criticism of the chart is that the CoC grantees are not positioned, in the scheme of state policy and public service systems, to affect the individual outcomes of their program participants' efforts to access mainstream resources. However, the chart, and the numeric points attributed to it by HUD, implies that they are. This critique points out that the actual outcomes are subject to many variations and variables from state to state and region to region that are well beyond these players realm of influence. This is not to say that the grantees and CoCs cannot provide services and engage in local collaborations to improve the climate in their region and on behalf of their participants. Their point is that the chart does not capture this picture.

3. Social service only projects are considered at a particular disadvantage vis a vis the chart given that they see program participants in a relatively shorter time frame during which participants are less likely to access mainstream resources.

4. CoC grantees that are targeting chronically homeless people feel disadvantaged vis a vis the chart

given that they have lesser outcomes to demonstrate –a reflection of the fact that this population is categorically ineligible for many mainstream resources in many states.

5. The chart is criticized for the seeming arbitrariness of only capturing the success of exiting program participants. For CoCs with extensive permanent supportive housing in their inventory of programs, the exiting group can be a small fraction of those served in a year. These CoCs miss the opportunity to demonstrate their success with stabilized, housed program participants. Furthermore, exiting participants may be a subset population that does not, in fact, reflect upon the trends of the entire group of persons served.

6. Some CoCs feel that their HMIS systems have what they consider better data sets than the chart that better capture the activity of grantees related to mainstream resource access. They recommend HUD consider these data sets as a possible model for an alternative chart.

7. Some CoCs feel that an opportunity to present qualitative information about grantees efforts to build local collaborations, identify challenges to access, and better all parties relevant knowledge base and skills is missing from the chart.

8. Some CoCs suggest that the reporting in the chart may not be entirely accurate given the inherent bias of those who put in the data. They suggest that the only way to obtain genuine accurate data would be from a third party not invested in the chart's data.

9. Some CoCs explain that, as a small or rural homeless service system, they are disadvantaged in the mechanics of capturing accurate data for the chart as a result of low capacity of their staff systems.

We hope this summary is of some use to HUD in efforts to improve the APR. Please do not hesitate to contact us with questions.

APPENDIX C

SSI and State Medicaid Programs [1]

Figure 7. **1634 States** *In 1634 states, SSA makes Medicaid eligibility determinations and—essentially—authorizes Medicaid when a person is approved for SSI.*			
Alabama	Kentucky	New Jersey	Tennessee
Arizona	Louisiana	New Mexico	Texas
Arkansas	Maine	New York	Vermont
California	Maryland	North Carolina	Washington
Colorado	Massachusetts	Pennsylvania	Washington DC
Delaware	Michigan	Rhode Island	West Virginia
Florida	Mississippi	South Carolina	Wisconsin
Georgia	Montana	South Dakota	Wyoming
Iowa			

Figure 8. **SSI Criteria States** *SSI criteria states use SSI eligibility criteria for Medicaid but, beyond those criteria, may make their own Medicaid determinations or ask SSA to determine eligibility.*			
Alaska	Kansas	Nevada	Oregon
Idaho	Nebraska	Northern Mariana Islands	Utah

Figure 9. **209(b) States** *209(b) states use at least one criterion that is more restrictive than the SSI program's criteria for determining eligibility.*			
Connecticut*	Indiana	New Hampshire*	Oklahoma
Hawaii	Minnesota	North Dakota	Virginia
Illinois	Missouri*	Ohio	
** Indicated states do not include individuals who are not blind and who are under the age of 18 in their definition of disability.*			

1 Information current as of July 2003.