Social Security and Supplemental Security Income

Adapted from Excerpts of the Texas Poverty Law Handbook

The Differences between Social Security and SSI

Social Security is an insurance program. A worker ("wage earner") pays premiums for Social Security insurance through withholdings from paychecks. The insurance protects the wage earner against the loss of earning ability from death, retirement, or disability. If the wage earner dies, retires or becomes disabled (unable to work for one year), the wage earner and/or family may be eligible for monthly benefits. Unlike private insurance, Social Security coverage does not begin with the payment of the first premium. It begins after the wage earner has contributed for several years. Likewise, the coverage does not end as soon as the wage earner stops contributing (stops working), but coverage continues for several years thereafter.

Supplemental Security Income (SSI) is a welfare, means-tested program. It provides a minimum income to people who are both sufficiently poor and either disabled or age 65 or older. To determine if a claimant is poor enough, the Social Security Administration (SSA) considers (1) all income the claimant may have, including any Social Security benefits, and (2) any property (known as resources) which the claimant owns. To be considered disabled for SSI, the claimant must be unable to do any type of work for one year. A claimant need never have worked though to be eligible for SSI -- children and housewives may be eligible for SSI even though they have not earned Social Security insurance protection. An eligible person who lives in a public shelter may receive SSI for 6 months in any 9 month period.

Social Security is sometimes called "Title II," and SSI is called "Title XVI." These are references to the subchapters of the Social Security Act in which they are found.

Many people are eligible for both Social Security and SSI simultaneously. These are called concurrent claims. For example, for 2013 an individual who received only SSI would receive $710 per month. If she had worked long enough to also be covered by Social Security, but her Social Security was less than $730, she would receive an SSI check as well to make up the difference. SSI will not reduce other family members' eligibility for Temporary Assistance for Needy Families (TANF). This means when a disabled mother of a TANF household is eligible for SSI of $710 per month, her children can still be eligible for TANF and Medicaid benefits.

SSI recipients automatically receive Medicaid, even if they receive only one dollar per month in SSI. Medicare is available to persons 65 or older and persons who have received Social Security disability benefits (not SSI) for at least two years or who are diagnosed with either End Stage Renal Disease or ALR (Lou Gehrig's Disease).

Applications and Appeals

See 42 US §§405 and 1383, and 20 CFR §§404.900 and 416.1400 et seq. Claims for both Social Security benefits and SSI follow the same application and appeal procedures.

A. Initial Application

The claimant must file an application to receive benefits. If a claimant goes to a Social Security Office to apply for benefits, but is turned away before doing so, he cannot appeal that refusal and cannot receive benefits unless and until he completes an application, even if SSA admits he would have been found eligible. *Schweiker v. Hansen*, 450 U.S. 785 (1981). A claims representative should never refuse to take an application from anyone. If it is obvious to the claims representative that the claimant would not be found eligible, the claims representative should at least give the individual a paper indicating the date on which the claimant went to the Social Security Office to inquire about eligibility. If the claimant thereafter files an application for those benefits within 60 days of this informal denial, the application will be predated (i.e., given a "protective filing date") to the date of the informal denial.

The application should always be filed as soon as possible. Social Security disability benefits (as opposed to SSI) can be paid for the 12 months prior to when the application is filed, assuming the claimant was otherwise eligible during those 12 months. (Thus an individual who has been disabled for three years prior to applying for Social Security disability benefits would receive retroactive benefits for no more than one year prior to his application date.) Social Security survivor's benefits can be paid for 6 months prior to the application. In SSI cases, benefits are paid back only to the month following the month of the date when the application was filed, regardless of whether the claimant would have been eligible in prior months had he applied earlier. (An exception to this is Medicaid. All SSI recipients receive Medicaid, and their Medicaid coverage may extend for the three months prior to when the application was filed if the claimant would have been eligible for SSI during those three months had he filed earlier.)

After the application is filed, the claimant may submit any evidence establishing his eligibility. In disability cases, SSA makes a preliminary determination of whether the person is insured for purposes of Social Security (i.e., has "sufficient quarters of coverage"), and/or is poor enough for SSI. The disability file is then sent to the Disability Determination Service Center, which gathers the medical records about the claimant, and decides whether the claimant meets SSA's definition of disability. If not (DDS denies about 75% of the disability claims it reviews), SSA sends the claimant a denial notice. If the claimant filed applications for both Social Security and SSI, separate notices for each program may be sent to the claimant. It takes SSA approximately three to four months to make an initial decision on most claims.

B. Request for Reconsideration and Request for Hearing

A claimant has sixty days to file his first appeal, which is called a request for reconsideration. (In fact, one has sixty days to file each of the subsequent appeals.) After another three or four months, the claim is usually again denied. (The reconsideration is little more than a rubber stamp of the initial denial.) After the reconsideration denial, the claimant has sixty days to request a hearing. SSA forms for requesting appeals are available in bulk from local Social Security offices and on-line, although any appeal in writing is sufficient. Because the eligibility rules applied at the initial and reconsideration levels are much stricter than those applied by the ALJ, always appeal to a hearing. More than half of all denials, higher if the claimant is represented, that are appealed to a hearing are reversed. After both the request for reconsideration and the hearing request, SSA has the claimant complete additional forms.

C. 10-Day Deadline for Continuing Benefits in Cessation Cases

The most important appeal is the 10-day appeal. An individual who is already receiving either Social Security or SSI, and who is notified by SSA that he is no longer eligible may elect to have his benefits continue during his appeal, if he appeals within 10 days of receiving the cessation notice. If he does not appeal within 10 days, he still may appeal within the 60 day time limit, but in that case he cannot have his benefits continue unless he is able to show good cause for not appealing within 10 days. Claimants' whose benefits are ceased based on a determination that they are no longer disabled can choose to continue their benefits through the ALJ hearing level. If SSI was ceased based on some non-disability reason (e.g., the claimant has excess income or resources) they may continue only through the reconsideration stage, although the reconsideration must have all the procedural trappings of an ALJ hearing. See *Goldberg v. Kelly*, 397 U.S. 254 (1970).

D. Good Cause for Missed Deadline

If you miss an appeal deadline (even the 10 day appeal time), the deadline can be extended for good cause. Examples of good cause are found at 20 CFR §§404.911 and 416.1411. Generally, the longer the time past the deadline, the better the cause must be. If you miss the reconsideration deadline, the ALJ will decide if there is good cause for extending the appeal time. If you miss the deadline for filing in federal court, the Appeals Council will decide good cause. Although technically you cannot appeal a decision refusing to extend an appeal deadline, it is frequently done. If SSA refuses to extend the deadline, have your client reapply, and ask SSA to give you a protective filing date of the day when you filed your good cause request.

E. Reopening Final Decisions

Any decision that is not appealed becomes final and is res judicata: that is, you cannot file a second application to challenge any of the findings made in the earlier decision. (You can always reapply for disability benefits by alleging that, whether you were disabled before or not,

you are disabled now.) A final decision can, however, be reopened even years later. A denied claim can be reopened for any reason within one year of the initial denial (even if further appeals were filed). It can be reopened within four years (two years in SSI cases) for good cause (see 20 CFR §§404.989 and 416.1489 for examples of good cause), or any time if the decision was obtained by fraud or similar fault. The importance of this is that an ALJ who is convinced of your client's eligibility can sometimes be persuaded to reopen and reverse an earlier ALJ's decision denying a previous application, thus entitling your client to benefits retroactive to the prior application. More than one application may be reopened in "piggy back" fashion. Federal courts, however, have no jurisdiction to review SSA's decision not to reopen an application.

F. ALJ Hearings

Social Security hearings are conducted by the Office of Disability Adjudication and Review (ODAR). ODAR is made up of Administrative Law Judges (ALJs) and their staff. The ALJ must conduct the hearing within 75 miles of the claimant, or pay the travel expenses for the claimant and his representative. It often takes over a year from the date of the Hearing Request for a hearing to be held. The ALJ must give you and your client 20 days notice of the hearing; this is to allow you to subpoena any witnesses. Subpoenas must be requested in writing at least five days before the hearing.

Present at the hearing will be the ALJ, his assistant who is responsible for operating the tape recorder, you, your client, any expert witnesses called by the ALJ, and any witnesses you may wish to bring. SSA is not represented by an attorney at the hearing. The ALJ is required to be both a fact finder for SSA and the neutral judge of the evidence. The ALJs are lawyers.

The ALJ typically begins with some introductory remarks specifying what the hearing is about. Pay attention to the application dates he cites to make sure they are accurate, as this will determine the amount of your client's retroactive award should you win. He will ask if you have seen the exhibits in SSA's file. You have a right to see them, as well as a right to make copies of those exhibits. You may object to the introduction of an exhibit, although most objections are overruled as going to the weight of the evidence rather than its admissibility. The Social Security Act and Regulations specifically provide that the rules of evidence and procedure applicable in federal court do not apply at Social Security hearings. 20 CFR §§404.950(c) & 416.1450(c). Interestingly, however, the Supreme Court has ruled that an objection to the hearsay nature of a document (they are virtually all hearsay) must be sustained if the objecting party has requested that the hearsay declarant be subpoenaed for live cross-examination. *Richardson v. Perales*, 402 U.S. 389 (1971); *Lidy v. Sullivan*, 911 F.2d 1075 (5th Cir. 1990). The ALJ will also offer you an opportunity to submit anything else you have in writing. You may make an opening statement if you wish.

The ALJ will usually ask the first series of questions. You are then allowed to ask your client any questions you like. Again, objections are infrequent since they are so often ignored. Leading questions are allowed, although the answers tend not to be very convincing. Any additional witnesses may also be questioned. (Witnesses are particularly helpful where the

issue is pain, epileptic seizures, alcoholism or mental or emotional disorders.) You may also offer a closing statement summarizing the evidence.

After the hearing you may continue to submit any written evidence until the decision is issued. The ALJ must send both you and your client a copy of the decision, usually three to four months, sometimes longer, after the hearing. If it is favorable, it usually takes SSA about two months to compute the retroactive award and begin sending the claimant his or her checks. If it is unfavorable, you again have sixty days to appeal, this time by requesting review by Appeals Council. The address for the Appeals Council appears on the cover of the hearing decision.

G. Appeals Council Request for Review

The Appeals Council frequently reverses the ALJ, usually for technical errors rather than on the weight of the evidence. Thus the Appeals Council is less likely to reverse the ALJ if you argue that his decision is contrary to the weight of the evidence, but will readily reverse if, for example, the ALJ finds the claimant to have transferable skills without the testimony of a vocational expert, or if the ALJ cites a grid rule that clearly does not apply to the claimant, or the ALJ sends the claimant to a consulting examination following the hearing, but fails to send a copy of the consultant's report to you for comment before rendering his decision. If the Appeals Council reverses the ALJ, it will normally remand the case for a new hearing, although occasionally it will itself find the claimant eligible for benefits. It usually takes over a year to 18 months for an Appeals Council decision. If the Appeals Council affirms the ALJ's decision, the claimant has sixty days to file an appeal in federal court.

The claimant can file a new application in addition to appealing the old claim to the Appeals Council (although some SSA claims representatives do not readily agree). (See discussion below regarding reapplying simultaneous with federal court appeal.)

H. Judicial Review

The civil litigation must be filed in the U.S. District Court of the district where the claimant resides. The Defendant is the Commissioner of the Social Security Administration. The Complaint must allege that jurisdiction lies under the provisions of 42 USC §§405(g) (Social Security cases) and/or 1383(c)(3) (SSI cases). The Complaint should also allege that the Secretary's decision is not supported by substantial evidence and or based on errors of law. You may attach new evidence (e.g., a new doctor's report) to the Complaint, provided you establish that the new evidence could not have been submitted earlier during SSA's consideration of the claim. The new evidence cannot be used, however, to defeat the Secretary's decision; it can only be referred to as establishing good cause for the remand of the case for a new hearing. Most, but not all, clients eligible for Legal Aid should be entitled to proceed in forma pauperis.

Have your client reapply for benefits simultaneously with your litigation of her previous claim; she is likely to get a hearing on the reapplication before the litigation is complete. If the decision on the second application is favorable, it can be submitted in federal court as tending to show that the claimant should have been found eligible on the first application. If SSA is alerted that your client is litigating a prior application when she attempts to reapply, SSA may either refuse the application, or do nothing with it once it is filed. Nobody is quite sure how to

handle this: some ALJs dismiss the hearing request on the second application, others issue only a recommended decision, and still others will issue a second decision as if there were no litigation.

The U.S. Attorney's Office represents the Secretary, and is allowed sixty days within which to answer. They often request an additional sixty days, their excuse being that the Social Security Act requires them to submit along with their answer a transcript of the claimant's hearing and exhibits in the case, which transcripts take time to prepare.

After the Secretary answers, the District Judge may refer the case to a U.S. Magistrate for his recommended decision or to render the final decision. Both parties file motions for summary judgment (the Plaintiff may also move to remand the case based on the new evidence or for some other reason). Oral argument may be allowed in an unusual case. Depending on the district court where the case is filed, the whole procedure may take from several months to years to complete.

Some judges are willing to reverse Social Security's decision outright and order the award of benefits, although some do no more than to order the case remanded for a new hearing. It may take six months for the new hearing to be held, and if the decision is again unfavorable, the case goes back to federal court for another round of briefing. This can add another year or two to a final decision in the case. Appeal lies for either party from the district court's order to the Tenth Circuit.

Continuing Disability Reviews (CDRs)

A claimant's Social Security or SSI disability benefits continue only so long as the claimant continues to meet the disability standard. SSA can conduct a continuing disability review (CDR) to determine whether the claimant continues to be disabled. 42 USC § 423(f); 20 CFR §§ 404.1594, 416.994 & 416.994a.

A. Cessation Notice and Appeal Process

If SSA determines at the initial level of a CDR that the claimant is no longer disabled, SSA must notify the claimant of that decision in writing. The claimant has a right to the same appeals process described above--with some additional safeguards and deadlines. After the initial cessation notice, the claimant would file a "Request for Reconsideration-Cessation." As mentioned above, although the claimant has 60 days to file this appeal, he has only 10 days to do so if he is requesting that his benefits continue during the appeal (with the good cause for late filing exceptions discussed above). At the reconsideration stage in a cessation case--unlike at this stage in an initial application for benefits--the claimant can have a face-to-face hearing with a hearing officer from DDS--but only if expressly requested. If denied at the reconsideration stage, the claimant appeals to ODAR for an ALJ hearing. This Request for Hearing stage has the same 60-day deadline and 10-day deadline for continuing benefits. If denied at the ALJ stage, the claimant can appeal to the Appeals Council and beyond that to Federal Court as discussed above. The claimant has no right to continuing benefits, however, at

the Appeals Council stage of appeal or beyond (unless the claim is remanded to an ALJ, at which point the claimant can request continued benefits again pending the ALJ's decision).

B. Continued Benefits during Appeal; Waiver of Overpayment

If the claimant received benefits during his appeal and does not ultimately win the appeal, SSA may ask the claimant to repay the benefits received during the appeal. However, the claimant may request and should be granted a waiver of any such overpayment as long as the claimant: (1) cannot afford to repay the benefits, and (2) appealed in good faith. The claimant is presumed to have appealed in good faith unless, for example, she did not cooperate with the agency during the appeal (by refusing to provide information about her treating medical sources or refusing to attend a consultative evaluation, etc.). 20 CFR § 416.996(g).

C. Medical Improvement Standard

To decide that the claimant is no longer disabled, SSA must first determine that there has been a medical improvement in the claimant's condition. SSA must consider not only the impairments that were the basis for the claimant's approval, but also any additional impairment he currently has. If, on balance, there has been no medical improvement, the claimant remains disabled (unless one of several exceptions apply).

If there has been medical improvement, SSA must then determine, for adults, whether the improvement is related to the ability to work, and if so, whether the claimant is currently able to engage in SGA. For children, if SSA determines that there has been medical improvement, SSA must then determine whether the claimant nonetheless still meets or medically or functionally equals a listing.

SSA can determine that the claimant is no longer disabled without a finding of medical improvement when: (1) advances in medical or vocational therapy or technology would enable the claimant to work (not applicable to children); (2) the claimant has undergone vocational therapy that would enable him to work (not applicable to children); (3) new or improved diagnostic techniques show the impairments are not as disabling as previously thought; (4) substantial new evidence shows that the prior decision was in error; (5) the claimant is engaged in SGA (SSA must first consider whether the claimant is entitled to a trial work period and extended period of entitlement); (6) the prior determination was fraudulently obtained; (7) the claimant has not cooperated with the continuing disability review; (8) the claimant cannot be located; (9) the claimant has failed to follow prescribed treatment expected to restore his ability to work (for adult) (or for children, the claimant has not been receiving medically necessary and available treatment).

D. Disability Reviews That Are Not CDRs

Certain categories of disability reviews necessitated by changes in the statutory definition of disability are not considered "CDRs." So, advocates should determine whether a disability review is a redetermination or a CDR.

Retirement and Family Benefits

See 42 USC §§402 and 416, and 20 CFR §§404.301 and 404.715 et seq.

A. SSI Aged Benefits

At age 65 an individual who is sufficiently poor can begin receiving SSI regardless of their medical condition. (These are not actually retirement benefits as one need never have held a formal job to be eligible for SSI.) But there are no family benefits which go along with any award of SSI: only the SSI claimant himself can receive the SSI, regardless of how poor the other family members are. (They, of course, may also apply for SSI, or for other forms of assistance such as TANF or county assistance.)

B. Social Security Benefits

In a Social Security claim, however, there may be an entire cloud of secondary beneficiaries surrounding the claimant. To be eligible on the wage earner's account, the secondary beneficiaries must be both related to the wage earner (by blood, adoption, or marriage), and dependent on the wage earner for support at the time the wage earner became eligible. These secondary beneficiaries most often include the wage earner's spouse and children, but may also include the wage earner's parents, former spouse, stepchildren, or even grandchildren. As noted above, detailed information is available at socialsecurity.gov.

1. Retirement Benefits

Usually, but not always, the wage earner him or herself must be either disabled, retired, or deceased before the secondary beneficiaries are eligible for benefits. For persons born between 1943 and 1954, full retirement age is 66. The wage earner may receive full retirement benefits at age 66, although those benefits will be reduced somewhat if the wage earner continues to work. At age 70 a wage earner's continued work will not reduce his or her retirement benefits. A wage earner may retire at age 62, although he would thereafter receive only 75% of the monthly benefit he would have received had he waited to retire at age 66. For persons born after 1960, full retirement age is 67.

If a wage earner dies, any secondary beneficiary may apply to receive benefits from his earnings record. A wage earner who disappears for seven years without any trace is presumed to be dead, thereafter entitling the secondary beneficiaries to survivor's benefits.

2. Child's Benefits

A wage earner's legitimate minor children (if unmarried) are obviously related to the wage earner, and are presumed to have been dependent on the wage earner at the time the wage earner became disabled, retired, or died, whether or not they were in fact living with or supported by the wage earner at that time. A wage earner's illegitimate children must prove that they were dependent on the wage earner by one of several ways: by showing a paternity order finding the wage earner to have been the child's natural father, by showing that the wage earner was liable for court-ordered child support to the child, by showing that the wage earner

acknowledged the child to be his or hers in writing, by showing that the wage earner was living with the child at the time the wage earner became disabled, retired or died, or by showing that the wage earner was in fact contributing to at least one-half of the child's support at that time. The written acknowledgment must specify the child by name, but may be anything such as a letter, Christmas card, family Bible, or an acknowledgment of the child on the wage earner's tax return or company insurance. Most cases involve other forms of proof where it is argued that the child would be entitled to inherit from the deceased wage earner under the law of the state where the wage earner died. In these cases multiple statements from persons to whom the wage earner acknowledged paternity may be sufficient proof, particularly written statements from his family or friends. If all else fails, a posthumous paternity suit can be filed in state court and DNA testing done on paternal relatives, such as his parents or siblings of the child claimant. Under these inheritance-based entitlement claims no proof of actual dependency is required.

3. Husband's or Wife's Benefits

The spouse of a disabled or retired wage earner may be eligible for benefits if the spouse is 62 or older or has in his or her care a child who is entitled to child's benefits on the wage earner's record and who is either under 16 years old or disabled. The spouse qualifies even if separated from the wage earner. (Different rules apply for a divorced spouse.)

A common problem with these spousal benefits arises when SSA determines that a previous marriage between the wage earner and another spouse was never dissolved by divorce or death. Typically SSA requires the most recent spouse to prove that the prior marriage was dissolved.

4. Widow's and Widower's Benefits

The unmarried widow of a deceased wage earner may be eligible for benefits from his work record at age 60, or at age 50 if she is disabled. The divorced ex-spouse of the wage earner (if they were married for at least 10 years) may also be eligible for benefits from the wage earner's work record when the ex-spouse retires or dies. Spousal benefits are payable without regard to the family maximum other applicable to auxiliary beneficiary claims.

Overpayments

See 42 USC §§ 404 and 1383(b), and 20 CFR §§ 404.501 and 416.501 et seq. See also *Califano v. Yamasaki*, 44 U.S. 682 (1979).

An overpayment occurs whenever SSA determines that it has sent a claimant more Social Security or SSI than the claimant was entitled to. The claimant can, of course, agree that he or she was in fact overpaid, and repay SSA in any of three ways: (1) by giving SSA one lump sum payment for the entire amount of the overpayment, (2) by paying SSA so much each month until the overpayment is repaid, or (3) by allowing SSA to reduce the claimant's current Social Security or SSI benefits by an agreed amount. If the overpaid claimant does not

voluntarily repay the overpayment, SSA may reduce whatever benefits it is currently sending the claimant. SSI payments may not be reduced by more than 10%. 20 CFR § 416.571.

If the claimant was not in fact overpaid, he or she may appeal. The claimant has 60 days (just as with any other decision) in which to appeal the overpayment determination by reconsideration, a hearing, Appeals Council review, or even into federal court. Even if the claimant was overpaid, he may request that recovery of the overpayment be waived (i.e, that he be excused from repaying the overpayment). The claimant has 30 days within which to request a waiver. The claimant may do both, appeal and request waiver, simultaneously. That is, in the same appeal the claimant can contend that he was not overpaid, but that if it is finally decided he was overpaid, recovery of the overpayment should be waived. Both issues can be appealed further, and somehow both issues are usually considered at the same ALJ hearing. In *Califano v. Yamasaki*, 422 U.S. 682 (1979), the Supreme Court held that SSA may not begin reducing a recipient's current benefit to recover an overpayment until after affording the recipient a waiver hearing.

Waiver will be granted if two things are true: First, the claimant must show that he was not at fault in causing the overpayment. Second, the claimant must show that he cannot afford to repay the overpayment. In proving the first element of fault, it is not enough for the claimant to show that SSA was also at fault in causing the overpayment. For example, if one month SSA mistakenly sends the claimant two checks, SSA's fault in this will not preclude a finding that the claimant was also at fault if the claimant should have known he was entitled to only one check and failed to report the mistake.

Even if the claimant was not at fault in causing the overpayment, the waiver will be denied if the claimant can afford to repay. To determine this, SSA compares the claimant's income against the claimant's expenses. If the expenses are less than the income, the claimant will be required to pay the difference towards the balance of the overpayment. If the expenses slightly exceed the claimant's income, the claimant will be found unable to repay. If, however, the expenses alleged by the claimant greatly exceed the claimant's income, the expenses will likely be disbelieved. It is presumed that a claimant whose only income is SSI is unable to repay any overpayment. 20 CFR 416.553. Thus, most SSI recipients need only prove that they were not at fault in the overpayment in order to have recovery waived.

The most common question in determining the issue of fault is whether the claimant reported to SSA information which would have reduced the amount of the claimant's monthly check. For example, an SSI recipient begins receiving $50 per month in unearned income. The claimant calls the SSA district office to report this, and is advised over the phone that his SSI benefits may be adjusted accordingly. For whatever reason, the SSI benefits are not reduced; when SSA learns for a second time that the recipient has unearned income, it computes that the recipient should not have received as much SSI as he has, and declares that an overpayment has occurred. If the recipient admits that he in fact had the unearned income, it may be pointless to appeal the question of whether or not he was overpaid. As to whether or not recovery of the overpayment should be waived, the questions will be whether or not the claimant did in fact report the unearned income, and if so, whether the claimant should have

known to expect his SSI check to be reduced. Usually, the claimant's allegation that he reported the unearned income will not be believed unless the claimant can support the allegation with some third party evidence. Moreover, the claimant's allegation that he believed he was still eligible for an unreduced amount of SSI may not be believed unless the claimant has little education or suffers from a mental disability that would have interfered with the claimant's ability to understand this.