Homeless with Schizophrenia Presumptive Disability Pilot Evaluation

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Many homeless individuals with a serious mental illness are potentially eligible for Supplemental Security Income (SSI) payments, but the nature of their impairment poses obstacles to completing the SSI application process. In this article, we evaluate the Homeless with Schizophrenia Presumptive Disability (HSPD) pilot that tested whether providing support during the application process improves SSI application outcomes—such as increasing the allowance rate and shortening the time to award—in selected communities in California. Importantly, the HSPD pilot included a presumptive disability determination that provided up to 6 months of SSI payments before an award. Relative to the comparison groups chosen in the surrounding geographic areas, in an earlier period, and in the same locations, we found that the pilot intervention led to higher allowance rates at the initial adjudicative level, fewer requests for consultative examinations, and reduced time to award. We also discuss policy options for this population.

Introduction

Having a disability is a factor that increases the risk of becoming homeless. In 2009, almost 38 percent of the homeless population had a disability, compared with about 16 percent of the total U.S. population (Department of Housing and Urban Development 2010). Individuals with a serious mental illness are particularly vulnerable to homelessness. Additionally, the nature of mental illness prevents many from applying for assistance. Two serious and chronic mental illnesses—"schizophrenia" and "schizoaffective disorder"—together affect about 1 out of every 100 people (National Alliance on Mental Illness 2012, 2013). Individuals with those disorders face formidable challenges to gaining much needed support, such as adequate housing and treatment, and accessing public benefits.

Supplemental Security Income (SSI)—a potential source of income for this population—is a means-tested program that makes monthly payments to individuals who have limited income and resources and who are aged 65 or older, blind, or disabled. Section 223 of the Social Security Act defines disability as, "the inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment, which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." For this study—the Homeless with Schizophrenia Presumptive Disability (HSPD) pilot—we focused on homeless SSI applicants in specific geographic locations who alleged schizophrenia or schizoaffective disorder.

Many homeless individuals with a serious mental illness are potentially eligible for SSI payments, but

Selected Abbreviations

C1	main comparison group
C2	second comparison group
C3	third comparison group
CE	consultative examination
DDS	Disability Determination Services
HSPD	Homeless with Schizophrenia Presumptive Disability

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Selected Abbreviations—*Continued*

OQR	Office of Quality Review [SSA]
PD	presumptive disability
SSA	Social Security Administration
SSI	Supplemental Security Income

the nature of their impairment poses obstacles to completing the SSI application process. For an applicant to meet the Social Security Administration's (SSA's) definition of a disability, the evidence presented must be thorough. However, the treatment history of applicants who are homeless and have a serious mental illness may be intermittent, inaccurate, or incomplete, and involve multiple locations and doctors. Additionally, the lack of stable housing makes it difficult for homeless individuals to maintain or safeguard required documentation, such as identification and medical records, and to provide accurate contact information. These complications in turn affect the individual's access to many social services and his or her ability to schedule and keep appointments, such as the consultative examination (CE), that SSA may require to make a disability determination. In most cases, an SSI award for an adult depends on the degree of functional limitation, not solely on a medical diagnosis (Wixon and Strand 2013). The evaluation of a disability on the basis of schizophrenia or schizoaffective disorder requires documentation of the medically determinable impairment(s), consideration of the degree of limitation such impairment(s) may impose on the individual's ability to work, and consideration of whether those limitations have lasted or are expected to last for a continuous period of at least 12 months.

In this article, we assess whether helping individuals in our target population with completing the SSI application process, coupled with providing presumptive disability (PD) payments, helps to improve several programmatic outcomes. Specifically, we compare the processing times and payment outcomes for individuals receiving application assistance and PD payments prior to SSA's final disability determination with individuals not receiving those services in nearby locations, in a prior period, or in the same location and time period. Our results are not causal; however, we find that the intervention is associated with a shorter application process and an increase in SSI payments over a defined follow-up period. We also discuss the implications of our findings for national policy.

The HSPD Pilot

SSA designed the HSPD pilot to address the factors that prevent homeless adults with schizophrenia or schizoaffective disorder from receiving SSI payments. In 2012, SSA's San Francisco Regional Office partnered with community health agencies in San Francisco and Santa Cruz, California, to implement the project. In 2013, SSA expanded the project by bringing onboard an additional community health agency in Los Angeles. These partners—the San Francisco Department of Public Health, the Human Services Agency of San Francisco, the County of Santa Cruz Health Services Agency, and the Los Angeles County Department of Health Services—all had experience with providing services both to individuals with mental illnesses and to those experiencing homelessness. Additionally, all partners were established institutions providing comprehensive and multidisciplinary programs and services to address public-health issues in their communities. They also employed staff experienced in working with individuals in specialized programs who could implement the HSPD interventions by connecting persons in the target population to an array of services to help address their medical, psychological, advocacy, and housing needs. A crucial step for developing the study populations for the project evaluation was identifying individuals who were potentially homeless during the period of interest. For details on the measures used in determining homelessness, see Appendix A.

The HSPD project included two intervention components: SSI application assistance and a PD recommendation. First, the community partners used their established outreach processes to identify homeless individuals who had schizophrenia or schizoaffective disorder, then they helped those individuals with the SSI application process. Throughout the process, community-partner staff helped individuals with a confirmed diagnosis by scheduling and coordinating necessary appointments, gathering medical evidence, and ensuring that the local participating SSA field office received the application.

Second, community-partner staff recommended PD payments for SSI recipients who were homeless and had a confirmed diagnosis of schizophrenia or schizoaffective disorder. The PD policy allows an individual applying for SSI based on a disability to receive payments for up to 6 months prior to SSA's initial disability determination; the existence of certain disabilities "presume" approval for SSI. Generally, the

field office may approve PD payments for persons with conditions that fall under a limited number of specific categories, such as an amputated leg or an allegation of total deafness, for which the evidence strongly reflects that the impairment would meet SSA's definition of a disability. Repayment of any monies received is not required, as long as SSA does not deny the application for nonmedical reasons (SSA 2014b).

For the HSPD pilot, three SSA field offices—San Francisco Downtown, Santa Cruz, and Los Angeles Downtown—authorized PD payments based on a confirmed diagnosis of schizophrenia or schizoaffective disorder (SSA 2014a). Community partners used the PD recommendation form created for this project—the Schizophrenia Presumptive Disability Recommendation Form (SSA-121)—on which licensed physicians or psychologists were required to attest whether the individual's condition met criteria consistent with SSA's medical listings for schizophrenia or schizoaffective disorder. SSA's standard PD process does not require such a recommendation form.

The HSPD Process

To learn more about how the HSPD process was actually implemented, all local partners responded (via e-mail or telephone) to a standard set of questions about their processes. From their responses, we learned that the length of the application process varied with each individual case, but usually took from several days to a few months to complete. During the outreach process, partners identified individuals who potentially met the HSPD pilot criteria and referred them to staff and clinicians for individual case management and professional assessments. The case manager reviewed existing medical records, obtained additional information from treatment providers and family, and scheduled an appointment with a physician or psychologist to further document the nature of the disability. If the assessment indicated that the disability was schizophrenia or schizoaffective disorder, then the physician or psychologist completed the PD recommendation form, certifying that the individual showed certain symptoms and correlated functional limitations and that the applicant's condition was not caused by substance abuse (alcohol or drugs). The case manager submitted the completed SSI application, PD form, and supporting evidence to the participating SSA field office and the Disability Determination Services (DDS) then expedited HSPD cases through the determination process. Additionally, community-partner staff provided assistance throughout the full adjudication process, when needed.

At each site, the intervention process involved intensive case-management and follow-up services. Staff members conducted face-to-face meetings several times with individuals in the pilot and monitored their cases closely. They reminded individuals of and accompanied them to various appointments, coordinating activities with other members of the team, when needed. They also assisted individuals with finding other support services that could help them with their housing, transportation, and other basic needs.

The pilot operated for 24 months, from April 2012 to April 2014. During that time, SSA and its partners assisted 260 homeless individuals in California with their SSI applications and PD recommendations: 78 in San Francisco, 24 in Santa Cruz, and 158 in Los Angeles.

Data and Methodology

At the outset, we decided that it was not feasible to use a randomized design because of the vulnerability of the homeless population and the obligations of SSA's partners and service providers. Instead, we chose a quasi-experimental design aimed at identifying the effects of application assistance and PD payments on the outcomes of interest. The primary outcomes from the research questions we focused on in this article address the extent to which the pilot had the following effects:

1. Increased SSI allowance rates at the initial adjudicative level (and increased SSI payment receipt after 6 and 12 months)
2. Reduced the need for CEs
3. Reduced the time required to adjudicate the claim (including specific segments of the application process)
4. Reduced appeals
5. Increased total payments
6. Reduced deaths

Specifically, we wanted to compare the outcomes of individuals who received SSI application assistance and PD payments—the treatment group—with the outcomes of individuals in the three comparison groups—main group (C1), second group (C2), and third group (C3). Table 1 summarizes the four groups observed during the pilot evaluation. All individuals included in our analyses met the selection criteria in Appendixes A and B.

Table 1.
Selection criteria for HSPD pilot treatment and comparison groups

Criterion	Treatment group	Comparison group		
		C1	C2	C3
Filing location				
Treatment field office				
Northern California				
San Francisco Downtown	X	X		X
Santa Cruz	X	X		X
Los Angeles Downtown	X	X		X
Nontreatment field office				
Northern California surrounding area [a]			X	
Los Angeles surrounding area [b]			X	
Claim established				
Prior period (April 20, 2010–April 18, 2012)		X		
Pilot period (April 20, 2012–April 18, 2014)	X		X	X
SSI application contained indication of—				
Schizophrenia or schizoaffective disorder [c]	X	X	X	X
Homelessness [d]	X	X	X	X

SOURCES: SSA's Office of Research, Demonstration, and Employment Support and SSA's San Francisco Regional Office.

NOTES: C1 = same field office, prior period; C2 = surrounding area field office, pilot period; C3 = same field office, pilot period.

a. Northern California surrounding area field offices—Berkeley, Campbell, East Oakland, Gilroy, Oakland Downtown, Salinas, San Francisco Mission, San Jose East, San Jose South, and Watsonville.

b. Los Angeles surrounding area field offices—Hollywood, University Village, and Wilshire Center.

c. Indication of schizophrenia or schizoaffective disorder noted on the SSI application in the allegation text field, or a "2950" primary diagnosis code.

d. One indication of homelessness noted as 1) homeless flag on the SSI application, 2) keywords suggesting homelessness in the address field or remarks field on the Field Office Disability Report (SSA Forms 3367 or 3368), 3) emergency shelter listed in the address field on the SSI application, or 4) residence type that indicated transiency.

Treatment Group

Our treatment group consisted of 238 homeless individuals who met the criteria for the pilot, established a claim during the pilot period (April 20, 2012–April 18, 2014), and received assistance. We excluded 22 other applicants from the group for various reasons, including establishing a claim outside the pilot period, applying in a nonparticipating field office, and not having schizophrenia or schizoaffective disorder indicated on the application. We also excluded applicants who applied for Disability Insurance rather than SSI and those who did not meet the criteria for homelessness. For SSA, the date a claim is established is the date on which the agency officially enters the applicant's claim into its records. This is typically later than the date that the applicant filed the claim.

Comparison Groups

In total, our comparison groups consisted of 2,571 individuals. The largest comparison group C1 (with 1,038 members) included individuals who had applied for benefits in the prior 2-year period (April 20, 2010–April 18, 2012). Comparison group C2 (with 676 members) and comparison group C3 (with 857 members) consisted of individuals who had established their claims during the pilot period.

In our main comparison group (C1), SSI applicants alleged either schizophrenia or schizoaffective disorder according to their applications, met the criteria for homelessness, and had applied for SSI payments in *one of the three pilot field offices in the 2 years before the pilot.* Individuals included in C1 did not receive PD payments based on an allegation of schizophrenia or schizoaffective disorder, but may have received some assistance from SSA's community partners.

Comparing individuals in the treatment group with those in comparison group C1 provided us with an estimate of the impact of the PD payments, without the confounding influence of location differences. However, some bias in the results may remain, as there may be year-specific differences between the two groups. Additionally, we note that this does not necessarily separate the effects of the PD payments from the application assistance provided to the target population as part of our designed intervention.

SSI applicants in our second comparison group (C2) alleged schizophrenia or schizoaffective disorder, met the criteria for homelessness, and applied for SSI payments in the *surrounding area field offices during the study period*. Individuals in C2 might have been eligible for PD payments had they received assistance, but they were not in a participating location served by SSA's community partners. Thus, comparing the differences between the treatment group and comparison group C2 should avoid any year-specific distinction and identify the effects of the PD payments along with the assistance given by the providers. However, some selection into those two groups based on location may bias our estimated effect.

Our third comparison group (C3) included SSI applicants who allegedly had schizophrenia or a schizoaffective disorder, met the criteria for homelessness, and had applied for SSI benefits in *one of the three pilot field offices during the pilot period*. Individuals in C3 did not receive the schizophrenia or schizoaffective disorder PD payments or the same application support received by the treatment group. However, they may have been eligible for application assistance and PD payments had the community partners identified them and provided assistance. Alternatively, they may have received some assistance from the partners, but were not considered eligible for PD payments. As with the treatment-to-C2 comparison, the difference between the treatment group and comparison group C3 avoids any year-specific factors.

Estimation Methods

We estimated the unadjusted means and proportions for the outcomes for each study group—treatment, C1, C2, and C3—calculated the difference between the groups, and applied the appropriate statistical tests to determine if the differences were significant. For continuous and binary outcomes, such as benefit amounts or elapsed days, we used a standard two-sample *t*-test (or proportion test) on the equality of means or proportions. Because of the exploratory nature of the study, we tested at the 10 percent significance level. (We did not use regressions or other means to adjust our estimates for observed characteristics. In future research, we may explore regression-adjusted, difference-in-differences, and propensity-score-based estimates.)

Data Sources

We combined administrative data from three SSA sources—the Structured Data Repository, the Supplemental Security Record, and the Numerical Identification System (Numident)—to answer our research questions. The Structured Data Repository, which includes demographic and programmatic information on SSI applications, was the primary data source for the study. Specifically, this source provided field office codes; alleged diagnosis descriptions; primary diagnosis codes selected by the DDS examiners or medical consultants; CE requests; application dates; appeals data, including decisions at each level of adjudication with corresponding dates; and field office and DDS case processing dates. The Supplemental Security Record provided us with information on current-pay statuses and total SSI payments in the first year after application. The Numident gave us information on deaths that occurred within the first 12 months after applicants had established their claims.

Characteristics of the Treatment and Comparison Groups

Table 2 presents selected demographic, geographic, and disability-related characteristics of the treatment group and three comparison groups. For our analyses, we combined the San Francisco Downtown and Santa Cruz field offices and surrounding area field offices into one Northern California location because of the smaller number of participants in those geographic areas.

Men made up the largest percentage of the treatment and comparison groups (71–76 percent) with no statistically significant differences between those groups. The distribution of ages at the time of application ranged primarily from age 18 to 59. Persons aged 30 to 49 accounted for more than half of all groups combined. At the time of their application, individuals who had applied at the same three treatment field offices in both the prior period (C1) and pilot period (C3) were slightly older, compared with those in the treatment group, with differences significant at the 5 percent and 10 percent levels.

Most of the cases in the treatment group originated in the Los Angeles Downtown field office (about

Table 2.
Selected characteristics of the HSPD pilot treatment and comparison groups (in percent)

Characteristic	Treatment group	Comparison group			Difference between the treatment group and—		
		C1	C2	C3	C1	C2	C3
Number of cases	238	1,038	676	857	. . .	. . .	. . .
Sex							
Men	71.0	74.8	76.3	74.6	-3.8	-5.3	-3.6
Women	29.0	25.2	23.7	25.4	3.8	5.3	3.6
Age							
18–29	22.7	17.2	25.1	18.2	5.4*	-2.5	4.5
30–39	26.9	20.5	22.8	22.1	6.4**	4.1	4.8
40–49	29.8	34.0	26.9	29.9	-4.2	2.9	0.0
50–59	19.7	25.4	22.8	26.3	-5.7*	-3.0	-6.5**
60 or older	0.8	2.8	2.4	3.6	-2.0*	-1.5	-2.8**
Filing location							
Northern California							
San Francisco Downtown field office	26.1	17.7	. . .	16.0	8.3***	26.1***	10.1***
Santa Cruz field office	9.2	3.0	. . .	3.6	6.3***	9.2***	5.6***
Los Angeles Downtown field office	64.7	79.3	. . .	80.4	-14.6***	64.7***	-15.7***
Northern California surrounding area [a]	. . .	. . .	42.3	. . .	. . .	. . .	. . .
Los Angeles surrounding area [b]	. . .	. . .	57.7	. . .	. . .	. . .	. . .
Disability							
Alleged "schizo"	96.6	77.3	75.7	77.4	19.4***	20.9***	19.3***
Schizo"phrenia"	42.4	52.3	65.8	53.9	-9.9***	-23.4***	-11.5***
Schizo"affective"	54.2	25.4	8.7	23.6	28.8***	45.5***	30.6***
Primary diagnosis, 2950: Schizophrenic, paranoid, and other psychotic disorders	95.0	67.0	56.5	62.7	28.0***	38.4***	32.3***

SOURCE: Authors' calculations using SSA administrative data.

NOTES: C1 = same field office, prior period; C2 = surrounding area field office, pilot period; C3 = same field office, pilot period.

. . . = not applicable.

* = statistically significant at the 10 percent level.

** = statistically significant at the 5 percent level.

*** = statistically significant at the 1 percent level.

a. Northern California surrounding area field offices (C2)—Berkeley, Campbell, East Oakland, Gilroy, Oakland Downtown, Salinas, San Francisco Mission, San Jose East, San Jose South, and Watsonville.

b. Los Angeles surrounding area field offices (C2)—Hollywood, University Village, and Wilshire Center.

65 percent), followed by San Francisco Downtown (26 percent), and Santa Cruz (9 percent). These three field offices also managed the cases in comparison groups C1 and C3: Los Angeles Downtown (79–80 percent), San Francisco Downtown (16–18 percent), and Santa Cruz (3–4 percent). We found the differences between the treatment group and comparison groups C1 and C3 statistically significant at the 1 percent level for these field offices. For the surrounding areas in comparison group C2, the percentage of cases from Northern California (42 percent) was slightly less than those from Los Angeles (58 percent), which reflects the manner in which we chose these field offices for the study.

As would be expected, nearly all cases in the treatment group indicated schizophrenia or schizoaffective disorder in the allegation text field (97 percent), and the majority of those cases had a primary diagnosis code of 2950 (95 percent), indicating schizophrenic, paranoid, and other psychotic disorders. We found some variations of schizoaffective (54 percent) in the allegation text field more often than we found

variations of schizophrenia (42 percent). A small share of the treatment group did not receive a PD payment based on having a primary diagnosis code of 2950 (5 percent). Those individuals had alternative diagnosis codes for disabilities, such as affective disorders, anxiety-related disorders, and substance addiction disorders (alcohol or drugs), although not all received an allowance under those categories (not shown).

A notably smaller percentage of comparison-group cases had an allegation of schizophrenia or schizoaffective disorder (around 77 percent) or a primary diagnosis code of 2950 (ranging from 57 to 67 percent) on which SSA made a disability determination. Differences between the treatment and comparison groups (each significant at the 1 percent level) suggested that under the normal process, an allegation of schizophrenia did not consistently result in a determination based on a diagnosis of schizophrenia. However, we did not examine secondary diagnoses and because schizophrenia may be difficult to document, we may simply have observed that the medical determinations relied on thorough diagnoses of schizophrenia or schizoaffective disorder for the treatment group, but comorbidities for the comparison groups. We also emphasize that this was not a randomized control trial so our comparison groups were subjected to selection bias.

Results for Research Questions

The HSPD evaluation design report identified 10 research questions. However, with the data available, we could not answer two questions concerning cost savings and reductions in homelessness. In this section, we provide the results for the remaining research questions, some of which are combined, and related findings.

The Intervention Led to a Significantly Higher Allowance Rate at the Initial Disability Adjudication Level

The allowance rate for the entire treatment group was 94 percent, ranging from 87 percent in Northern California to 97 percent in Los Angeles (Table 3). Overall, the treatment group saw a higher allowance rate at the initial-decision level than the three comparison groups, with differences of 28 percentage points (C1), 36 percentage points (C3), and 53 percentage points (C2). According to SSA's records, at the national level, 7 percent of PD findings in fiscal years 2012, 2013, and 2014 did not result in an eventual SSI payments allowance.[1] With a 95 percent ultimate allowance rate for the treatment group, the reversal-of-PD-finding rate for the pilot is in line with the national rate during the same period.

When we reviewed SSI awards at any level, the percentage of individuals in the HSPD pilot with an allowance increased slightly for the treatment group (less than 1 percentage point), rising a little more in comparison groups C3 (3 percentage points) and C2 (5 percentage points). Comparison group C1, which had a longer time for processing appeals, experienced the highest allowance-rate increase (8 percentage points). The difference in allowance rates between the treatment and C1 groups was 28 percentage points at the initial level, falling to 21 percentage points using the allowance rate at any level. We expect the difference to shrink over time, as all appeals are fully processed given the pattern we have observed during the 2-year follow-up period used for comparison group C1; however, we do not expect it to decline too much.

The Intervention Reduced Requests for CEs at the Initial Level of Application

The DDSs requested fewer CEs for cases in the treatment group (4 percent) than for any comparison group. The differential impact was largest when comparing the treatment group to comparison group C2 (31 percentage points). The treatment/comparison group differences remained strong across both regions and were statistically significant at the 1 percent level for nearly all comparisons. Additionally, we observed large differences in CE requests for the Northern California and Los Angeles regions, which were likely attributable to differences in either the intake processes (at the partner, field office, or DDS levels) or in the population characteristics.

The Intervention Reduced the Time Required to Adjudicate the Claim

For the treatment and comparison groups, we compared the processing time for three individual time segments: 1) the earliest filing date to the date the claim was established; 2) the date the claim was established to the date the field office released the case to the DDS; and 3) the date the field office released the case to the DDS to the initial decision. The pilot appeared to have a modest impact on the time between the earliest filing date to the date the claim was established. Compared with the C1 group, the pilot reduced that time by 7 days (from 27 to 20 days); however,

Table 3.
SSI allowance rates and consultative examinations for the HSPD pilot, by location (in percent)

Outcome and location	Treatment group	Comparison group			Difference between the treatment group and—		
		C1	C2	C3	C1	C2	C3
Number of cases	238	1,038	676	857	. . .	. . .	. . .
Allowed at initial-decision level	93.7	65.8	41.0	58.1	27.9***	52.7***	35.6***
Northern California [a]	86.9	60.9	43.0	45.8	26.0***	43.9***	41.1***
Los Angeles [b]	97.4	67.1	39.5	61.1	30.3***	57.9***	36.3***
Allowance at any level	94.5	73.7	46.3	61.1	20.8***	48.2***	33.4***
Northern California [a]	89.3	73.0	48.3	52.4	16.3***	41.0***	36.9***
Los Angeles [b]	97.4	73.9	44.9	63.3	23.5***	52.5***	34.1***
Consultative examinations requested	4.2	18.2	35.1	11.0	-14.0***	-30.9***	-6.8***
Northern California [a]	7.1	27.9	30.4	19.1	-20.8***	-23.3***	-11.9**
Los Angeles [b]	2.6	15.7	38.5	9.0	-13.1***	-35.9***	-6.4***

SOURCE: Authors' calculations using SSA administrative data.

NOTES: C1 = same field office, prior period; C2 = surrounding area field office, pilot period; C3 = same field office, pilot period.

. . . = not applicable.

* = statistically significant at the 10 percent level.

** = statistically significant at the 5 percent level.

*** = statistically significant at the 1 percent level.

a. Northern California—includes the combined Northern California (San Francisco Downtown and Santa Cruz) field office locations for the treatment group and comparison groups C1 and C3 and the surrounding area field office locations for C2 (Berkeley, Campbell, East Oakland, Gilroy, Oakland Downtown, Salinas, San Francisco Mission, San Jose East, San Jose South, and Watsonville).

b. Los Angeles—includes Los Angeles Downtown field office location for the treatment group and comparison groups C1 and C3 and the surrounding area field office locations for C2 (Hollywood, University Village, and Wilshire Center).

that difference was not significant when comparing the treatment group with the other comparison groups (Table 4).

The average number of days for the second segment—the date the claim was established to the date the field office released the case to the DDS—was only reduced by the pilot in Los Angeles. This was not completely unexpected as there should be little reason for the claim to remain at the field office once it had been established.

For the third segment—from the date the field office released the case to the DDS to the initial decision—the HSPD intervention reduced the processing time by 66 to 77 percent, to 30 days, on average. The processing time averaged 58 days in Northern California and 15 days in Los Angeles for the treatment group. All differences were statistically significant at the 1 percent level. It is important to note that the California DDS had a significant backlog of claims from 2010 to present, resulting in longer processing times for many cases. Treatment cases were not subject to the backlog, which may have led to larger differences in processing times between treatment and comparison group cases. By contrast, for the comparison groups, it took 86 days, on average, in the same field offices during the prior period (C1), compared with 107 days in the same field offices during the pilot period (C3) and 131 days in the surrounding field offices during the same period (C2).

In addition to these specific segments of the application process, we also looked at two combined time segments or overall time periods. We saw large, statistically significant reductions in the time between the date a claim was established and the individual's first SSI payment. For the treatment group, this averaged just 10 days. For the comparison groups, the average number of days for this measure was significantly higher: C1 (91 days), C2 (144 days), and C3 (106 days). Thus, the pilot reduced the time between the date the claim was established and the applicant's first SSI payment by 3 to 5 months. As would be expected, we find similar results when we look at the time between the

Table 4.
SSI case processing times for the HSPD pilot, by time segment and location

Time segment and location	Treatment group	Comparison group			Difference between the treatment group and—		
		C1	C2	C3	C1	C2	C3
				Individual time segments			
(1) Earliest filing to claim established							
Number of cases	235	1,000	671	839	. . .	. . .	. . .
Total days	20	27	19	35	-7**	1	-15
Northern California [a]	24	24	22	22	0	2	2
Los Angeles [b]	18	27	17	38	-10***	1	-21
(2) Claim established to field office release (to DDS)							
Number of cases	238	1,016	663	836	. . .	. . .	. . .
Total days	6	6	8	8	-1	-2	-3
Northern California [a]	11	4	9	8	7	2	3
Los Angeles [b]	2	6	7	8	-4**	-5***	-6**
(3) Field office release (to DDS) to initial decision							
Number of cases	236	1,014	651	815	. . .	. . .	. . .
Total days	30	86	131	107	-57***	-101***	-77***
Northern California [a]	58	117	132	124	-59***	-74***	-66***
Los Angeles [b]	15	79	130	103	-64***	-116***	-89***
				Combined time segments			
(1) Claim established to initial decision							
Number of cases	237	1,038	651	841	. . .	. . .	. . .
Total days	32	90	137	112	-58***	-105***	-80***
Northern California [a]	60	113	139	119	-53***	-79***	-60***
Los Angeles [b]	17	85	136	110	-68***	-119***	-93***
(2) Claim established to first SSI payment							
Number of cases	236	652	276	471	. . .	. . .	. . .
Total days	10	91	144	106	-81***	-134***	-96***
Northern California [a]	16	131	152	134	-115***	-136***	-118***
Los Angeles [b]	7	83	138	102	-76***	-131***	-94***

SOURCE: Authors' calculations using SSA administrative data.

NOTES: The sample sizes differ for each measure because of missing and inconsistent dates. Negative values for the individual time segments and the first combined time segment were set to missing. Negative values for the second combined time segment were set to zero because all of the payment dates are set to the first of the month. The second combined time segment has a significantly smaller sample size because of the smaller number of individuals actually receiving a payment.

C1 = same field office, prior period; C2 = surrounding area field office, pilot period; C3 = same field office, pilot period.

. . . = not applicable.

* = statistically significant at the 10 percent level.

** = statistically significant at the 5 percent level.

*** = statistically significant at the 1 percent level.

a. Northern California—includes the combined Northern California (San Francisco Downtown and Santa Cruz) field office locations for the treatment group and comparison groups C1 and C3 and the surrounding area field office locations for C2 (Berkeley, Campbell, East Oakland, Gilroy, Oakland Downtown, Salinas, San Francisco Mission, San Jose East, San Jose South, and Watsonville).

b. Los Angeles—includes Los Angeles Downtown field office location for the treatment group and comparison groups C1 and C3 and the surrounding area field office locations for C2 (Hollywood, University Village, and Wilshire Center).

date a claim was established and the initial disability decision, although these were somewhat smaller differences, as treatment members tended to receive their first SSI payment before their initial decision.

The Intervention Did Not Have a Significant Impact on the Rate of Appeals

We also wanted to examine whether the intervention would have an effect on the rate of appeals. The percentage of all initially denied cases appealed to the reconsideration level or higher in the comparison groups was between 45 and 50 percent, while the appeal rate in the treatment group was 64 percent; these differences are not statistically significant (Table 5). We caution that the appeal rate for the treatment group was based on only 14 denials at the initial level, whereas each comparison group had more than 300 denials at the initial level. Secondly, we might expect to see a higher appeal rate for the treatment group because the intervention was designed to select cases with a high likelihood of approval, and treatment group members were already connected to representative and advocate resources.

The Intervention Led to an Increased Likelihood of Being in Current-pay Status

To examine the impact of the intervention over time, we analyzed cases at two intervals—6 months and 12 months after the claims were established—to learn whether individuals were in current-pay status.[2] Individuals in current-pay status were due a payment contingent upon meeting the reporting requirements during the month.

At the 6-month mark, a larger share of the treatment group received an SSI payment (81 percent), compared with those in the comparison groups: C1 (44 percent); C3 (35 percent); and C2 (22 percent). (Table 6). These findings were statistically significant at the 1 percent level, with differences between the treatment and comparison groups ranging from 37 to 59 percentage points. We continued to find statistically significant (albeit somewhat smaller) differences at the 1-year mark. About 74 percent of the treatment group received an SSI payment at 12 months, with differences between the treatment and comparison groups ranging from 23 to 39 percentage points. The share of

Table 5.
SSI denials at the initial level and appeals to the reconsideration level or higher for the HSPD pilot, by location

Outcome and location	Treatment group	Comparison group			Difference between the treatment group and—		
		C1	C2	C3	C1	C2	C3
Number of cases	238	1,038	676	857	. . .	. . .	. . .
Number denied at the initial level	14	332	367	326	. . .	. . .	. . .
Northern California [a]	11	79	145	82	. . .	. . .	. . .
Los Angeles [b]	3	253	222	244	. . .	. . .	. . .
Appealed to reconsideration or higher (%)	64.3	50.0	46.9	44.8	14.3	17.4	19.5
Northern California [a]	72.7	49.4	45.5	50.0	23.4	27.2*	22.7
Los Angeles [b]	33.3	50.2	47.7	43.0	-16.9	-14.4	-9.7

SOURCE: Authors' calculations using SSA administrative data.

NOTES: C1 = same field office, prior period; C2 = surrounding area field office, pilot period; C3 = same field office, pilot period.

. . . = not applicable.

* = statistically significant at the 10 percent level.

** = statistically significant at the 5 percent level.

*** = statistically significant at the 1 percent level.

a. Northern California—includes the combined Northern California (San Francisco Downtown and Santa Cruz) field office locations for the treatment group and comparison groups C1 and C3 and the surrounding area field office locations for C2 (Berkeley, Campbell, East Oakland, Gilroy, Oakland Downtown, Salinas, San Francisco Mission, San Jose East, San Jose South, and Watsonville).

b. Los Angeles—includes Los Angeles Downtown field office location for the treatment group and comparison groups C1 and C3 and the surrounding area field office locations for C2 (Hollywood, University Village, and Wilshire Center).

Table 6.
SSI payments and current-pay status at the 6- and 12-month marks and mortality rates at the 12-month mark for the HSPD pilot, by location

Outcome and location	Treatment group	Comparison group			Difference between the treatment group and—		
		C1	C2	C3	C1	C2	C3
				At 6 months after claim established			
Number of cases	238	1,038	676	857	. . .	. . .	. . .
Received a payment (%)	81.1	43.8	21.7	35.1	37.3***	59.3***	46.0***
Northern California [a]	72.6	33.5	22.7	19.0	39.1***	49.9***	53.6***
Los Angeles [b]	85.7	46.5	21.0	39.0	39.2***	64.7***	46.7***
In current-pay status (%)	82.8	60.7	42.0	52.0	22.1***	40.8***	30.7***
Northern California [a]	78.6	58.1	42.3	41.1	20.4***	36.3***	37.5***
Los Angeles [b]	85.1	61.4	41.8	54.7	23.7***	43.3***	30.3***
Average cumulative payments ($)	3,743	1,659	738	1,375	2,084***	3,005***	2,368***
Northern California [a]	3,658	1,127	735	704	2,531***	2,923***	2,954***
Los Angeles [b]	3,789	1,798	740	1,539	1,991***	3,049***	2,250***
				At 12 months after claim established			
Number of cases	198	1,038	523	720	. . .	. . .	. . .
Received a payment (%)	74.2	51.0	35.0	47.2	23.3***	39.3***	27.0***
Northern California [a]	66.2	43.3	35.7	27.1	22.9***	30.5***	39.1***
Los Angeles [b]	78.5	53.0	34.5	51.8	25.5***	43.9***	26.7***
In current-pay status (%)	78.3	58.7	42.3	54.2	19.6***	36.0***	24.1***
Northern California [a]	73.5	57.7	42.3	39.9	15.9**	31.3***	33.7***
Los Angeles [b]	80.8	58.9	42.3	57.4	21.8***	38.5***	23.4***
Average cumulative payments ($)	6,776	3,906	2,512	3,660	2,870***	4,264***	3,116***
Northern California [a]	6,525	3,223	2,447	2,077	3,302***	4,078***	4,448***
Los Angeles [b]	6,908	4,084	2,556	4,019	2,823***	4,351***	2,889***
Death within 12 months (%)	0.0	0.8	0.8	1.3	-0.8	-0.8	-1.3
Northern California [a]	0.0	0.9	0.5	1.5	-0.9	-0.5	-1.5
Los Angeles [b]	0.0	0.7	1.0	1.2	-0.7	-1.0	-1.2

SOURCE: Authors' calculations using SSA administrative data.

NOTES: Average cumulative payments are summed at the individual level and then averaged.

C1 = same field office, prior period; C2 = surrounding area field office, pilot period; C3 = same field office, pilot period.

. . . = not applicable.

* = statistically significant at the 10 percent level.

** = statistically significant at the 5 percent level.

*** = statistically significant at the 1 percent level.

a. Northern California—includes the combined Northern California (San Francisco Downtown and Santa Cruz) field office locations for the treatment group and comparison groups C1 and C3 and the surrounding area field office locations for C2 (Berkeley, Campbell, East Oakland, Gilroy, Oakland Downtown, Salinas, San Francisco Mission, San Jose East, San Jose South, and Watsonville).

b. Los Angeles—includes Los Angeles Downtown field office location for the treatment group and comparison groups C1 and C3 and the surrounding area field office locations for C2 (Hollywood, University Village, and Wilshire Center).

the treatment group who received payments declined in the interval between the 6- and 12-month marks. For the comparison groups, the shares receiving payments rose during that interval.

For all groups, the percentage of individuals in current-pay status was higher than the percentage who actually received a payment. For this measure, the impact of the intervention follows the same trend with the treatment group having a much higher percentage in current-pay status. The differences were not quite as large, but were still statistically significant.[3]

It was also important to examine why a person who had received the PD payments and subsequent SSI payments would have moved into nonpay status at those same two intervals. The most common reasons were the recipient's income exceeded the allowable threshold; the recipient was placed in a "failed to cooperate" or "unable to locate" category; the recipient had become an inmate of a penal institution during that time; or his or her payment-status code was missing (Table 7).

When we looked at the most common reasons why some individuals fell into nonpay status at the 6-month mark, we noted several differences between the groups. About 67 percent of persons in the treatment group had income that exceeded federal and state SSI thresholds, compared with 21 to 43 percent in the comparison groups. By contrast, no one in the treatment group "failed to cooperate" or was "unable to locate," compared with 12 to 29 percent of the comparison groups. The percentage of individuals who were inmates of a penal institution was higher in the treatment group than in the comparison groups in the Los Angeles subset, but not in the Northern California subset. However, the differences for the last reason—payment-status missing—were less consistent and not statistically significant across most group comparisons. The impacts for the most common reasons for nonpay status at the 12-month mark were similar, but generally smaller and less significant.

Table 7.
Selected reasons for nonpay status for the HSPD pilot at the 6- and 12-month marks, by location (in percent)

Reason and location	Treatment group	Comparison group			Difference between the treatment group and—		
		C1	C2	C3	C1	C2	C3
		At 6 months after claim established					
Number of cases	238	1,038	676	857	. . .	. . .	. . .
Number in nonpay status	33	139	42	82	. . .	. . .	. . .
Northern California [a]	13	31	22	22	. . .	. . .	. . .
Los Angeles [b]	20	108	20	60	. . .	. . .	. . .
Income exceeds federal and state SSI threshold	66.7	38.8	21.4	42.7	27.8***	45.2***	24.0**
Northern California [a]	84.6	29.0	18.2	27.3	55.6***	66.4***	57.3***
Los Angeles [b]	55.0	41.7	25.0	48.3	13.3	30.0*	6.7
Failure to cooperate on development of claim, or unable to locate	0.0	11.5	28.6	13.4	-11.5**	-28.6***	-13.4**
Northern California [a]	0.0	16.1	27.3	22.7	-16.1	-27.3**	-22.7*
Los Angeles [b]	0.0	10.2	30.0	10.0	-10.2	-30.0***	-10.0
Inmate of a penal institution	18.2	19.4	7.1	14.6	-1.2	11.0	3.5
Northern California [a]	7.7	19.4	9.1	18.2	-11.7	-1.4	-10.5
Los Angeles [b]	25.0	19.4	5.0	13.3	5.6	20.0*	11.7
Payment-status missing	3.0	20.1	21.4	14.6	-17.1**	-18.4**	-11.6*
Northern California [a]	0.0	25.8	27.3	18.2	-25.8**	-27.3**	-18.2
Los Angeles [b]	5.0	18.5	15.0	13.3	-13.5	-10.0	-8.3

(Continued)

Table 7.
Selected reasons for nonpay status for the HSPD pilot at the 6- and 12-month marks, by location (in percent)—*Continued*

Reason and location	Treatment group	Comparison group			Difference between the treatment group and—		
		C1	C2	C3	C1	C2	C3
				At 12 months after claim established			
Number of cases	198	1,038	523	720	. . .	. . .	. . .
Number in nonpay status	39	167	46	93	. . .	. . .	. . .
Northern California [a]	15	34	23	22	. . .	. . .	. . .
Los Angeles [b]	24	133	23	71	. . .	. . .	. . .
Income exceeds federal and state SSI threshold	59.0	35.3	32.6	44.1	23.6***	26.4**	14.9
Northern California [a]	73.3	23.5	26.1	36.4	49.8***	47.2***	37.0**
Los Angeles [b]	50.0	38.3	39.1	46.5	11.7	10.9	3.5
Failure to cooperate on development of claim, or unable to locate	2.6	10.2	15.2	11.8	-7.6	-12.7**	-9.3*
Northern California [a]	6.7	17.6	17.4	18.2	-11.0	-10.7	-11.5
Los Angeles [b]	0.0	8.3	13.0	9.9	-8.3	-13.0*	-9.9
Inmate of a penal institution	23.1	21.0	15.2	17.2	2.1	7.9	5.9
Northern California [a]	6.7	14.7	17.4	9.1	-8.0	-10.7	-2.4
Los Angeles [b]	33.3	22.6	13.0	19.7	10.8	20.3	13.6
Payment-status missing	7.7	24.6	17.4	17.2	-16.9**	-9.7	-9.5
Northern California [a]	6.7	38.2	21.7	27.3	-31.6**	-15.1	-20.6
Los Angeles [b]	8.3	21.1	13.0	14.1	-12.7	-4.7	-5.8

SOURCE: Authors' calculations using SSA administrative data.

NOTES: The list of reasons for nonpay status included in this table is not exhaustive, so the percentages may not sum to 100. Individuals may be in nonpay status for reasons not listed here.

C1 = same field office, prior period; C2 = surrounding area field office, pilot period; C3 = same field office, pilot period.

. . . = not applicable.

* = statistically significant at the 10 percent level.

** = statistically significant at the 5 percent level.

*** = statistically significant at the 1 percent level.

a. Northern California—includes the combined Northern California (San Francisco Downtown and Santa Cruz) field office locations for the treatment group and comparison groups C1 and C3 and the surrounding area field office locations for C2 (Berkeley, Campbell, East Oakland, Gilroy, Oakland Downtown, Salinas, San Francisco Mission, San Jose East, San Jose South, and Watsonville).

b. Los Angeles—includes Los Angeles Downtown field office location for the treatment group and comparison groups C1 and C3 and the surrounding area field office locations for C2 (Hollywood, University Village, and Wilshire Center).

The Intervention Resulted in Larger Cumulative Payments for the Treatment Group

We found large, statistically significant (at the 1 percent level) differences between the cumulative payments received by the treatment and comparison groups at the 6- and 12-month marks (Table 6). After 6 months, average SSI payments for the treatment group totaled about $3,700, which was $2,000 to $3,000 more than the $700 to $1,700 received by the comparison groups. Average cumulative payments for the treatment group were similar between the two regions (Northern California and Los Angeles); however, we saw a large difference between the two regions in average cumulative payments for comparison group C3—individuals who had applied in the same field offices during the same period. Cumulative payments for the C3 group averaged $704 for recipients in the San Francisco Downtown and the Santa Cruz locations and $1,539 for those in the Los Angeles Downtown location, leading to a smaller relative

impact for the Los Angeles region. We expect differences between the treatment and comparison groups to lessen as more comparison group cases receive allowances during the appeals process and eventually receive back payments.

The Intervention Did Not Appear to Have a Strong Effect on Mortality

There were no deaths in the treatment group and a very small percentage of individuals in the comparison groups died within 12 months of establishing their claims with SSA. The average mortality rate during that period was less than 1 percent for comparison groups C1 and C2 and just over 1 percent for comparison group C3 (Table 6).

HSPD Case Reviews

SSA's Office of Quality Review (OQR) reviewed almost all (223 of the first 225) treatment cases in the pilot. Of the 215 cases allowed (96 percent), OQR cited deficiencies in 48 percent of the cases, determining that three cases had been incorrectly allowed. Of the eight denied cases, OQR cited four as deficient, with two incorrect denials. The most common deficiency cited was that the cases relied on one piece of medical evidence for establishing disability, which OQR suggested was insufficient for a determination. However, this suggestion does not imply that the DDS made an incorrect determination on these cases.

In response to OQR's review, SSA's San Francisco Center for Disability (SFCD) reviewed 54 of the 108 cases that OQR cited with deficiencies. SFCD concurred with OQR for 33 cases (61 percent), acknowledging the potential for quality issues in the adjudication of those cases and noting the variation in deficiency rate by community partner. SFCD suggested that one piece of medical evidence may be sufficient to adjudicate a claim and that OQR may not have fairly weighed the evidence from third parties, such as case managers, which can be important for the population in this study.

Discussion

Overall, the HSPD pilot appears to have been successful. The group that received the PD payments was more likely to have received an initial allowance and less likely to have required a CE than were the comparison groups. They also received their decisions and first SSI payments sooner than did the comparison groups, along with higher cumulative payment amounts in the 12 months after establishing a claim. We were not able to observe other important outcomes, such as decreased homelessness, that the pilot was intended to address.

Although the pilot was generally successful, its scalability to the national level is unclear. The community partners who developed the cases had experience working with individuals who were homeless or had mental impairments, largely because of the high volume of similar cases in the target areas and prior involvement with SSA outreach efforts. Although many other locales have similar public-health agencies performing similar functions, it is uncertain how the services provided in the pilot will transfer to other settings.

Our community partners, particularly in Northern California, were somewhat conservative in their diagnoses, signing off on the PD form shown in Appendix C only after careful review to ensure that there was sufficient medical evidence (and the absence of drug abuse or alcoholism), consistent with SSA's medical listings. However, even with experienced partners making careful diagnoses, SSA's OQR reported issues with insufficient medical evidence for many cases.

The requirements for the PD finding followed SSA's medical listings for schizophrenia or schizoaffective disorder. As such, it required the applicant to have medically documented evidence of certain persistent symptoms resulting in increased restrictions or difficulty with specific functions or a history of a chronic schizophrenic, paranoid, or other psychotic disorder. It is unclear whether gathering such information for homeless individuals suffering from schizophrenia or schizoaffective disorder is generally feasible or cost effective, regardless of the legal requirement. One alternative to PD payments may be to require a shorter longitudinal medical history for homeless individuals alleging schizophrenia or schizoaffective disorder and to have SSA conduct a continuing disability review after 2 years that waives the medical improvement review standard. SSA could potentially combine such a policy with two existing fast-track programs—Quick Disability Determination and Compassionate Allowance—to expedite homeless cases. Changing the medical improvement review standard and required longitudinal history would likely require a statutory change. Because this study focused only on a small population of homeless individuals alleging schizophrenia or schizoaffective disorder, the appropriateness of such a policy change for the SSI program as

a whole is unclear. However, regardless of the policy implemented, it may be helpful for all disability adjudicators to receive additional training on the evidentiary requirements for claims with no longitudinal treatment history of a mental impairment or diagnosis, as suggested by SSA's San Francisco Regional Office.

We note that other locales have tested similar interventions. For example, in 1993, SSA initiated the Maryland SSI Outreach Project in the city of Baltimore, which also successfully awarded PD payments to homeless individuals meeting certain impairment criteria. Some of the recommendations from that project continue to be appropriate. For example, as the HSPD pilot demonstrated, replicating similar outreach projects would require SSA to work closely with organizations that are capable of both diagnosing and supporting homeless individuals with mental impairments (National Alliance to End Homelessness 2015).

The SSI/Social Security Disability Insurance (SSDI) Outreach, Access and Recovery (SOAR) project funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2001 aimed to increase access to federal disability benefits for adults who are homeless or at risk of being homeless and have a mental illness, medical impairment, and/or a co-occurring substance abuse disorder. SOAR programs have helped increase the award rate and reduce the time from application to decision for this vulnerable population. SAMHSA continues to fund the SOAR Technical Assistance Center, which facilitates state- and local-based SOAR programs (SAMHSA, n.d.). Based on experiences from the SOAR projects, the authors of a National Academy of Social Insurance (NASI) report suggested three policy changes: 1) expanding the list of acceptable medical sources for DDS examiners, 2) allowing individuals who have been homeless for at least 6 months and who have schizophrenia to qualify for PD payments, and 3) modifying SSA's processes to address the needs of homeless adults (Perret, Dennis, and Lassiter 2008). The authors also recommended that SSA improve its tracking of residential statuses and assign homeless cases to field office and DDS staff who have received additional training in working with this population.

As we noted earlier, detailed and longitudinal medical evidence often does not exist for the homeless population, whose records are sporadic or difficult to obtain. The authors of the NASI report suggest that professionals, such as licensed social workers, certified nurse practitioners, or certified physician assistants, should be able to provide evidence that is weighed as heavily as other evidence provided by physicians and psychologists. These individuals are often more likely to provide treatment for this population, making them better at providing the necessary information.

Although we did not conduct a formal cost-benefit analysis, the PD recommendation reduced the time spent by SSA to develop a case, and fewer CEs also clearly reduced costs for the agency. One study suggests that a CE for mental health impairments costs over $235 (Wittenburg and others 2012). However, the exams and tests required for a CE can vary and the costs in California in particular may differ from this average. The HSPD pilot demonstrated that the number of CEs requested for the treatment group was 14 percentage points less than the number requested for comparison group C1. A back-of-the-envelope calculation suggests that in the absence of the pilot, SSA would have requested an additional 33 CEs for the treatment group, which translates to a potential savings of about $7,755. This, combined with the higher initial allowance rate and reduced number of appeals for the treatment group, indicates that other administrative savings were likely as well. SSA incurred few administrative costs for the PD payments other than the fixed cost of setting up the process. We did not consider one-time cost items, such as staff training. SSI payments to individuals did not provide a cost in this setting because it is SSA's mission to administer such payments.

The results presented in this study are from a quasi-experimental design and are not causal in nature. The demographic characteristics presented in Table 2 suggest the treatment group is somewhat different from the comparison groups. In future work, policy analysts could use more rigorous statistical techniques that would control for these differences and provide estimates that are more robust than those presented here.

Finally, we note that many individuals in the treatment group also filed an application in the prior period, and those applications were initially included in the comparison groups. To avoid double counting these treatment group members, we removed their prior applications from the comparison groups. As noted in the report on the Maryland SSI Outreach Project, helping qualified individuals to receive SSI payments the first time they apply is likely more cost effective than granting an award after the second or third application.

Appendix A: Identification of Homeless Individuals

A crucial step to developing comparison groups for the HSPD pilot evaluation was identifying individuals who were potentially homeless during the period of interest. The community partners identified the individuals in the treatment groups as homeless (a criterion for participating in the pilot). For uniformity, we used the same selection process for both the treatment and comparison groups in our analyses. This inevitably meant removing some treatment group members from the analysis who did not have a clear indication of homelessness in SSA's administrative data. The five selection criteria for identifying homelessness follow:

1. Homeless flag on the SSI application.
2. A residence type of "transient" listed as the most recent residence type, with a start date on or before the date that the SSI claim was established in SSA's records. The five transient data files from 2010 to 2014 came from SSA's Office of Systems.
3. Residential address field contained a word or phrase from Keyword Set A1 or Keyword Set A2.
4. Residential address field contained the name of an emergency shelter from the Department of Housing and Urban Development's (HUD's) list of emergency shelters in California. Organization names and program names were pulled from HUD's list, a few abbreviations were removed (ERT and STAR), and shelter names were shortened, for example, MSC-South Shelter was shortened to MSC.
5. Remarks section in the Field Office Disability Report (SSA Form 3367) or Disability Report—Adult (SSA Form 3368) contained a word from Keyword Set A1.

Keyword Set A1 ***(9 elements)***

HOMELESS	HOMELSS	HOMLES	SHELTER	TRANSCIENT
HOMELES	HOMLESS	HOME LESS	TRANSIENT	

Keyword Set A2 ***(32 elements)***

CAR	FRIEND	522 S SAN PEDRO (JWCH)
TRUCK	NEIGHBOR	2707 S GRAND (DPSS)
IN VAN	SOFA	1122 N VINE (SSA office)
BUS	COUCH SURF	GENERAL DELIVERY
TRAIN	YMCA	3804 S BROADWAY (New Image Emer.Shelt.)
UNDER A BRIDGE	YWCA	3126 SHATTUCK (Homeless Action Center)
UNDER THE BRIDGE	DOUBLED UP	890 HAYES ST (Walden House)
ON THE STREET	SALVATION ARMY	815 BUENA VISTA WEST (Walden House)
IN THE STREET	UNITED WAY	
STREETS OF	CATHOLIC CHARITIES	
CAMPING	FIELD OFFICE	
TENT	SSA	

NOTE: CAR, BUS, TRAIN, and SSA all have leading and trailing blank spaces.

Department of Housing and Urban Development's California Emergency Shelter List ***(241 elements)***

Alpha Center
Angel Step Inn
Angel's Flight
Antelope Valley Domestic
Asian Women's
Assistance for Homeless Families
Beacon Light Mission
Bell Shelter
Bethel AME Church
Beyond Shelter
Bridge to Home
Cal Works
California Hispanic Commission On Alcohol
Calworks Family Voucher
Casa Libre
Catholic Charities
Center for Homeless Women
Center for Human Rights and Constitutional Law
Center for the Pacific Asian Family
Central City Hospitality
Chicana Service Action
Children of the Night
CHP
Chronically Homeless Program
Cold Weather Shelter
Community Action Board
Compass Community Services
Compass Family
Compton Welfare Rights Organization
Comunidad Cesar Chavez
Continuum HIV Day Services
Covenant House
CPAF
Crisis Shelter
Crossroads
Crossroad's
Daybreak
Defensa de Mujeres
Demontfort House
Department of Public Health
Dept. of Public Health
Diamond Youth
Dolores House
Dolores Street
Domestic Violence
Doors of Hope
Downtown Mental Health
DPH
DPSS
East L.A. Bilingual
East San Gabriel Valley Coalition
Emergency Housing
Emergency Overnight
Emergency Per Diem
Emergency Shelter
Emergency Youth Shelter
Emmanuel Baptist Mission
Episcopal Community Services
Essence of Light
Family Crisis
Family Shelter
Family Transitions
First Presbyterian Church
First To Serve
Footsteps
Free Spirit
Freedom House
Fresh Start
Fresh Start Ministries
Friends Research
Front Street
General Relief
Good Shepherd Center
Gospel Missions of America
Gower Youth
GR Homeless Assistance
Grace Resource
Hamilton Family
Harbor Interfaith
Harm Reduction
Haven Hills
HCFP
HCHV
Home At Last
Homeless Services
Hope Harbor
HOPWA
Hospitality House
House of Ruth
Huckleberry House
Inglewood Winter Shelter
Inland Valley Council
Integrated Recovery
James M. Wood Site
Jenesse Center
Jesus Mary and Joseph
Jovenes
Jump Start
JWCH
La Casa de las Madres
LA County Department
LA Family Housing
LA Gay & Lesbian Community
LA Homeless Services
LA House of Ruth
LA Mission
La Posada
LA Youth Network
LAHSA
LAMP Community
LAMP Village
Lancaster Community
Languille
Lark Inn for Youth
Larkin Street Youth
Los Angeles County
Los Angeles Family Housing

Continued

Department of Housing and Urban Development's California Emergency Shelter List—*Continued*

Los Angeles Gay & Lesbian Community
Los Angeles Homeless Services
Los Angeles House of Ruth
Los Angeles Mission
Los Angeles Youth Network
Lutheran Social Services
Main Street Emergency
Men's Emergency Shelter
Men's Guest Services
Mental Health Per Diem
Metropolitan
Midnight Mission
MJB
MSC
New City Emergency
New Directions
New Image
New Life
Next Door
NLCS
Ocean Park Community Center
OPCC
Our House Shelter
Our Saviour Center
Overnight Beds for Men
Paget Center
Pajaro Valley Shelter
Panama CDBG
Panama Hotel YRP
PATH
PATH Westside
Paul Lee Loft
People Assisting the Homeless
People in Progress
Peregrinos De Emaus
Pomona Neighborhood
Project Re-Connect
Providence Foundation
Providence Shelter
Proyecto Pastoral
Rainbow House
Rainbow Services
Raphael House
Rebele Family
Recovery From Homelessness
Recuperative Care-Bell Shelter
Restoration House
River Street Shelter
Rosalie House
Safe House
Salvation Army
Samoshel
San Fernando Valley Rescue
San Francisco Interfaith Council
Sanctuary
Santa Cruz Comm
Satellite Housing Center
Shelter Resident Services
short term lodging
Short-Term Lodging
Sienna House
Single Room Occupancy
Single Women Guest Services
Sojourn Services
South Bay Alcoholism
South Los Angeles Winter
Southern CA Alcohol
Southern California Alcohol
Special Service For Groups
St. Joseph
St. Vincent de Paul
St. Vincent's Cardinal
Stabilization Units
Su Casa
Swords to Plowshares
Taft House
Temporary Emergency Shelter
Tenderloin Health
Testimonial Community Love
The Bible Tabernacle
The Restoration Foundation
TSP Motel Vouchers
Union Rescue Mission
Upward Bound
Valley Oasis
VOA Rotary House
Volunteers of America
Walden House
Watts Labor Community Action Committee
Westside Access
Whittier Area First Day
Whittier Area Interfaith Council
WINGS
Winter Shelter Program
Women & Children's Crisis
Women and Children
Women and Children's Crisis
Women in Need Growing Strong
Women's and Children
Women's Emergency
Year Round Program
Year Round Shelter
YWCA
Zahn Emer

NOTE: The emergency shelters names were all capitalized in the search process, similar to the keyword lists.

Appendix B: Identification of Schizophrenia and Schizoaffective Disorder

The evaluation of the HSPD pilot required identifying SSI applicants who allegedly had, or had been diagnosed with, schizophrenia or schizoaffective disorder. We apply this same identification process to the treatment group for consistency. To be included in the evaluation, each case must have met at least one of the following criteria:

1. *Allegation description of schizophrenia or schizoaffective disorder*

   We mined the allegation text field for root words and various misspellings of "schizo" found in Keyword Set B1 (below). From this list, we searched again for root words more specific to "schizophrenia" and "schizoaffective" found in Keyword Set B2 and Keyword Set B3 to differentiate these two categories. The second search picked up one invalid observation, which we removed. Lastly, we used a "sounds like" function to search the text field for "schizophrenia" and "schizoaffective," to catch any additional common misspellings. This last procedure did not find any additional observations.

2. *Primary diagnosis code: 2950*

   We flagged any observations with a "2950" primary diagnosis code as a potential indicator of schizophrenia or schizoaffective disorder. The "2950" impairment code covers the Mental Disorder listing 112.03: Schizophrenic, Paranoid, and Other Psychotic Disorders. We included any individuals who received a denial based on this code, in addition to those who were approved, to capture as many individuals as possible who may have schizophrenia or schizoaffective disorder.

Keyword Set B1 ***(153 elements)***

SCHIZO	SCHIFO	SCHRIP	SCHZRO	SCZO
SCCHIZ	SCHIGO	SCHRIZ	SCHZYSO	SEHIZ
SCGZIO	SCHILO	SCHRIZO	SCICO	SHCIO
SCHCIZ	SCHINO	SCHRO	SCISO	SHCIZ
SCHEDSO	SCHIO	SCHROP	SCITO	SHCIZO
SCHEDZO	SCHIOZO	SCHRZ	SCITSZER	SHHIZ
SCHEIZ	SCHIP	SCHRZO	SCITZO	SHIZO
SCHENR	SCHIRO	SCHSO	SCIXO	SHRIZ
SCHENZ	SCHISO	SCHTIZ	SCIZ	SKHIZ
SCHENZO	SCHITS	SCHTZ	SCIZO	SKISO
SCHEO	SCHITZ	SCHY	SCIZSO	SKITI
SCHETS	SCHIX	SCHYCO	SCJIOZ	SKITO
SCHETZ	SCHIZ	SCHYDZO	SCKYSO	SKITS
SCHEZ	SCHIZA	SCHYSO	SCYO	SKITT
SCHEZA	SCHIZE	SCHYTS	SCYTZA	SKITZ
SCHEZE	SCHIZH	SCHYTSO	SCYZ	SKIZ
SCHEZI	SCHNIO	SCHYTZ	SCYZO	SKYS
SCHEZO	SCHNIZ	SCHYZ	SCZ	SKYTZ
SCHHIZ	SCHNOZ	SCHYZO	SCZE	SQIZO
SCHI	SCHOZ	SCHZ	SCZH	SSCHIO
SCHICHO	SCHOZO	SCHZE	SCZHIO	SSCHIZO
SCHICO	SCHRE	SCHZIO	SCZHO	SSHIZ
SCHICZO	SCHREN	SCHZIT	SCZI	SXHIZ
SCHIDZO	SCHREZ	SCHZIZ	SCZIO	SZCHI
SCHIEZO	SCHRIOZ	SCHZO	SCZIZ	SZCHIO

Continued

Keyword Set B1—*Continued*			
SZCHOZ	SZIO	SDCHIZ	PSYCHITZO
SZCHSO	SZIS	PSYCHOPHERN	PSYCHITSO
SZCIO	SZITSO	PSYCHOPHREN	PHYCHOPHRENIA
SZCO	SZIZH	PSYCHROPHREN	CHIZOPHRENIA
SZHIO	SZO	SKETSAPHRENK	ESQUISOFRENIA
SZHIZ	SZYO	SISOPHRENIA	SCHOPHRENIC
SZHO	SQUIZO	PSYZOPHREN	SCKITZOEFFECTIVE

Keyword Set B2			***(16 elements)***
PHREN	PHEN	PRENIC	PHREHIA
FREN	PHRAN	PREHIA	PRANIA
PHERN	PRHEN	PHRREN	PHRONIA
FERN	PRENIA	PHEREN	PHINEA

Keyword Set B3				***(25 elements)***
ZOAFFE	ZOEFFE	SOAFFE	SOEFFE	ZAFFE
ZOAFE	ZOEFE	SOAFE	SOEFE	ZAFE
ZO AFFE	ZO EFFE	SO AFFE	SO EFFE	ZEFFE
ZO-AFFE	ZO-EFFE	SO-AFFE	SO-EFFE	ZEFE
ZO-AFE	ZO-EFE	SO-AFE	SO-EFE	OAFECTIVE

Social Security Administration

Form Approved
OMB No. 0960-0793

Schizophrenia Presumptive Disability Recommendation Form

The claimant named below has filed for a period of disability and/or disability payments due to schizophrenia or schizoaffective disorder. If you complete this form, the claimant may be able to receive early payments. (This is not a request for an examination, but for existing medical information.)

Medical Release Information

☐ **Form SSA-827, "Authorization to Release Medical Information to the Social Security Administration," is attached.**

☐ **I hereby authorize the medical source named below to release or disclose to the Social Security Administration or State agency any medical records or other information regarding my treatment for mental health/chemical dependency.**

Claimant Signature (Required only if Form SSA-827 is NOT attached)	**Date**

Claimant Information

Name (Please Print)	**Claimant's SSN**	**Phone Number**
Address	**Date of Birth**	**Medical Source's Name**

For Presumptive Disability, the claimant's condition must meet the criteria noted in Section 1 or Section 2. Please check all applicable boxes.

Section 1 (Must meet criteria in Group A and Group B)

Group A

Medically documented persistence, either continuous or intermittent, of <u>one</u> or more of the following:

☐ Delusions or hallucinations

☐ Catatonic or other grossly disorganized behavior

☐ Incoherence, loosening of associations, illogical thinking, or poverty of content of speech if associated with one of the following:
- a. Blunt affect
- b. Flat affect
- c. Inappropriate affect

☐ Emotional withdrawal and/or isolation

Group B

Resulting in at least <u>two</u> of the following:

☐ Marked restriction of activities of daily living

☐ Marked difficulties in maintaining social functioning

☐ Marked difficulties in maintaining concentration, persistence, or pace

☐ Repeated episodes of decompensation, each of extended duration

Section 2

Medically documented history of a chronic schizophrenic, paranoid, or other psychotic disorder of at least 2 years duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and <u>one</u> of the following:

☐ Repeated episodes of decompensation, each of extended duration; or

☐ A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or

☐ Current history of 1 or more years inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

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Remarks: (Please use this space if you lack sufficient room in the above sections or to provide additional information that you believe would support a presumptive disability finding).

Diagnostic Certification (Required)

☐ **The claimant is *capable* of managing benefits.** ☐ **The claimant is *incapable* of managing benefits.**

☐ **The disturbance is *not* due to the direct physiological effects of substance use or a general medical condition, or due to a psychiatric condition other than *schizophrenia* or *schizoaffective disorder*. Supporting medical evidence will be forwarded to the disability adjudicative component.**

☐ **I declare under penalty of perjury that I have examined all the information on this form, and any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.**

Physician or Licensed Psychologist Name (Please Print)	**License Number**
Address	**Phone Number**
Signature	**Date**

Please provide all evidence necessary (i.e., medical records, psychiatric evaluation reports, list of prescribed psychotropic medication, and so forth) to support a diagnosis of schizophrenia or schizoaffective disorder.

Field Office Use Only

Meets Presumptive Disability Criteria: ☐ **YES** ☐ **NO** **Field Office Unit:**

SPECIAL TERMS USED IN THE FORM

WHAT WE MEAN BY "MARKED"

Where we use "marked" as a standard for measuring the degree of limitation, it means more than moderate but less than extreme. A marked limitation may arise when several activities or functions are impaired, or even when only one is impaired, as long as the degree of limitation is such as to interfere seriously with the individual's ability to function independently, appropriately, effectively, and on a sustained basis.

WHAT WE MEAN BY "ACTIVITIES OF DAILY LIVING"

"Activities of daily living" include adaptive activities such as cleaning, shopping, cooking, taking public transportation, paying bills, maintaining a residence, caring appropriately for your grooming and hygiene, using telephones and directories, and using a post office. In the context of an overall situation, we assess the quality of these activities by their independence, appropriateness, effectiveness, and sustainability. We will determine the extent to which the individual is capable of initiating and participating in activities independent of supervision or direction.

WHAT WE MEAN BY "SOCIAL FUNCTIONING"

"Social functioning" refers to the capacity to interact independently, appropriately, effectively, and on a sustained basis with other individuals. Social functioning includes the ability to get along with others, such as family members, friends, neighbors, grocery clerks, landlords, or bus drivers. The individual may demonstrate impaired social functioning by, for example, a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, or social isolation. The individual may exhibit strength in social functioning by such things as his or her ability to initiate social contacts with others, communicate clearly with others, or interact and actively participate in group activities. We also need to consider cooperative behaviors, consideration for others, awareness of others' feelings, and social maturity. Social functioning in work situations may involve interactions with the public, responding appropriately to persons in authority (e.g., supervisors), or cooperative behaviors involving coworkers.

WHAT WE MEAN BY "CONCENTRATION, PERSISTENCE, OR PACE"

"Concentration, persistence, or pace" refers to the ability to sustain focused attention and concentration sufficiently long to permit the timely and appropriate completion of tasks commonly found in work settings. Limitations in concentration, persistence, or pace are best observed in work settings, but may also be reflected by limitations in other settings. In addition, major limitations in this area can often be assessed through clinical examination or psychological testing. Wherever possible, however, a mental status examination or psychological test data should be supplemented by other available evidence.

WHAT WE MEAN BY "REPEATED EPISODES OF DECOMPENSATION"

"Episodes of decompensation" are exacerbations or temporary increases in symptoms or signs accompanied by a loss of adaptive functioning, as manifested by difficulties in performing activities of daily living, maintaining social relationships, or maintaining concentration, persistence, or pace. Episodes of decompensation may be demonstrated by an exacerbation in symptoms or signs that would ordinarily require increased treatment or a less stressful situation (or a combination of the two). Episodes of decompensation may be inferred from medical records showing significant alteration in medication; or documentation of the need for a more structured psychological support system (e.g., hospitalizations, placement in a halfway house, or a highly structured and directing household); or other relevant information in the record about the existence, severity, and duration of the episode.

The term "repeated episodes of decompensation, each of extended duration" means three episodes within 1 year, or an average of once every 4 months, each lasting for at least 2 weeks. If the individual experiences more frequent episodes of shorter duration or less frequent episodes of longer duration, we use judgment to determine if the duration and functional effects of the episodes are of equal severity.

WHAT WE MEAN BY "BASIC WORK ACTIVITIES"

"Basic work activities" are the abilities and aptitudes necessary to do most jobs. Examples include: (1) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (2) capacities for seeing, hearing, and speaking; (3) understanding, carrying out, and remembering simple instructions; (4) use of judgment; (5) responding appropriately to supervision, coworkers, and usual work situations; and (6) dealing with changes in a routine work setting.

WHAT WE MEAN BY "MINIMAL LIMITATION OF ABILITY TO DO BASIC WORK ACTIVITIES"

A limitation is minimal if the impairment (or combination of impairments) has such a minimal effect on the individual that it would not be expected to interfere significantly with the individual's ability to do basic work activities.

Privacy Act Statement
Collection and Use of Personal Information

Section 1110(b)(1) [42 U.S.C. § 1310(b)(1)] and 1631(a)(4)(B) [42 U.S.C. § 1383(a)(4)(B)] of the Social Security Act and 20 C.F.R. 416.933 authorize us to collect this information. We will use the information you provide to make a determination on your disability claim.

The information you furnish on this form is voluntary. However, failure to provide the requested information could prevent an accurate or timely decision on your disability claim or on the named individual's disability claim.

We rarely use the information you provide on this consent form for any purpose other than for the reasons explained above. We also may disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To a congressional office in response to an inquiry from that office made at the request of the subject of a record;

2. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;

3. To comply with Federal laws requiring the release of information from Social Security records to other agencies (e.g., to the Government Accountability Office, General Services Administration, National Archives Records Administration, and the Department of Veterans Affairs); and

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the U.S. Census Bureau and to private entities under contract with us).

A complete list of routine uses for this information is available in our System of Records Notice entitled, Disability Insurance and Supplemental Security Income Demonstration Projects and Experiments System, 60-0218. This notice, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at any Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. The OMB control number for this collection is 0960-0793. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

Notes

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[1] Available internally at SSA only at http://pmr.ssahost.ba.ssa.gov/rpt_SplashMsg.aspx.

[2] We removed individuals without the 12-month follow-up period for the 12-month measures. This restriction removed about 20 percent of the treatment group and C2 and C3 groups for these measures. All individuals had 6 months of follow-up services at the time of analysis.

[3] We hypothesized that the higher percentage of individuals in current-pay status, but who were not receiving a payment, was due to retroactively updating the payment status codes.

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