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Aged, Blind, Disabled Benefits (ABD)

April 25th, 2024

Patricia Bowen, Program Manager
Benefits Legal Assistance

solid-ground.org
206.694.6700

Ask a Lawyer Program

- Have a question about the application process?
- Have a question about eligibility?
- Was your client denied and need help appealing?
- Have a question about what ABD and SSI requirements?

- Email questions or real-life scenarios to **benefitslegalhelp@solid-ground.org**
- Put “Ask a Lawyer” in the subject line and Public Benefits attorney will respond.

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Aged, Blind, or Disabled (ABD)

- Cash assistance program to low-income individuals
- $450/month for individual
- $570/month for married couple
- ABD recipients get assistance applying for SSI benefits (SSI Facilitation); Referral to HEN (Housing & Essential Needs)

Who is Eligible for ABD?

- 65+ or Blind or
- 18+ with a disabling physical or mental condition keeping you from working for at least twelve months.
- Your disability is not primarily due to alcohol or drug addiction

- Meet income and resource requirements.
- Meet citizenship / immigration status requirements.
- Not eligible for ABD if
  - Receiving SSI benefits
  - Eligible for or receiving TANF

TIP: If you are not sure if your client is eligible, check out WashingtonConnections.org. Click "See if I qualify"

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ABD Income/Resource Limits

- **Income**:
- Earned Income - If your income is from a job, you can divide the amount you make in half (50%) and compare that to the income chart to see if eligible.
- Unearned Income - Income from another source such as unemployment, VA, then you must take the full amount (dollar for dollar) and income must be less than the Payment Standard
- **Resources:**
- Less than $12,000* in "liquid resources"
- Cash on hand, checking/savings accounts

Household Size	Monthly Income Limit
1	$339.00
2	$428.00
Resource Limit:	$12,000*

Caution: the monetary value of ABD cash assistance *paid prior to October 1, 2025*, that is duplicated by the person's receipt of SSI for the same period = a debt due to the state, subject to recovery

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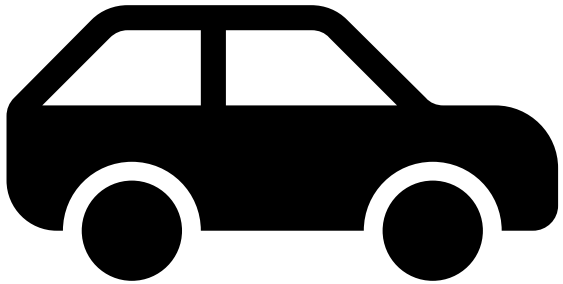
Changes in 2024 to Resource Limits

- Starting February 1, 2024, resource limit increased to $12,000 (was previously $6,000)
- The entire value of 1 vehicle is excluded



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How to Apply?

- Apply online at https://www.washingtonconnection.org/home/
  - Need to create an account, username and password
  - Need an email address to receive verification code
- Apply in person at a CSO
  - Office Locator: https://www.dshs.wa.gov/office-locations
- Apply over the phone: 1-877-501-2233

Washington State Department of Social & Health Services
Transforming lives

Application for Food and Cash Assistance

Ask us if you need help filling out this form.

1. FIRST NAME MIDDLE INITIAL LAST NAME	SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE (REQUIRED)	2. CLIENT IDENTIFICATION NUMBER (IF KNOWN)
3. STREET ADDRESS WHERE YOU LIVE CITY STATE ZIP CODE		4. PRIMARY PHONE NUMBER ☐ CELL ☐ HOME ☐ MESSAGE
5. MAILING ADDRESS (IF DIFFERENT) CITY STATE ZIP CODE		6. SECONDARY PHONE NUMBER(S) ☐ CELL ☐ HOME ☐ MESSAGE
		7. EMAIL ADDRESS

8. I am applying for (check all that apply):
☐ Cash ☐ Food ☐ Child care

9. I or someone in my household (check all that apply):
☐ Are in a domestic violence situation ☐ Have a disability
☐ Can't work because of health problems ☐ Are pregnant; name: _____ due date: _____

10. How much money do you expect your household to get this month? $_____
11. How much money does your household have in cash and bank accounts? $_____
12. How much does your household pay for rent or mortgage? $_____
13. What utilities does your household pay for? ☐ Heating/cooling ☐ Telephone ☐ Other: _____
14. Is anyone in your household a seasonal or migrant farm worker? ☐ Yes ☐ No
15. If applying for food assistance, how many people in your household do you buy and prepare food for? _____
16. If applying for child care, what activity do you need care for (check all that apply)?
☐ Work ☐ School ☐ WorkFirst ☐ Basic Food Employment and Training (BFET)

FOR OFFICE USE ONLY – Household eligible for expedited service: ☐ **Yes** ☐ **No Screener's Initials:** _____ **Date:** _____

17. ☐ I need an interpreter. I speak: _____ or ☐ sign; translate my letters into: _____

18. List everyone in your household even if you are not applying for them (attach additional sheets, if necessary).

NAME (FIRST, MIDDLE, LAST)	GENDER	HOW IS THIS PERSON RELATED TO YOU?	DATE OF BIRTH	CHECK IF YOU WANT BENEFITS FOR THIS PERSON	OPTIONAL FOR NON-APPLICANTS			
					SOCIAL SECURITY NUMBER	CHECK IF U.S. CITIZEN	RACE (SEE SAMPLES BELOW)	TRIBE NAME (For American Indians, Alaska Natives)
		Myself		☐		☐		
				☐		☐		
				☐		☐		
				☐		☐		
				☐		☐		
				☐		☐		
				☐		☐		

19. My ethnic background is Hispanic or Latino: ☐ Yes ☐ No

Race and Ethnic background information is voluntary and will not affect eligibility or benefit amounts. This information is used to assure program benefits are distributed without regard to race, color, or national origin. For Food Assistance the USDA requires us to answer for you if no information is provided. **Race examples:** White, Black or African American, Asian, Native Hawaiian, Pacific Islander, American Indian, Alaska Native, or any combination of races.

DSHS 14-001 (REV. 09/2022) (AC 04/2023)

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Application Process

- **Financial Interview** with DSHS to confirm the information that was submitted on their application.
  - Via Phone or In-Person at CSO
  - If you complete the application online, you can call the same day for the interview.
- **Social Worker Interview** with DSHS to share information about disabilities and work history.
  - Tell DSHS about all physical and mental conditions
  - Even ones that might seem “minor” like high blood pressure or nightmares.
  - Tell DSHS the names and address of all medical providers seen in the last 90 days, including primary care, specialists, hospitals, emergency rooms.

Tip for Application Process

- Advocates can attend Financial and Social Worker interviews!
- Help clients get copies of medical records
- Help client ask DSHS to schedule a psychological evaluation if necessary
- Advocates/clients can follow up with the DSHS social worker to make sure they are getting all the medical records.
- Advocates can write letters of support for their clients or help clients ask their medical providers for these letters of support.

Authorization

AUTHORIZATION TO DISCLOSE DSHS RECORDS OF:

NAME LAST	FIRST	MIDDLE	DATE OF BIRTH

The following information may help in locating records:	FORMER NAMES

CLIENT IDENTIFICATION NUMBER	OTHER IDENTIFICATION NUMBER	DATES OF SERVICE	LOCATION OF SERVICE

DISCLOSE TO:

NAME LAST	FIRST	MIDDLE	TITLE

ORGANIZATION OR BUSINESS NAME IF APPLICABLE

ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE NUMBER (INCLUDE AREA CODE)	FAX NUMBER (INCLUDE AREA CODE)	E-MAIL ADDRESS

REASON FOR DISCLOSURE (NOT REQUIRED)

AUTHORIZATION:

SOURCES: I authorize the following DSHS programs to disclose or give access to confidential information about me as described below. Information may be provided verbally or by computer data transfer, mail, fax, or hand delivery.

☐ The following programs only (check all that apply):

- ☐ Behavioral Health Administration (BHA)
- ☐ Child Support (DCS)
- ☐ Developmental Disabilities (DDA)
- ☐ Vocational Rehabilitation (DVR)
- ☐ Special Commitment Center (SCC)
- ☐ Other: _____
- ☑ Community Services (CSD – public assistance)
- ☐ Home and Community Services (HCS)
- ☐ Residential Care Services (RCS)
- ☐ State Mental Health Institutions (ESH, WSH, CSTC)
- ☐ Human Resources and Payroll

☐ All parts of the Department of Social and Health Services (DSHS)

RECORDS: I authorize the following DSHS records to be disclosed:

- ☐ Client records held by parts of DSHS marked above
- ☐ Other confidential records held by parts of DSHS marked above
- ☐ Personal information in employment-related records
- ☐ All my client records
- ☐ Records on the attached list
- ☐ The following records only:

I want to limit the records to be disclosed as follows (by date, type of record, etc.):

☐ I am not asking that records be disclosed at this time. Please place this authorization in my client file.

PLEASE NOTE: If your client or other confidential records include any of the following information, you must also complete the below section to allow disclosure of these records.

SPECIAL RECORDS: I give my permission to disclose the following information held in DSHS records (check all that apply):

- ☐ HIV/AIDS and STD test results, diagnosis or treatment records (RCW 70.02.220)
- ☐ Mental health records (RCW 70.02.230 or 240)
- ☐ Substance Use Disorder records (42 CFR Part 2)

- This permission is valid for 180 days or ☐ until _____ (date or event, if not checked, will be 180 days).
- I may revoke or withdraw my permission in writing at any time, but that will not affect information already produced.
- I understand that my records may no longer be protected under the laws that apply to DSHS after this they are produced.
- A copy of this form is valid to give my permission to disclose records. DSHS may charge to provide copies of its records.

AUTHORIZED BY (SIGNATURE)	DATE SIGNED	TELEPHONE NUMBER (AREA CODE)

PRINT NAME	WITNESS/NOTARY (SIGN AND PRINT NAME, IF APPLICABLE)

If I am not the person who is the subject of the records, I am authorized to sign because I am the: (attach proof of authority)

☐ Parent of minor ☐ Legal Guardian ☐ Personal Representative ☐ Other:

Notice to those receiving information: If these records contain information about HIV, STDs, or alcohol or drug abuse, you may not further disclose that information under federal and state law without specific permission of the subject and meeting specific legal requirements.

What does "disability" mean?

- Unable to work because of a diagnosed physical or mental health impairment that has or is expected to last at least 12 months or result in death.
- "Work" means **substantial gainful activity**, or earning less than $1550 (this $ changes annually).

TIP: If a client is working very part time or sporadically, they may still be eligible for ABD because their work is not "substantial"

Co-occurring disorders

- If a client has a substance use disorder or chemical dependency, they can still apply and be approved for ABD.
- “Your disability is not primarily due to alcohol or drug addiction”
- SUD treatment may be required to keep benefits.

How do you prove “disability”?

- You must give recent medical evidence about your physical and/or mental health conditions, including **diagnoses** and how they **affect your ability to perform regular and continuous work activity**
- If you need help getting or paying for medical records or exams, DSHS must help you.
- Not every healthcare professional can provide the diagnosis that is required for ABD eligibility.

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Who can diagnose a physical impairment?

- Medical doctor (MD)
- Doctor of osteopathy (DO)
- Doctor of optometry (OD) for visual disorders
- Doctor of podiatry (DP) for foot and ankle disorders
- Physician assistant (PA) for impairments within their licensed scope of practice
- Advanced registered nurse practitioner (ARNP) for impairments within their licensed scope of practice
- Audiologist for impairments of hearing loss, auditory processing disorders, and balance disorders within their licensed scope of practice
- Qualified speech-language pathologist, for purposes of establishing speech or language impairments.

Who can diagnose a mental impairment?

- Psychiatrist
- Psychologist
- Advanced registered nurse practitioner (ARNP) for impairments within their licensed scope of practice
- Physician assistant (PA) for impairments within their licensed scope of practice
- School psychologist

TIP: Ask DSHS to schedule a Psychological Evaluation if your client needs a formal diagnosis. This is free to clients.

Who can prove "inability to work"?

After you have a diagnosis, these healthcare providers can explain how the impairment impedes the ability to work.

- Physician treating you for a mental impairment
- Clinical social worker
- Mental health professional (MHP)
- Naturopath
- Chiropractor
- Physical therapist
- Chemical dependency professional (CDP)

TIP: This information comes from medical records and/or letters of support

Physical and Psychological Evaluations

- If the client needs a formal diagnosis of a mental health impairment, DSHS will schedule a free psychological evaluation.
  - You can ask for this during the interview process!
- A client's medical provider may be asked to complete a physical evaluation form (sample on next page)
- If the client needs help paying for a certain exam, test, or radiology, ask DSHS to pay for this.

TIP: Link to the Form:

Physical

www.dshs.wa.gov/sites/default/files/forms/pdf/13-021.pdf

Mental Health

www.dshs.wa.gov/sites/default/files/forms/pdf/13-865.pdf

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Physical Functional Evaluation

1. Payment for a general or comprehensive physical evaluation is contingent upon receipt of available chart notes from within the past six months, as well as supporting evidence including lab results, pathology reports, diagnostic imaging reports, and range of motion studies. You must be enrolled in ProviderOne to claim reimbursements for these services.
2. As you examine this patient, please evaluate all medical conditions that may limit their ability to work. You are not limited to evaluating the presenting condition(s). **You are not required to complete any special test of functional capacity to render your professional medical opinion on this form.**

Confidentiality: The information you provide is subject to Washington State Public Disclosure laws and may be released to the client upon request. DSHS discloses no further information without the written consent of the individual to whom it pertains or as otherwise permitted by state law.

A. Client Information

NAME	BIRTH DATE	CLIENT IDENTIFICATION NUMBER

B. Authorization to Release Information

I authorize _____ to release the following information to the Department of

EXAMINING PROFESSIONAL'S NAME

Social and Health Services (DSHS). This release includes the contents of this evaluation as well as diagnostic testing or treatment information concerning mental health, alcohol or drug use , sickle cell disease, and sexually transmitted disease, including HIV/AIDS (Chapter 70.02 Revised Code of Washington (RCW) (42 Code of Federal Regulations (CFR) Part 2).

This authorization is valid for one year or until

_____

(date). I may revoke or withdraw this authorization in writing at any time.

I understand that the information provided to DSHS may be re-disclosed only with a valid authorization from me or if required by law.

CLIENT'S SIGNATURE	DATE

C. Subjective

Chief complaints and reported symptoms:

Sample Letter of Support

- “I am a Case Manager with ABC Outreach and I have worked with Sam as her case manager from January 1, 2021 to the present. I interact with Sam on a daily basis, and we have formal appointments once a week”
- “Sam completed a mental health assessment on January 10, 2021 with XYZ Clinic and was diagnosed with Post Traumatic Stress Disorder with symptoms of…”
- “During my time working with Sam, I have observed severe impairments in independently completing her activities of daily living, her ability to interact with others and care for herself and her basic needs.”

Sample Letter of Support

- “She regularly struggles to maintain her personal hygiene and is typically observed in dirty clothing.”
- “I have observed Sam engage in repetitious behaviors, like repeating the same word.”
- “Sam’s concentration appears to be impaired and during our meetings she is only able to discuss one topic and needs to be redirected often.”
- “Sam needs at least two reminders before our appointments. I send her a text and a phone call to remind her.”

Tips for Disability Evaluation

- Issue: DSHS will request medical records directly from providers BUT this 1) takes time, 2) not a lot of follow up from DSHS, 3) limited date range.
- Solution:
  - Help client get a copy of their medical records (directly from provider, patient portals)
  - Follow up with DSHS social worker to ensure requests are made (hard to get through to DSHS BUT keep track of attempts for appeals)
  - Schedule or request MH evaluation

Common reasons ABD is denied

- Medical Evidence not received within 45 days of application
- Medical Evidence is not current, more than 90 days old.
- Very common reasons is “failure to prove the disability” or “lack of objective evidence”
- Physical and Mental Health Function Evaluation Forms (DSHS 13-021 and DSHS 13-865) not completed correctly.
- Mental health evaluations done by DSHS contract providers may have implicit bias in their evaluations.

TIP: Help the client ask their MH provider or primary care doctor to complete an evaluation form.

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Appeal vs. Re-Apply

- You should reapply if any of these is true:
- You think DSHS correctly denied you, but your situation has since changed.
- Reconsideration: If you give DSHS additional information within 30 days of the denial, they will review your application again.
  - You can do this **and** ask for a hearing.
- BUT if you think DSHS incorrectly denied benefits, you can appeal!
- May be able to get back benefits if appeal instead of just reapplying

How to Avoid Benefits Pitfalls

Report Changes in Circumstances

- Report required changes in household income, household size, or resources by the 10th day of the month following the change.
- Contact DSHS or BLA if you are in doubt about what needs to be reported.

Comply with Program Requirements

- Comply with treatment requirements, if required after approval.
- OR tell DSHS why you cannot comply.

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How to Avoid Benefits Pitfalls, cont.

Request an Equal Access Plan

DSHS must provide Necessary Supplemental Accommodations to all persons with a mental, neurological, physical or sensory impairment or other limitation that prevents them from accessing or maintaining benefits in the same way that an unimpaired person would.

Designate an Authorized Representative

- Someone you designate to represent you when you apply for or receive benefits with DSHS.
- The individual or organization is authorized to act on behalf of the client for eligibility purposes.
- They can also receive copies of all your DSHS notices.

What do to if something goes wrong?

If benefits are denied, reduced, terminated, overpayment:

- **Request a Hearing**
- How to request a hearing?
  - Call or write DSHS or the Office of Administrative Hearings.
- You have the right to be represented by an attorney
- DSHS Customer Service – 1-877-501-2233
- Office of Hearing Administration – 360-407-2700 or 800-583-8271

Deadlines to Request a Hearing

- **<u>90 days</u>** to request a hearing from the adverse action (termination, denial, or change in benefits).
- **Continuing Benefits.** You can keep getting your benefits while you are waiting for you hearing.
- Ask for this within 10 days of the date on the DSHS notice.
  - If the tenth day falls on a weekend or holiday, you have until the next business day to ask for a fair hearing to get continued benefits.

Questions?

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Referrals to Benefits Legal Assistance

For General Referrals

- **Intake line: 206.694.6742** (client or advocate can leave message and we will return call within 24 hours)
- **General Email:** benefitslegalhelp@solid-ground.org

To Contact us Directly with Specific Questions

- Patricia Bowen, Program Manager, patriciab@solid-ground.org
- Janelle Stark, Legal Assistant (manages all intakes) janelles@solid-ground.org

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