COUNTY OF SAN BERNARDINO STANDARD PRACTICE	No. 6-3 11	Issue 07/2003
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	By Bertha Morris	Effective 07/2003
DEPARTMENT BEHAVIORAL HEALTH	APPROVED Rudy Lopez, Director	
SUBJECT Consumer Benefit Assistance Protocol		

I. Purpose

To establish uniform procedures for staff to follow when assisting consumers to apply for benefits.

NOTE - Case Manager as it is used in this protocol may refer to Clinicians, Social Workers, Mental Health Specialist, Financial Interviewers, Eligibility Workers and Clerical Support Staff. It is expected that case management team members will work collaboratively to assist eligible consumers in applying for financial benefits.

II Policy

All consumers without financial means are to be assisted in applying for financial benefits, specifically Medi-Cal or Supplemental Security Insurance (SSI), and these efforts are to be documented in the consumer's chart and related support documents, i.e. the Medical Eligibility Tracking Form. This assistance is to be provided from initial application through disposition. **Consumer Case is to remain open until eligibility is determined.**

III. Responsibility

A. **Fee For Service (FFS) Hospitals** - Compliance Unit will fax the regions the 24-hour notice to notify staff/regions of an admission to a FFS hospital. Indigent Admission Notification Form will also be sent for indigent clients.

B. **Arrowhead Regional Medical Center (ARMC)** is to provid DBH with a daily roster of admissions.

NOTE - If case is not already assigned to a DBH clinic the Hospital Aftercare case manager will be responsible for assisting consumer apply for assistance. If there is an open case, the case manager from the assigned clinic will be responsible for assisting the consumer apply for assistance

IV General Procedure Overview

A. All consumers identified to be without financial means or otherwise indigent, and/or has chosen to receive assistance from DBH – as indicated in part 2 of the Clinical Assessment (Resource Needs) Form, shall be assessed for potential eligibility for Medi-cal or Supplemental Security Income (SSI) (See Attachment 1).

B Case managers will complete the *Indigent Admission Tracking Form* (See Attachment 2) for targeted consumers. Whenever possible this form is to be completed **prior** to the consumers' discharge from the hospital and not later than the case managers' initial consumer contact after discharge. NOTE – A response must be submitted to the Compliance Unit by the due date indicated on the tracking form for FFS admitted consumers.

1. **Medi-Cal Eligibility** - If any responses on the *Indigent Admission Questionnaire* are **yes** the consumer is considered immediately eligible for Medi-Cal and may be eligible for SSI. DBH Case managers are to assist consumers in applying for Medi-Cal benefits, as their abilities and needs dictate. See Medi-Cal Application Process in Section IV.

2. **SSI Eligibility** - If all the responses on the *Indigent Admission Questionnaire* are **no** the consumer may be eligible for SSI. DBH Case managers are to assist consumers in applying for SSI benefits, as their abilities and needs dictate. See Supplemental Security Income (SSI) Application Process in Section V.

C Case mangers will complete and have the consumer sign an **Authorization to Release Confidential Information Form** (See Attachment 3). NOTE – A separate form must be completed and signed for each agency the case manager will need to communicate and exchange information with. *Case managers are to ensure that the most current version of the form is used*

V. Medi-Cal Application Process

Applying for Medi-Cal benefits, dealing with an often-busy TAD office and an abundant amount of paperwork can be an overwhelming process for a consumer. The case managers presence and guidance will serve to reduce the anxiety for the consumer and facilitate a more positive experience.

STEP 1 - DBH Case managers are to assist client in applying for the Medi-Cal benefits, as the client's abilities and needs dictate. This may include:

- Making the consumer's appointment at the appropriate Transitional Assistance Department (TAD) office *(This appointment should be made within 10 working days following initial client contact*

- Transporting the consumer to the TAD office and remaining with them through the interview. *(NOTE – At the time of the appointment consumer should bring their ID and Social Security Card. Case Managers should ID themselves and request a private room for the interview process)*

- Assisting the consumer complete the application packet. *This process typically takes 30 minutes.*

- Assisting the consumer in obtaining additional support documentation to process the Medi-Cal application by the deadline established by the TAD Eligibility Worker (EW), typically 10 days.

Once the EW receives all documents, the completed application will be processed Typically within 45 days the consumer will receive an approval notice from the state followed by a Beneficiary Insurance Card (BIC)

STEP 2 - DBH Case managers are to immediately notify the Financial Interviewers Office that a consumer has applied for Medi-Cal and request that the financial status code be updated. The Financial Interviewer will do follow-up with the consumer within 45 days of notification.

For FFS Admissions ONLY – The compliance unit needs to be notified when a consumer has applied for Medi-Cal and once the Medi-Cal benefit has been approved/denied.If denied, state the reason for denial

STEP 3 – Case manager is to document all benefit application assistance provided to the consumer in the interdisciplinary notes and file in the consumer case file, report logs, along with other required episode documents, including signed consents.

VI. Supplemental Security Income Application Process

Applying for SSI benefits can be a lengthy process as detailed in the procedures below. The case managers continual proactive involvement in ensuring that the consumer has complied with all necessary steps is an integral part of a successful application process, up to and including the appeal process.

STEP 1 - DBH Case managers are to assist clients in applying for the SSI, as the client's abilities and needs dictate. This may include:

- Making the consumer's appointment. Ideally, the appointment should be made when the consumer is present, as the SSI staff may want to speak to the consumer or conduct a telephone interview. Call the SSI office at **1-800-772-1213**. *(This appointment should be made immediately following completion of the questionnaire. The date of the call is important because the application is activated the month after the consumer files for benefits This activation date is important because it is the date which retroactive benefits are calculated.)*

- Transporting the consumer to the Social Security Office and remaining with them through the interview. (ID yourself to the SSI staff.)

- Assisting the consumer complete the **SSI Disability Questionnaire**. (See Attachment 4A/B). This form must be completed as thoroughly and accurately as possible. (NOTE – This can be completed prior to the interview. Incomplete documents will not be accepted. *The interview can take up to two hours)*

- If available, the Case manager may also submit the consumer's psych-social to the SSI staff in a sealed envelope at the time of the interview.

STEP 2 - DBH Case managers are to immediately notify the Financial Interviewers Office that a consumer has applied for SSI and request that the financial status code be updated. The Financial Interviewer will do a follow-up with the consumer within six-months and periodically thereafter.

STEP 3 – Case manager is to document all benefit application assistance provided to the consumer in the interdisciplinary notes and file in the consumer case file, along with other required episode documents, including signed consents.

Typically it takes the four to six months for an initial response from the Social Security Administration from the time of application

STEP 4 - If the initial SSI application is denied and the case is open the assigned clinic case manager will continue to assist the consumer obtain SSI benefits by assisting the consumer to file a reconsideration application. **This request for reconsideration must be filed within 60 days of the denial notice date** (See Attachment 5).Assist the consumer in completing the **Reconsideration for Reconsideration SSA-561-U2 and Reconsideration Disability Report SSA –3341-56** (See Attachment 6) and hand deliver it to the appropriate Social Security Office. The benefit application assistance is to be documented in the case notes as appropriate. *Thisreconsideration process can take up to 18 months*

STEP 5 – If the reconsideration is denied the case manager will refer the consumer's SSI case to the DBH SSI legal advocate via the DBH SSI Liaison for further consideration. See SSI Denial Advocacy Process in Section VI.

VII. SSI Denial Advocacy Process

If the SSI application is denied after reconsideration the case manager will work with the DBH SSI Advocate and assist the consumer to appeal the decision. **This request must be filed within 60 days of the reconsideration denial notice date.**

STEP 1 - Upon notice of the reconsideration denial case managers are to assist consumers in appealing the decision.

- Within 10-days, the case manager will notify the DBH SSI Liaison that a consumer is to be referred to the SSI Legal Advocate. The DBH liaison will serve as the initial point of contact with the advocate, provide on- going assistance and continually track the status of the consumer's application until disposition.

- The case manager will complete the SSI Advocate Referral Form (See Attachment 7) and forward to the DBH SSI Liaison along with the following documents:

  - Signed Release of Information
  - Copy of the SSI Reconsideration Denial Letter
  - *For consumers in board and care placement only, attach a completed SSP 14 (Attachment8)*

- The case manager will document the referral to the legal advocate on the 17 D Log.

STEP 2 – The DBH SSI Liaison shall forward the documents to the SSI Legal Advocate and schedule an interview for the consumer with Inland Counties Legal Service at the appropriate office in the region. The DBH SSI Liaison will notify the case manager of the appointment.

STEP 3 – The case manager shall transport and/or accompany consumer to initial assessment interview.

STEP 4 –The SSI Advocate shall return completed copies of the referral form to the DBH SSI Liaison for distribution. The SSI Advocate will submit monthly reports of consumers SSI benefit case status to DBH. The case manager will keep in communications with the advocate and the liaison regarding relevant changes that may impact the case. In all cases case managers are to maintain:

- *Communication with Advocate and the DBH SSI Liaison*
- *Provide appropriate and relevant information in a timely fashion as requested*
- *Follow-up with consumer and advocate as appropriate*

When SSI application is approved the case manager will request that Medi-Cal be retro active and notify all relevant parties which may include case management team members, including the financial interviewer, and the business office. The case manager will narrate results in the case management file. The consumers DBH case file will remain open until disposition. (See Attachment 9)

1-OFFICE 4-HOME 5-SATELLITE 6-SCHOOL 2-OTHER FIELD (ADD CODE 3 IF NON-FACE-TO-FACE) (LOC IS 1 IF NOT SPECIFIED)

DATE: BILLING TIME: LOCATION: SERVICE TYPE: ASSESSMENT

ALL ITEMS BELOW MUST BE COMPLETED (EVEN WITH N/A OR "NOT AVAILABLE"). THE ASSESSMENT SHOULD ILLUSTRATE ALL MEDICAL NECESSITY PRESENT AND PROVIDE THE BASIS FOR THE DSM-4 DIAGNOSIS.

PART 2 of 3 (completed by LPHA or non-LPHA)

RESOURCE NEEDS (appropriate to client's desires and culture)

INCOME: ☐ No need Describe need and recommendation/plan:_____

_____

_____ ☐ Client declines help at this time

FOOD: ☐ No need Describe need and recommendation/plan:_____

_____

_____ ☐ Client declines help at this time

HOUSING: ☐ No need Describe need and recommendation/plan:_____

_____

_____ ☐ Client declines help at this time

EDUCATION: ☐ No need Describe need and recommendation/plan:_____

_____ ☐ Client declines help at this time

WORK/VOLUNTEER WORK/PREPARATION FOR WORK: ☐ No need Describe need and recommendation/plan:____

_____

_____ ☐ Client declines help at this time

CHILDCARE: ☐ No need Describe need and recommendation/plan:_____

_____ ☐ Client declines help at this time

TRANSPORTATION: ☐ No need Describe need and recommendation/plan:_____

_____ ☐ Client declines help at this time

LEGAL ADVICE: ☐ No need Describe need and recommendation/plan:_____

_____ ☐ Client declines help at this time

IMMIGRATION ASSISTANCE: ☐ No need Describe need and recommendation/plan:_____

_____ ☐ Client declines help at this time

OTHER:_____ ☐ No need Describe need and recommendation/plan:_____

_____ ☐ Client declines help at this time

_____ _____

Date/Provider Signature/Printed Name Date/Client Signature, if possible

CLINICAL ASSESSMENT (PART 2 of 3)
County of San Bernardino
DEPT. OF BEHAVIORAL HEALTH
Confidential Pt. Information
Sec W&I Code 5328

NAME:

CHART NO.:

DOB: / /

PROGRAM:

INDIGENT ADMISSION NOTIFICATION TRACKING/STATUS FORM

ATTACHMENT 2

SPM 6-3.11

THIS IS TO INFORM YOU THAT AN INDIGENT CONSUMER HAS BEEN HOSPITALIZED IN YOUR REGION AND REQUIRES YOUR IMMEDIATE ATTENTION AND FOLLOWUP

Consumer Name: John Doe Date Faxed to Region 10/25/02

Social Security Number: 000-00-0000 DOB: 00/00/0000

Hospital: Canyon Ridge Admit Date: 10/24/02

The Regional Hospital Aftercare case manager is to answer the following questions no later than 11/03/02 (Within 10 days from date of admission)

If response to any of the following questions is yes, the Regional case manager is responsible to ensure that a Medi-Cal application is taken and followed up on this consumer.

Is the consumer pregnant? Yes ☐ No ☐

Over 65 years of age? Yes ☐ No ☐

Legally blind? Yes ☐ No ☐

Under 21 years of age? Yes ☐ No ☐

If yes, is consumer married and living with parent(s)? Yes ☐ No ☐

Is consumer in United States as a refugee? Yes ☐ No ☐

Does doctor expect the consumer's illness/injury to keep them from any kind of employment for more than 1 year? Yes ☐ No ☐

Does consumer have a child under 21 years of age in their home? Yes ☐ No ☐

Date Medi-Cal application taken _____

TAD caseworker name and phone number _____

DBH case manager name and phone number _____

Fax completed form to the Compliance Unit (909) 387-7041 by the due date

ATTACHMENT 3

County of San Bernardino
DEPARTMENT OF BEHAVIORAL HEALTH SPM 6-3.11

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

_____ / / _____ - - _____
Print Client's Name | Date of Birth | Social Security Number

I AUTHORIZE: _____
Name of Facility or Provider
to release information obtained during the course of contact with your facility to:

_____ _____
Facility Name **Person To Receive Information** (required)

_____
Address To Which Records Are To Be Sent Street, Suite City State Zip Code

The disclosure of records authorized herein is required for the following **specific purpose** (required for DBH release of information only): _____

_____

The following specific types of information are requested for the above purpose:
Such disclosure shall be limited to the minimum specific types of information that pertain to the purpose of this authorization.

☐ Diagnosis ☐ Prognosis ☐ Medication ☐ Side Effects of Meds Rx ☐ Dates of Treatment
☐ Evaluation/Assessment ☐ Lab Reports ☐ Medical History-Evaluations

☐ OTHER: Please specify "other" information and the specific purpose for which it is needed:

_____

- An additional AUTHORIZATION must be obtained for any other transfer or disclosure of information.
- This Authorization is subject to cancellation by the undersigned at any time except to the extent that action already has been taken. Cancellation of this authorization must be in writing to the treating professional. This action will not affect your right to further treatment or your right to future treatment.
- If not earlier cancelled, this authorization shall terminate 90 days from date the authorization is signed, or:
  ☐ On completion of this request ☐ One year or end of treatment, whichever comes first.

- I understand that I have a right to receive a copy of this authorization if I so request.
- I understand that the information disclosed by this authorization may be re-disclosed by the facility receiving it and may not be further protected.

DATE: _____ WITNESS: _____
Staff witnessing signature will sign as witness

Signed: _____ * _____
* If signed by other than client, indicate relationship

Note: ***Parents must have legal custody. Legal guardians and conservators must show proof.***

CONFIDENTIAL CLIENT INFORMATION

_____
Physician or licensed Clinician in charge of the patient will sign if approval is needed under the Lanterman-Petris-Short Act.

California W & I Code Section 5328
Federal Regulation 42 Code, part 2
HIPAA Federal Regulation 45 Code, part 2

BLUE revised 4/25/03 D60\release403

SSI Disability Questionnaire

Things We Need to Know When You Are Filing For Disability

In order for us to decide whether or not you are eligible to receive disability payments from the Social Security Administration you need to provide us with as much information as is available about your disability and any care or treatment you have received. **You do not need to ask doctors or hospitals for any medical records that you do not already have.** With your permission, we will do that for you. **You may file an application even if you do not have all of this information.** We will assist you in obtaining any information that you do not have. If you wait to file, you may lose benefits. Please complete both sides of this form.

Who Has Your Medical Records?

- Name of Doctor, Hospital or Clinic
- Telephone Number
- Dates of Visits
- Treatments Received
- Address
- Chart/HMO/Clinic #
- The Reason for the visit
- Doctors' Business Card (if available)

1.)_____ 2.)_____

_____ _____

3.)_____ 4.)_____

_____ _____

5.)_____ 6.)_____

_____ _____

What Medications are you taking?

Medicine	Dosage	Prescribing Doctor

NOTE: If available, you may bring in your medicine bottles so we can extract the needed information.

What Medical Tests Have You Had?

Test	Date of Test	Doctor Ordering Test

Questions about Your Work History

If you have worked in the past 15 years you will need to describe all types of work that you have done, the type of business, dates worked, hours per day, days per week, and rate of pay. We **do not** need to know all the employers for whom you have worked only the **types** of jobs that you have had. For example, if you did the same job for multiple employers, you would only list the job once.

1.)_____

2.)_____

3.)_____

4.)_____

5.)_____

6.)_____

If you prefer, you can complete the disability report prior to your scheduled appointment via the Internet at **www.ssa.gov/adultdisabilityreport/** .

SOCIAL SECURITY ADMINISTRATION TOE 710

REQUEST FOR RECONSIDERATION

(Do not write in this space)

The information on this form is authorized by regulation (20 CFR 404.907 - 404.921 and 416.1407 - 416.1421) and Public Law 106-169 (section 809(a)(1) of section 251(a)). While your response to these questions is voluntary, the Social Security Administration cannot reconsider the decision on this claim unless the information is furnished.

NAME OF CLAIMANT	NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON *(If different from claimant.)*
SOCIAL SECURITY CLAIM NUMBER	SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFITS (SVB) CLAIM NUMBER
SPOUSE'S NAME *(Complete ONLY in SSI cases)*	SPOUSE'S SOCIAL SECURITY NUMBER *(Complete ONLY in SSI cases)*

CLAIM FOR *(Specify type, e g., retirement, disability, hospital insurance, SSI, SVB, etc.)*

I do not agree with the determination made on the above claim and request reconsideration. My reasons are:

SUPPLEMENTAL SECURITY INCOME OR SPECIAL VETERANS BENEFITS RECONSIDERATION ONLY

(See reverse of claimant's copy)

"I want to appeal your decision about my claim for supplemental security income (SSI) or special veterans benefits (SVB). I've read the back of this form about the three ways to appeal. I've checked the box below."

☐ Case Review ☐ Informal Conference ☐ Formal Conference

EITHER THE CLAIMANT OR REPRESENTATIVE SHOULD SIGN - ENTER ADDRESSES FOR BOTH

SIGNATURE OR NAME OF CLAIMANT'S REPRESENTATIVE ☐ NON-ATTORNEY ☐ ATTORNEY			CLAIMANT SIGNATURE		
STREET ADDRESS			STREET ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
TELEPHONE NUMBER *(Include area code)*		DATE	TELEPHONE NUMBER *(Include area code)*		DATE

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

See reverse of claim folder copy for list of initial determinations

1. HAS INITIAL DETERMINATION BEEN MADE? ☐ YES ☐ NO

2. CLAIMANT INSISTS ON FILING ☐ YES ☐ NO

3. IS THIS REQUEST FILED TIMELY? ☐ YES ☐ NO
(If "NO", attach claimant's explanation for delay and attach only pertinent letter, material, or information in social security office.)

RETIREMENT AND SURVIVORS RECONSIDERATIONS ONLY (CHECK ONE) REFER TO (GN 03102.125)

SOCIAL SECURITY OFFICE ADDRESS

☐ NO FURTHER DEVELOPMENT REQUIRED (GN 03102.125)

☐ REQUIRED DEVELOPMENT ATTACHED

☐ REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAYS

ROUTING INSTRUCTIONS (CHECK ONE) →

☐ DISABILITY DETERMINATION SERVICES *(ROUTE WITH DISABILITY FOLDER)*
☐ ODO, BALTIMORE
☐ PROGRAM SERVICE CENTER
☐ OIO, BALTIMORE
☐ OEO, BALTIMORE
☐ DISTRICT OFFICE RECONSIDERATION
☐ CENTRAL PROCESSING SITE (SVB)

NOTE: TAKE OR MAIL COMPLETED COPIES TO YOUR SOCIAL SECURITY OFFICE

ADMINISTRATIVE ACTIONS THAT ARE INITIAL DETERMINATIONS
(See GN03101.070, GN03101.080, and SI04010.010)

NOTE: These lists cover the vast majority of administrative actions that are initial determinations. However, they are not all inclusive.

Title II

1. Entitlement or continuing entitlement to benefits;
2. Reentitlement to benefits;
3. The amount of benefit;
4. A recomputation of benefit;
5. A reduction in disability benefits because benefits under a worker's compensation law were also received;
6. A deduction from benefits on account of work;
7. A deduction from disability benefits because of claimant's refusal to accept rehabilitation services;
8. Termination of benefits;
9. Penalty deductions imposed because of failure to report certain events;
10. Any overpayment or underpayment of benefits;
11. Whether an overpayment of benefits must be repaid;
12. How an underpayment of benefits due a deceased person will be paid;
13. The establishment or termination of a period of disability;
14. A revision of an earnings record;
15. Whether the payment of benefits will be made, on the claimant's behalf to a representative payee, unless the claimant is under age 18 or legally incompetent;
16. Who will act as the payee if we determine that representative payment will be made;
17. An offset of benefits because the claimant previously received Supplemental Security Income payments for the same period;
18. Whether completion of or continuation for a specified period of time in an appropriate vocational rehabilitation program will significantly increase the likelihood that the claimant will not have to return to the disability benefit rolls and thus, whether the claimant's benefits may be continued even though the claimant is not disabled; and
19. Nonpayment of benefits because of claimant's confinement in a jail, prison, or other penal institution or correctional facility for conviction of a felony.

Title XVI

1. Eligibility for, or the amount of, Supplemental Security Income benefits;
2. Suspension, reduction, or termination of Supplemental Security Income benefits;
3. Whether an overpayment of benefits must be repaid;
4. Whether payments will be made, on claimant's behalf to a representative payee, unless the claimant is under age 18, legally incompetent, or determined to be a drug addict or alcoholic;
5. Who will act as payee if we determine that representative payment will be made;
6. Imposing penalties for failing to report important information;
7. Drug addiction or alcoholism;
8. Whether claimant is eligible for special SSI cash benefits;
9. Whether claimant is eligible for special SSI eligibility status;
10. Claimant's disability; and
11. Whether completion of or continuation for a specified period of time in an appropriate vocational rehabilitation program will significantly increase the likelihood that claimant will not have to return to the disability benefit rolls and thus, whether claimant's benefits may be continued even though he or she is not disabled.

NOTE: Every redetermination which gives an individual the right of further review constitutes an initial determination.

Title VIII (See VB 02501.035)

1. Meeting or failing to meet the qualifying and/or entitlement factors for special veterans benefits (SVB);
2. Reduction, suspension or termination of SVB payments;
3. Applicability of a disqualifying event prior to SVB entitlement;
4. Adminstrative actions in SVB cases similar to those listed under title II--items 3, 4, 10, 11 & 16.

Title XVIII

1. Entitlement to hospital insurance benefits and to enrollment for supplementary medical insurance benefits;
2. Disallowance (including denial of application for HIB and denial of application for enrollment for SMIB);
3. Termination of benefits (including termination of entitlement to HI and SMI).

SOCIAL SECURITY ADMINISTRATION

REQUEST FOR RECONSIDERATION

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SPOUSE'S NAME *(Complete ONLY in SSI cases)*	SPOUSE'S SOCIAL SECURITY NUMBER *(Complete ONLY in SSI cases)*

CLAIM FOR *(Specify type, e.g., retirement, disability, hospital insurance, SSI, SVB, etc.)*

I do not agree with the determination made on the above claim and request reconsideration. My reasons are:

SUPPLEMENTAL SECURITY INCOME OR SPECIAL VETERANS BENEFITS RECONSIDERATION ONLY

(See reverse of claimant's copy)

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SIGNATURE OR NAME OF CLAIMANT'S REPRESENTATIVE ☐ NON-ATTORNEY ☐ ATTORNEY			CLAIMANT SIGNATURE		
STREET ADDRESS			STREET ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
TELEPHONE NUMBER *(Include area code)*		DATE	TELEPHONE NUMBER *(Include area code)*		DATE

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

See reverse of claim folder copy for list of initial determinations

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2. CLAIMANT INSISTS ON FILING ☐ YES ☐ NO

3. IS THIS REQUEST FILED TIMELY? ☐ YES ☐ NO
(If "NO", attach claimant's explanation for delay and attach only pertinent letter, material, or information in social security office)

RETIREMENT AND SURVIVORS RECONSIDERATIONS ONLY (CHECK ONE) REFER TO (GN 03102.125)

SOCIAL SECURITY OFFICE ADDRESS

☐ NO FURTHER DEVELOPMENT REQUIRED (GN 03102.125)

☐ REQUIRED DEVELOPMENT ATTACHED

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ROUTING INSTRUCTIONS (CHECK ONE) →

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☐ PROGRAM SERVICE CENTER
☐ OIO, BALTIMORE
☐ OEO BALTIMORE
☐ DISTRICT OFFICE RECONSIDERATION
☐ CENTRAL PROCESSING SITE (SVB)

NOTE: TAKE OR MAIL COMPLETED COPIES TO YOUR SOCIAL SECURITY OFFICE

HOW TO APPEAL YOUR SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFIT (SVB) DECISION

There are three different ways to appeal. You can pick the appeal that fits your case. The person who gave you this form can tell how these appeals work. You can have a lawyer, friend, or someone else help you with your appeal.

Here are the three ways to appeal:

1. CASE REVIEW:

You can give us more facts to add to your file. Then we'll decide your case again. You don't meet with the person who decides your case.

You can pick this kind of appeal in all cases.

2. INFORMAL CONFERENCE:

You'll meet with the person who will decide your case. You can tell that person why you think you're right. You can give us more facts to help prove you're right. You can bring other people to help explain your case.

You can pick this kind of appeal in all SSI cases *except* two. You can't have it if we turned down your SSI application for medical reasons or because you're not blind. Also you can't have it if we're giving you SSI but you disagree with the date we said you became blind or disabled. In SVB cases, you can pick this kind of appeal only if we're stopping or lowering your SVB payment.

3. FORMAL CONFERENCE:

This is a meeting like an informal conference. Plus, we can make people come to help prove you're right. We can do this even if they don't want to help you. You can question these people at your meeting.

You can pick this kind of appeal only if we're stopping or lowering your SSI or SVB payment. You can't get it in any other case.

Now you know the three kinds of appeals. You can pick the one that fits your case. Then fill out the front of this form. We'll help you fill it out.

There are groups that can help you with your appeal. Some can give you a free lawyer. We can give you the names of these groups.

NOTE: DON'T FILL OUT THIS FORM IF WE SAID WE'LL STOP YOUR SSI DISABILITY CHECK FOR MEDICAL REASONS OR BECAUSE YOU'RE NO LONGER BLIND. WE'LL GIVE YOU THE RIGHT FORM (HA-501-U5) FOR YOUR APPEAL.

☆ U S GOVERNMENT PRI NTING OFFICE. 2002-486-943/51245

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0144

For SSA Use Only - Do NOT Complete This Item.	
Name of Wage Earner	Social Security Number
Name of Claimant	Social Security Number
Type of Claim:	
Title II - ☐ Freeze ☐ DIB ☐ DWB ☐ CDB Title XVI - ☐ Disability ☐ Blind ☐ Child	

RECONSIDERATION DISABILITY REPORT

PLEASE PRINT, TYPE OR WRITE CLEARLY AND ANSWER ALL ITEMS TO THE BEST OF YOUR ABILITY. If you are filing on behalf of someone else, answer all questions. COMPLETE ANSWERS WILL AID IN PROCESSING THE CLAIM.

PRIVACY ACT: The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1633(a) of the Social Security Act. The information on this form is needed by Social Security to make a decision on your claim While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on your claim and could result in the loss of benefits. Although the information you furnish on this form is almost never used for any purpose other than making a determination on your disability claim, such information may be disclosed by the Social Security Administration as follows: (1) To enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal laws requiring the release of information from Social Security records (e.g., the General Accounting Office and the Veterans Administration); (3) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security). These and other reasons why information about you may be used or given out are explained in the **Federal Register**. If you would like more information about this, any Social Security office can assist you.

Date Claim Filed

PART I - INFORMATION ABOUT YOUR CONDITION

1. Has there been any change (for better or worse) in your illness or injury since you filed your claim? ..... ☐ Yes ☐ No
   If "Yes," describe any changes in your symptoms.

2. Describe any physical or mental limitations you have as a result of your condition since you filed your claim.

3. Have any restrictions been placed on you by a physician since you filed your claim?..... ☐ Yes ☐ No
   If "Yes," give name, address, and telephone number of the physician and show what kinds of restrictions have been imposed.

4. Do you have any additional illness or injury that you feel we should know about? ☐ Yes ☐ No
   If "Yes," describe the kind of illness or injury and the date that it occurred.

PART II - INFORMATION ABOUT YOUR MEDICAL RECORDS

5. Have you seen any physician since you filed your claim? ..... ☐ Yes ☐ No
If "Yes," provide the following about the physician you last visited:

NAME	ADDRESS *(Include ZIP Code)*
AREA CODE AND TELEPHONE NUMBER	
HOW OFTEN DO YOU SEE THIS PHYSICIAN?	DATE YOU SAW THIS PHYSICIAN

REASONS FOR VISITS

TYPE OF TREATMENT RECEIVED *(Include drugs, surgery, tests)*

6. Have you seen any other physician since you filed your claim?..... ☐ Yes ☐ No
If "Yes," show the following:

NAME	ADDRESS *(Include ZIP Code)*
AREA CODE AND TELEPHONE NUMBER	
HOW OFTEN DO YOU SEE THIS PHYSICIAN?	DATE YOU SAW THIS PHYSICIAN

REASONS FOR VISITS

TYPE OF TREATMENT RECEIVED *(Include drugs, surgery, tests)*

If you have seen other physicians since you filed your claim, list their names, addresses, dates and reasons for visits in Part V

7. Have you been hospitalized, or treated at a clinic or confined in a nursing home or extended care facility for your illness or injury since you filed your claim?..... ☐ Yes ☐ No
If "Yes," show the following:

NAME OF FACILITY	ADDRESS OF AGENCY *(Include ZIP Code)*
PATIENT OR CLINIC NUMBER	
WERE YOU AN INPATIENT? *(Stayed at least overnight)* ☐ Yes ☐ No IF "YES," SHOW →	DATES OF ADMISSIONS AND DISCHARGES
WERE YOU AN OUTPATIENT? ☐ Yes ☐ No IF "YES," SHOW →	DATES OF VISITS

REASON FOR HOSPITALIZATION, CLINIC VISITS, OR CONFINEMENT

TYPE OF TREATMENT RECEIVED *(Include drugs, surgery, tests)*

If you have been in other hospitals, clinics, nursing homes, or extended care facilities for your illness or injury, list the names, addresss, patient or clinic number, dates and reasons for hospitalization, clinic visits, or confinement in Part V.

8. Have you been seen by other agencies for your injury or illness? ..... ☐ Yes ☐ No
(VA, Workmen's Compensation, Vocational Rehabilitation, Welfare, Special Schools, Unions, etc.)
If "Yes," show the following:

NAME OF AGENCY	ADDRESS OF AGENCY (Include ZIP Code)
YOUR CLAIM NUMBER	
DATES OF VISITS	NAME OF COUNSELOR, SOCIAL WORKER, ETC.

TYPE OF TREATMENT OR EXAMINATION RECEIVED (Include drugs, surgery, tests)

If more space is needed, list the other agencies, their addresses, your claim numbers, dates, and treatment received in Part V

PART III - INFORMATION ABOUT WORK

9. Have you worked since you filed your claim?..... ☐ Yes ☐ No

If "Yes," you will be asked to give details on a separate form.

PART IV - INFORMATION ABOUT YOUR ACTIVITIES

10. How does your illness or injury affect your ability to care for your personal needs?

11. What changes have occurred in your daily activities since you filed your claim?
(If none, show, "None")

PART V - REMARKS AND AUTHORIZATIONS

12.(a) READ CAREFULLY: I authorize the Social Security Administration to release information from my records, as necessary to process my claim, as follows:

Copies of my medical records may be furnished to a physician or a medical institution for background information if it is necessary for me to have a medical examination by that physician or medical institution. The results of any such examination may be given to my personal physician.

Information from my records may also be furnished, if necessary, to any company providing clerical and administrative services for the purposes of transcribing, typing, copying or otherwise clerically servicing such information. The State Vocational Rehabilitation Agency may also have access to information in my records to determine my eligibility for rehabilitative services.

I understand and concur with the statement and authorizations given above, except as follows (If there are no exceptions, write "None" in the space below. If you do not concur with any part of the above statement, state your objections clearly):

12.(b)	Telephone number where you can be reached:	Best time to reach you:

12.(b) Use this section to continue information required by prior sections. Identify the section for which the information is provided. Note: This section may also be used for any special or additional information which you wish to be recorded.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paper Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 30 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.

Knowing that anyone making a false statement or representation of a material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal Law, I certify that the above statements are true.

NAME (SIGNATURE OF CLAIMANT OR PERSON FILING ON THE CLAIMANT'S BEHALF)

SIGN HERE ▶

DATE

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address *(Number and street, city, state, and ZIP code)*	Address *(Number and street, city, state, and ZIP code)*

PART VI - FOR SSA USE ONLY - DO NOT WRITE BELOW THIS LINE

ıe of Wage Earner	Social Security Number
Name of Claimant	Social Security Number

13. Check each item to indicate whether or not any difficulty was observed:
(Explain all items checked "Yes," in Item 14 below)

Reading:	☐ Yes	☐ No	Using Hands:	☐ Yes	☐ No
Writing:	☐ Yes	☐ No	Breathing:	☐ Yes	☐ No
Answering:	☐ Yes	☐ No	Seeing:	☐ Yes	☐ No
Hearing:	☐ Yes	☐ No	Walking:	☐ Yes	☐ No
Speaking:	☐ Yes	☐ No	Sitting:	☐ Yes	☐ No
Understanding:	☐ Yes	☐ No	Assistive Devices:	☐ Yes	☐ No

Other *(Specify)*: _____

. If any of the above items were checked "Yes," describe the observed difficulty:

15. Describe fully: General appearance, behavior, any unusual observed difficulties not noted elsewhere, any unusual circumstances surrounding the interviews.

16. Claimant requires assistance ..... ☐ Yes ☐ No

If "Yes," show name, address, phone number, and relationship of interested person. Also show why claimant requires assistance (foreign-speaking, unable to ambulate, etc.)

17. Capability development appears needed ..... ☐ Yes ☐ No

If "Yes," indicate whether DO will undertake development because it is also developing medical evidence from a special arrangement source. (Show name and address of source.)

18. Is development of work activity necessary?..... ☐ Yes ☐ No

If "Yes," is an SSA-821 or SSA-820-F4 ☐ Pending ☐ In File

19. SSA-3441 Taken By:

☐ Personal Interview
☐ DO/BO ☐ Home ☐ Other_____
☐ Telephone
☐ Mail

Signature of Interviewer or Reviewer	Title	DO, BO, or TSC	Date

San Bernardino County Department of Behavioral Health

REFERRALS TO SSI ADVOCATE ATTORNEY

(For referrals to Inland Counties Legal Service)

TO: **Inland Counties Legal Services**

☐ **San Bernardino Office**
715 North Arrowhead, Ste 113
San Bernardino, CA 92401
Phone (909) 884-8615, ext 510
Fax (909) 884-8281

☐ **Victorville Office**
14196 Amargosa Road, Ste K
Victorville, CA 92392
Phone (760) 241-7073, ext 710
Fax (760) 241-2111

☐ **Rancho Cucamonga Office**
10601 Civic Center Drive Ste 260
Rancho Cucamonga, CA 91730
Phone (909) 980-0982
Fax (909) 980-4871

DBH SSI LIAISON
Department of Behavioral Health
939 North D Street
San Bernardino, CA
(909) 388-4313
(909) 388-4312

Section 1: CLIENT INFORMATION

Client Name _____
Last Name First M I

Client SSN ___ __ ___ __ __ ___ ___ ___ DOB ___ ___ ___ ___ ___ ___
Mo Day Yr

Phone (___ ___ ___) ___ ___ ___ ___ ___ ___ ___ DBH Case #: _____

☐ check if "message" only

Address _____
Street

_____
City State Zip Code

Section 2: SSI STATUS

☐ SSI Application Date _____
☐ Reconsideration has been denied, Reconsideration Denial Letter Attached **(REQUIRED).**
☐ Other _____

Section 3: CLIENT DECLARATION

_____ **I understand San Bernardino County Department of Behavioral Health and Inland Counties**
(Initial) **Legal Services are working cooperatively on my behalf to obtain Social Security benefits, specifically, SSI/SSP.**

_____ **I authorize the Department of Behavioral Health and/or Inland Counties Legal Services, contractor**
(Initial) **with San Bernardino County for SSI Advocacy, to release any necessary information between one another and with social Security Administration as it relates to my mental health status for the purpose of obtaining Social Security SSI/SSP benefits.**

_____
Client Signature (Initial Lines Above Also) **Date**

_____ ( )
DBH Case Manager Name **Phone**

Section 4: SSI ADVOCACY ATTORNEY

Complete this section and return canary and pink copies to DBH SSI Liaison

☐ Initial Appointment/Conference Completed _____
Date

☐ Comments: _____

_____ _____
Attorney Signature Date

Contract Attorney

Original –

ATTACHMENT 8 SPM 6-3.11

FOR COUNTY/STATE USE:	
SOCIAL SECURITY NO	GR CODE

AUTHORIZATION FOR REIMBURSEMENT OF INTERIM ASSISTANCE GRANTED PENDING SSI/SSP ELIGIBILITY DETERMINATION

I understand that the public assistance paid to me, or on my behalf, by _____ is considered interim assistance if it is paid during the period of time that my supplemental security income (SSI)/state supplementary payment (SSP) eligibility is being determined (Assistance financed wholly or partly with Federal funds shall not be considered interim assistance)

In consideration of such interim assistance paid to me, or on my behalf, I, _____, authorize the Secretary of the United States Department of Health and Human Services, through the Social Security Administration (SSA) to send the first payment of any SSI/SSP benefits for which I may be determined eligible, to the above Agency

I authorize the above Agency to retain from that payment an amount equal to the sum of public assistance payments the above agency and other California interim assistance agencies paid to me, or on my behalf, to meet my basic needs both before and after the date of this authorization, but limited to the period my SSI/SSP eligibility determination was pending,

☐ Initial — beginning with the month for which I am found eligible for an SSI/SSP payment and ending with the month my SSI/SSP payments begin,

or

☐ Post Eligibility — beginning with the month for which my SSI/SSP payments are reinstated after a period of suspension or termination and ending with the month my payments resume

I understand that, after making the above deduction from my SSI/SSP payment, the above agency shall pay to me the balance, if any, no later than ten (10) working days from the day the above Agency receives my payment from SSA

I understand that, if I feel that the amount deducted from my SSI/SSP retroactive payment is more than the amount of public assistance paid to me, or on my behalf, by the above Agency, or if I feel the above Agency failed to pay me the excess within the ten (10) day period, I have a right to request a fair hearing from the State Department of Social Services This request must be filed within ninety (90) days of the date the above Agency notifies me of the receipt and disbursement of the payment

I understand that if I file an initial claim for SSI/SSP benefits at a Social Security Office within 60 days of the date the above Agency receives this signed form, my eligibility for SSI/SSP benefits can begin as early as the date the above Agency receives this signed form

I understand that this authorization is effective from the date the above Agency receives this signed form and that it will cease to have effect

☐ Initial Claim — at the end of one (1) year from the date the above Agency receives this signed form, unless I file for SSI/SSP within that time, or one of the events listed below occurs earlier, in which case the authorization will cease to have effect as of the date of such event,

- SSA makes an initial payment or reinstates payment on my claim,
- SSA denies my claim and I do not file a timely appeal of that determination,
- The above Agency and I agree to terminate this authorization

or

☐ Post Eligibility — at the end of one (1) year from the date the above Agency receives this signed form, or at the end of the maximum period within which to request review of the determination to suspend or terminate my SSI/SSP payments, whichever period of time is longer, unless I file a timely request for review, or one of the events listed above occurs earlier, in which case the authorization will cease to have effect as of the date of such an event

SIGNATURE OF APPLICANT OR DESIGNATED REPRESENTATIVE (TITLE)		DATE
SIGNATURE OF IA AGENCY REPRESENTATIVE	PHONE	DATE

If recipient signs form with a mark, the signature must have two witnesses who provide their signature, address, and the date below

WITNESSED BY	WITNESSED BY
ADDRESS (NUMBER STREET)	ADDRESS (NUMBER STREET)
CITY STATE ZIP CODE	CITY STATE ZIP CODE

SOCIAL SECURITY ADMINISTRATION USE *(For turnaround information to the county/state agency)*

☐ This form has been transmitted to the SSA system	☐ Another GR is already in system NO _____

DBH PROCEDURE FOR REFERRAL TO SSI ADVOCATE

Regina Owens will be the contact person that will track and forward the referrals to the SSI advocate.

Regina's duties are:

- Keep department log to track referrals to SSI advocate.
- Contact SSI advocate to make sure a monthly status report is sent to our department.
- Contact Clinic Case Managers and clients when necessary to get additional information and to make sure of clients's whereabouts. (Some clients tend to move around frequently and we want to be able to stay in contact with them in order to further assist them in this matter).
- Keep SSI advocate informed of client's whereabouts or changes that may affect this process.
- Submit monthly status reports to Assistant Director, Program Managers and Clinic Supervisors.
- Maintain a filing system (keep copies of all referrals submitted along with copy of Reconsideration Denial Letter attached).

Clinic Responsibilities:

- Assist clients in applying for SSI
- Make client signs a Release of Confidentiality Information, one Social Security Administration and another for Inland Counties Legal Services.
- Once client receives first letter of denial, assist client in filing a Letter of Reconsideration.
- Once the Letter of Reconsideration is denied, complete the DBH Referral to SSI advocate and submit it to Regina Owens (send to "D" Street clinic)
- Maintain a log of the referrals submitted to Regina.
- Do not have client contact Regina directly. She is out of the office frequently and this may frustrate the client. Regina will work closely with the Clinic Case Managers in answering their questions/concerns. Please-mail her