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ASPE RESEARCH BRIEF

OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

OFFICE OF HUMAN SERVICES POLICY - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

The federal Supplemental Security Income (SSI) program, which includes children with disabilities from low-income households, has grown in recent years (1998–2013). Caseload growth has varied by state and recent (2013) caseload sizes also vary by counties within states. The factors driving this variation are not well understood and have received limited study. Site visits to four states explored pathways to the child SSI program. Interviews with local Social Security field office staff, representatives of state and local safety net programs, and other service providers revealed few formal mechanisms for referring potentially eligible children to the SSI program. Interviewees stressed the significance of informal referrals, such as from family and friends, in connecting applicants to SSI, though schools, health care providers, and legal services staff also play a role. More consistent formal mechanisms for screening and referral have the potential to reduce state and county variation in program participation. This would likely increase income and reduce poverty for new child SSI recipients, but would increase federal expenditures for SSI benefits.

THE CHILD SSI PROGRAM AND THE CHANGING SAFETY NET: PATHWAYS TO SSI

The child Supplemental Security Income (SSI) program is a federal income support program administered by the Social Security Administration (SSA) for children younger than age 18 with disabilities from low-income households.[1] From 1998 to 2013, a period in which there were no major changes in eligibility requirements, child SSI caseloads grew by 45 percent nationally. The growth in the child SSI caseload has varied substantially by state, and the factors driving this growth are not well understood.[2] The variation in growth in the child SSI program raises questions about pathways to the program and how low-income households with potentially eligible children may learn about and receive assistance to apply for SSI benefits.

More broadly, given child SSI caseload growth and geographic variations, the role of the program in the broader safety net may be changing, as the surrounding policy and program environments at the state and local level are changing. **ASPE's *The Child SSI Program and the Changing Safety Net* project** explores these changes. The first brief in this series examined the growth of the child SSI program at the national level over time (1991-2011) in

ABOUT THIS RESEARCH BRIEF

This brief examines pathways to the child SSI program. It was prepared by John Tambornino, Bonnie O'Day and Hannah Burak. The analysis was conducted by Mathematica Policy Research staff in collaboration with staff in HHS's Office of the Assistant Secretary for Planning and Evaluation.

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comparison to the adult and elderly SSI programs and other safety net programs serving children (Tambornino et.al 2015a). The second brief examined how child SSI caseload growth (1998-2013) has varied substantially by state, and how recent (2013) caseloads also vary substantially by county, even after controlling for the size of the low-income population (Wittenberg et al. 2015). The third brief examined coordination between the child SSI program and the Temporary Assistance for Needy Families (TANF) program in select states, and concluded that TANF programs have a limited role in child SSI program referrals, as a result of the TANF caseload declines and changes in administrative processes (Tambornino et al. 2015b).

Questions

This brief discusses pathways to the child SSI program other than TANF, based on examination of four diverse states that vary substantially in child SSI caseload sizes: Kentucky, Oregon, Pennsylvania, and Texas. It addresses the following research questions:

- What are common sources of referral to the SSI program for low-income households with a child with a disability?
- Are there specific state or local efforts from social services, health, or educational agencies to refer children to the SSI program?
- What is the role of advocates or Legal Aid staff in facilitating child SSI applications?
- Do SSA administrative processes appear to influence pathways into the SSI program?

Findings

Findings are based on site visits to selected counties in the four states, descriptive analysis of child SSI, TANF, Medicaid/Children's Health Insurance Program (CHIP) and Supplemental Nutrition Assistance Program (SNAP, formerly food stamps) caseloads, and document review. Regardless of child SSI caseload size, we did not observe concerted efforts by human services or Legal Aid agencies to refer children to the SSI program. Instead, we found that:

- Family, friends, and neighbors were cited as the most important sources of referrals to the child SSI program, especially in states with larger child SSI caseloads.
- Health care providers, special education staff, and targeted state programs have a role in referring certain groups of children to SSI.
- Legal Aid staff were more active in age-18 redeterminations and in appealing application denials than in assisting with initial applications.
- SSA administrative processes were not cited as significant local factors in the number of child SSI applications or varying pathways into the program.

The Child SSI Program

Eligibility Requirements

The SSI program provides cash benefits to people with a disability (or to their household or legal guardian) and limited income and resources, and to people older than 65 with limited income and resources. Since its start in 1974, the SSI program has become an increasingly important source of income support to low-income households with children who have a disability. To meet the child disability criteria for SSI, a child must have "a medically determinable physical or mental impairment which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months" (42 U.S. Code 1382c).

The income eligibility requirements are complex; the rules include income "deeming" for both parental and child income in the calculation of the SSI benefit amount, and households generally must have limited resources to qualify for benefits.[3] According to Bailey and Hemmeter (2014), three-quarters of children who receive SSI have household incomes below 200 percent of the federal poverty level (which in 2014 was $39,580 per year for a household of three), and approximately one-third live in households with incomes below the federal poverty level (which was $19,790 per year for a household of three).[4] In 2014, the maximum SSI benefit was $721 per month, and all but four states supplemented federal SSI benefits with an additional state benefit for certain recipients, averaging $48 per month.[5]

Previous Findings

The factors driving growth in the child SSI caseload, large state and county variations, and specific pathways to the program have received limited attention.[6] A number of findings from previous briefs in this series led us to examine pathways to SSI. First, from 1998 through 2013, the national child caseload sizes of the SSI, Medicaid/CHIP, and SNAP programs increased substantially, whereas TANF caseloads experience even greater declines (Wittenburg et al. 2015). There were no major eligibility changes to the SSI program between 1998 and 2013, but the other programs' policies changed significantly in ways that might have influenced pathways to the SSI program. In addition, the increase in the number of child SSI recipients and corresponding reduction in the number of child TANF cash benefit recipients suggest that low-income households, in aggregate, now rely more on SSI than in the past.[7] In site visits to four states, TANF agencies appeared to play a diminishing role in referrals to SSI, due to smaller caseloads and changes in administrative processes (Tambornino et al. 2015b).

Study Approach

Drawing on document review, telephone discussions, and site visits to Kentucky, Oregon, Pennsylvania, and Texas, we collected qualitative data to assess whether differences in program environments appear to influence pathways to SSI and the size of the state's child SSI

caseload. As explained below, the selected states represent different geographic regions that vary substantially in their child SSI and TANF cash benefit caseload sizes, and modestly in their SNAP and Medicaid/CHIP caseload.[8] The states also vary in other dimensions, such as advocacy efforts within the state or special programs to identify and assist SSI recipients. The large difference in safety net program caseloads in these states directs attention to potential state variations in administrative processes or human services agency initiatives that might influence pathways to SSI.[9]

Safety Net Caseloads

Exhibit 1 summarizes the caseload sizes of the child SSI, TANF cash benefit, SNAP, and Medicaid/CHIP programs using ratios that adjust for the size of the child low-income population in the four states. Ratios illustrate the size of program caseloads relative to the number of low-income children in the state who might meet the income eligibility requirements. Specifically, this exhibit presents child SSI, TANF cash benefits, SNAP, and Medicaid/CHIP caseloads relative to the number of children from low-income households (defined as below 200 percent of the federal poverty level). [10]

Exhibit 1. Comparison of the child SSI program with other federal safety net programs serving children

	SSI-child low-income population ratio	TANF-child low-income population ratio	SNAP-child low-income population ratio	Medicaid/CHIP-child low-income population ratio
	2013	2013	2013	2010
United States	4.1%	9.5%	64.5%	93.5%
Kentucky	6.1%	10.3%	71.2%	95.4%
Oregon	2.8%	19.6%	74.8%	78.9%
Pennsylvania	7.2%	12.0%	64.4%	90.8%
Texas	4.3%	2.3%	64.5%	76.6%

Sources: Wittenburg et al. 2015

Note: Low-income population ratios in each program are calculated as the number of program participants divided by the number of children in low-income households (defined as below 200 percent of the federal poverty level). The figures for the TANF program include only recipients of TANF cash benefits. The most recent available data for Medicaid/CHIP are from 2010 due to lags in administrative data processing.

The 2013 national average SSI-child low-income population ratio is 4.1 percent (meaning 4.1 per 100 children from low-income households in the United States received SSI), yet there are substantial variations in these ratios among the four selected states (as there are across the United States). The SSI-child low-income population ratios ranged from 2.8 percent (Oregon) to more than 6 percent (Kentucky and Pennsylvania), with one state (Texas) having a ratio closer to the national average. The large variation in state ratios reflects our previous findings showing large variations in these ratios in all states, with the higher child SSI ratios more heavily concentrated in northeastern and southern states (Wittenburg et al. 2015).

As we noted in the third brief in this series, there is also variation in the relative sizes of child SSI and child TANF cash benefit caseloads across the four states, which is a function of the SSI differences noted above and the sizes of the TANF cash benefit caseloads (Tambornino et al. 2015b). Nationally, and in three of the four study states (Kentucky, Pennsylvania, and Oregon), the TANF-child low-income population ratios are higher than the corresponding SSI-child low-income population ratios. This is expected, given that the TANF program does not require that recipients demonstrate a disability.

In Oregon, caseload differences appear to be large, given the much higher number of child TANF cash benefit recipients relative to child SSI recipients. However, the TANF cash benefit caseload in Oregon in 2013 included a substantial number of working households receiving a minimal TANF cash benefit as a nutritional supplement; if such households are excluded, the caseload appears much smaller and the ratio of TANF cash benefit recipients to SSI recipients diminishes and becomes closer to the other states examined.[11] Conversely, one state (Texas) has more child SSI recipients than child TANF cash benefit recipients, which is primarily a function of Texas's very low TANF-child low-income population ratio of 2.3 percent (approximately one-fourth the national average of 9.3 percent).[12]

The child SSI ratios generally are much lower relative to those of other programs, especially SNAP and Medicaid/CHIP. This is not surprising, given that SSI targets a much narrower population for benefits (i.e. individuals with a serious disability) in comparison to SNAP and Medicaid/CHIP. For Medicaid/CHIP, Oregon and Texas have ratios below the national average, whereas Kentucky and Pennsylvania have ratios closer to the national average.[13] For SNAP, the four states examined have ratios at or above the national average. In summary, the four states represent different combinations of child SSI and other safety net program caseloads, presenting an opportunity to explore administrative factors that might influence these differences.

Stakeholder Interviews

Through interviews we attempted to identify formal efforts by program administrators, advocacy groups, or other private entities that facilitate low-income households' applications to the child SSI program. Specifically, we interviewed stakeholders who were most familiar with SSI program coordination, including state and local officials from income, food, and medical assistance programs; SSA field offices; Legal Aid organizations; and hospitals and schools. We asked these stakeholders about the ways in which households that have children with a disability learn about and apply for SSI benefits. **Appendix A** describes the counties visited and **Appendix B** describes the organizations and stakeholders interviewed in the visits.[14]

Findings

Interviewees indicated that informal networks tend to be more frequent sources of referrals than any concerted effort by private or public entities, though health care providers, special education staff and targeted state programs play a role. As such, pathways to SSI do not necessarily involve formal administrative processes to identify and refer potentially eligible children, or specific efforts on the part of organizations to facilitate program application. Below are the most common sources of referral to the child SSI program cited during stakeholder interviews.

Family and friends are common sources of referrals to the child SSI program

The most frequently cited source of referrals to the child SSI program in all four study states was friends and family, especially in low-income communities in Kentucky, Pennsylvania, and Texas. As noted earlier, these states had the highest SSI-child low-income population ratios, suggesting that more people are likely to learn about SSI through personal relationships. Some interviewees in Oregon mentioned family and friends as a referral source but did not stress their importance nearly as much as the stakeholders in the other states, which might reflect the relatively smaller child SSI caseload in Oregon. Nonetheless, even in Oregon, stakeholders generally stated that households learned how to apply for SSI through acquaintances.

SSA field office and TANF office staff in Kentucky, Pennsylvania, and Texas all noted that applicants for TANF, SNAP or medical benefits were very familiar with the SSI program. Additionally, the SSA field office staff stated that many child SSI applicants have other household members already receiving SSI or knew of someone in the program. This is consistent with findings from Bailey and Hemmeter (2014) that in 2010, more than 20 percent of child SSI recipients lived in a household with another child SSI recipient, and approximately 20 percent of child SSI recipients lived with an adult recipient. We did not observe any concerted outreach efforts to inform low-income households about SSI, as the program was already very well known in the communities visited. These findings also support the observations in the second brief in this series that SSI recipients tend to cluster more heavily in certain geographic regions and localities. Recipients who live in close proximity have more opportunities to share information about SSI with those who may be eligible.

Health care providers, special education staff, and targeted state programs refer children in specific age groups to the child SSI program

Stakeholder interviews cited a mix of secondary referral sources (other than informal referrals from family and friends) for child SSI applicants, which generally varied depending on the child's age. SSA field office staff and other interviewees cited health care providers, including staff of medical practices and hospitals, as sources of referrals for infants and young children to apply for SSI. Neonatal intensive care units were by far the most commonly cited source of support,

as low birth weight newborns are automatically eligible for SSI. Hospital staff assists parents of these children to establish medical eligibility for the SSI program.

Health care providers have an incentive to assist patients who may be eligible for the SSI program in applying, given that SSI recipients are automatically eligible for Medicaid in most states, which can reimburse providers for hospital and outpatient care. Medicaid is also an important source of coverage for crucial in-home services for people with a disability, such as medical equipment and respite services. The ways in which health care providers and agencies assisted beneficiaries varied; in some, social workers affiliated with these agencies completed applications for SSI benefits and assisted with appeals if applicants were denied. Other providers refer households to the SSI program without providing such assistance.

According to SSA field office staff, schools are a common source of referral for school-age youth (ages 5 to 17) to the SSI program. Staff noted that they receive an influx of child SSI applications at the beginning of the school year. For example, SSA field office staff in Houston and Portland stated that parents who have been referred by special education teachers or school administrators visit the field office with results from educational assessments that document a need for special education services and a disability that might qualify the child for SSI. School personnel in these locales occasionally assist households in applying for SSI.

Finally, some stakeholders noted targeted state programs that facilitate SSI applications, although these programs generally play a relatively small role given their focus on a narrow target population. For example, programs in Oregon and Kentucky assist children with disabilities in foster care to apply for SSI benefits and to appeal application denials.[15]

Legal Aid organizations are not a major source of referral

In addition to health agencies and schools, we examined whether Legal Aid organizations are a common source of referral to the child SSI program, given that they help individuals and households obtain and retain public assistance (e.g. SSI, TANF, veterans' benefits, and Medicaid/CHIP).[16] Representatives of Legal Aid organizations in all four states said they occasionally provide clients with information about SSI benefits and refer them to SSA, but that their organizations do not have sufficient staff to assist these households with completing the SSI application. Rather, Legal Aid representatives said they generally focus on assisting applicants who were denied disability benefits, who had their benefits terminated, or were approaching the age-18 redetermination. Community Legal Services, the Legal Aid program in Pennsylvania, and AppalReD, the Legal Aid program in Kentucky, have particularly strong services in these areas. The program in Pennsylvania has a special grant to assist children with the age-18 redetermination process, and a contract with the Pennsylvania Department of Public Welfare to assist TANF applicants and recipients with the appeals process if their SSI applications are denied.

Relationships between SSA field offices and local organizations do not appear to drive referrals to the child SSI program

Because the local SSA field offices follow federal regulations and procedures, there are minimal differences across states in how they process SSI applications. SSI applicants or their guardians or legal representatives must apply at an SSA field office for an initial eligibility determination (limited to non-disability requirements, such as income, resources, and citizenship). The field office refers potentially eligible applications to state Disability Determination Services (DDS) offices—state offices funded by SSA to make disability determinations based on federal policy.[17]

Relationships between human services organizations and the SSA local field offices vary across sites, but this variation did not appear to significantly influence pathways to SSI, because these organizations refer a small number of applicants to the SSI program, relative to the total number of SSI applicants. In some cases, health care, education, and Legal Aid staff reported collegial and open relationships with the local SSA field office; others stated that stronger relationships with SSA staff would enable them to assist clients more effectively.

Discussion

The child SSI program operates within a broader safety net that varies substantially across states and counties. As Exhibit 1 shows, substantial variation exists across states in their TANF cash benefit caseloads, suggesting that in many states, the SSI program is playing an increasingly important role in the safety net for poor households relative to TANF (primarily as a result of substantial declines in TANF caseloads). There is more limited variation in SNAP and Medicaid/CHIP caseloads across states, as the participation ratios for these programs are much higher and more consistent across states compared to the SSI and TANF ratios. In terms of program coordination, our site visits revealed differences in the extent to which human services programs assist children with disabilities and their households to apply for SSI benefits.

Pathways and Referrals

Despite the substantial variation across localities in policy and program environments, the consistent theme across interviews was that informal referrals, such as from family and friends, are the primary means of connecting households with children with disabilities to the SSI program. Such pathways were emphasized much more by interviewees in Kentucky, Pennsylvania, and Texas than in Oregon—which is not surprising, given that these three states have much higher SSI-child low-income population ratios than Oregon, and higher levels of poverty.

The specific efforts by hospitals and schools to link children to the SSI program, especially for infants and young children, generally were targeted narrowly to specific populations. These more formal public and private efforts, where they exist, provide pathways to SSI for specific

groups, though they do not necessarily affect general pathways to SSI for broader populations, particularly relative to the informal influences noted above. Given that children with disabilities are likely to interact with the health care system (and may become more likely to do so as additional households gain health insurance under the Affordable Care Act), this pathway may become more common.[18]

Potential Explanations

There are at least three potential explanations for the limited role public and private entities appear to play in referring households to the child SSI program. First, and most important, information about the SSI program appears to be relatively widespread, particularly in low-income localities with higher percentages of households receiving SSI benefits. In the low-income counties we visited, local media advertisements offering assistance with disability applications and appeals also acquaint households with the SSI program. States and advocates were very active in the late 1990s, following welfare reform, in helping households transition from county or state programs to the SSI program (Stapleton et al. 2001/2002), but these efforts may now be less necessary in certain parts of the country given SSI caseload increases. According to interviewees in all four states, most potential applicants already know about the program, making outreach and referrals unnecessary (since we did not interview applicants we do not know if their experience differs from this account).

Second, the limited formal efforts, particularly through TANF, SNAP, and Medicaid/CHIP programs, likely reflects the fact that health, education, and human services staff generally have large caseloads and may lack the resources necessary to provide individual attention to assist households with a child SSI application. Third, the administrative rules and application processes for determining eligibility for the child SSI program are complex, and service providers understandably often lack the knowledge of these rules and processes to assist households with an application.

Conclusion

As concluded in earlier briefs in this series, there does not appear to be a uniform state or local trend in child SSI caseload growth and geographic variation, or a single administrative, demographic, economic, or other factor driving these changes. The clustering of child SSI recipients observed in the second brief in certain regions and localities, which often spans state borders and thus different policy and program environments, supports the finding that households learn about SSI through informal networks. Formal analysis of these networks would advance understanding.

A limitation of this study is that it was not feasible to interview SSI recipients and their households to better understand their experiences regarding pathways into SSI. Nonetheless, the findings from interviews with various stakeholders regarding the role of informal networks provide insight into how clusters of higher child SSI participation - and also of lower participation – may emerge. The findings illuminate how SSI, although a federally uniform

program, resides within a safety net that varies substantially by state and often by county, which affects the role of the program in serving low-income households.

Given this variation in the broader safety net, and the role of informal networks, some households may have fewer referral pathways to the child SSI program. As a result, they may be less likely to receive income support for which they are eligible. More consistent formal mechanisms for screening and referral (such as through health care settings and schools) have the potential to reduce state and county variation in child SSI participation.[19] Increased participation in child SSI would likely increase income and reduce poverty for these households, but would increase federal expenditures for SSI benefits (and potentially increase state expenditures for state supplemental SSI benefits).[20]

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[1] This brief uses the term "child SSI program" for ease of reference; technically, there is no separate SSI program for children, but rather a single program with differing eligibility requirements for people younger than under age 18, ages 18–64, and age 65 or older. The child SSI benefit does not necessarily go directly to the household, but rather to a child recipient's "representative payee," who may or may not be a member of the household, to be spent by the child or the child's parent or guardian.

[2] For discussions of child SSI caseload growth see U.S. Government Accountability Office 2012; Schmidt 2012; Aizer et al. 2013; Tambornino et al. 2015a; Wittenburg et al. 2015. Regarding the relationship of child SSI caseload growth and the prevalence of disabilities in the general low-income population, Pulcini et al (2015) conclude that the increase in the number of child SSI recipients with certain mental health impairments (from 2000 to 2011) reflects the growing number of children in the general low-income population diagnosed with these impairments, rather than changes in SSI program eligibility or administration.

[3] "Deeming" refers to the process of determining the portion of a household's income and resources that is available to the applicant or recipient, and affects eligibility determination and benefit levels. For more details on the income eligibility requirements for SSI, see http://www.ssa.gov/ssi/text-child-ussi.htm.

[4] For federal poverty thresholds, see http://www.census.gov/hhes/www/poverty/data/threshld/index.html.

[5] Each state determines its state supplement amount (see http://www.socialsecurity.gov/ssi/text-benefits-ussi.htm, accessed November 2, 2014). For average state supplements for child SSI benefits in 2014, see Table 7 of https://www.socialsecurity.gov/policy/docs/statcomps/ssi_monthly/2014/, accessed November 2, 2014.

[6] A 2012 Government Accountability Office investigation examined national trends in child SSI program caseloads between 2000-2011, with a focus on mental impairments, and identified several possible explanations for caseload growth: the increase in the child population and changing demographics, the increase in the number of children living in poverty, the expansions of health insurance coverage and special education services, improvements in diagnosing mental impairments, and the decrease in the number of children receiving Continuing Disability Reviews and thus having SSI benefits terminated (GAO, 2012). In a state-level examination, Aizer et al (2013) concludes that the factors driving varying child SSI caseload growth are unclear.

[7] Complete analysis of the relative importance of child SSI in the low-income population would need to include the Earned Income Tax Credit (EITC) and child support benefits, among other sources of income. When limiting the comparison to TANF, a related observation is that, although more children receive TANF cash benefits than receive SSI benefits, federal spending on child SSI benefits exceeds combined federal and state spending on child TANF cash benefits (Tambornino et al. 2015a). Note that our analysis does not examine the number of *individual* households that transition from the TANF cash benefit program to the SSI program or that participate in both programs. Data in this area are limited; an analysis of merged TANF and SSI administrative data for adults in 26 states found that only six percent of SSI adult applicants had received TANF in the several months before applying for SSI (Skemer and Bayes, 2013).

[8] ASPE selected these four states based on a number of quantitative and qualitative factors (including caseload sizes, geographic diversity, urban/rural status, nature of TANF program and broader safety net, special programs serving transition-age youth, and advocacy activity) and after consulting a range of independent experts.

[9] A more complete analysis would include examination of geographic differences in child population demographics and prevalence of disability, and state Disability Determination Services (DDS) approval rates, among other factors.

[10] This analysis uses *ratios* rather than program participation *rates*, given that not all children from low-income households are eligible for SSI or other low-income programs, and that some program recipients are above the low-income threshold (this is primarily the case for SSI and CHIP). Ratios indicate program size relative to the population of low-income households, which helps control for the differences in the percentage of children in low-income households across states (see Wittenburg et al. 2015). We present all ratios as percentages, for ease of exposition and to facilitate comparisons across states and programs.

[11] Communication with Office of Family Assistance, Administration for Children and Families, May 12, 2015. For further information on Oregon's TANF program see: http://www.dhs.state.or.us/caf/ss/tanf/.

[12] In addition to Texas, 10 other states (Arkansas, Florida, Georgia, Illinois, Indiana, Louisiana, Mississippi, North Carolina, Oklahoma, and Wyoming) had more child SSI recipients than child TANF cash benefit recipients in 2013 (Wittenburg et al. 2015).

[13] For Medicaid/CHIP ratios, another comparison would be the percentage of uninsured children (i.e. those without any source of health insurance) in each state. For example, Oregon, despite having a relatively low Medicaid/CHIP-child low-income ratio in 2010, has an uninsured rate for children under 200 percent of federal poverty level (13.6 percent) that is close to the national average (14.5 percent)

for years 2009-2011. In comparison, the rate of uninsured children under 200 percent of federal poverty level in Texas for these years is 20.5 percent. See U.S Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2010 – 2012, http://www.census.gov/cps/data/cpstablecreator.html.

[14] An important caveat to these findings is that they represent the views of select stakeholders from one or two counties in each state. As in many states, significant county-level variation exists in child SSI program participation within these four states, particularly in Texas and Pennsylvania (Wittenburg et al. 2015). Given this, the findings presented are not representative of the entire state or of the United States.

[15] In Oregon, the Children's Benefit Unit in the Department of Human Services is a special unit that assists households with children in foster care, or other children for whom the state holds custody, to apply for public assistance for which they might qualify. In Kentucky, the Child Welfare Fiscal Services Branch contracts with the Public Consulting Group (PCG), a private firm specializing in assisting state and local governments, to expedite applications for SSI for individuals enrolled in state or local government income assistance programs. PCG uses Medicaid claims data and other data to identify foster children who might qualify. Staff assists with filing the application, become the representative payee, and manage the child's SSI benefits if approved, and also assist with appeals of denied claims and assist with the age-18 redetermination process for children in foster care. A portion of the SSI benefits are placed in a trust fund to offset state costs in caring for these foster children and to purchase incidentals.

[16] Legal Aid organizations are funded primarily through grants from the Legal Services Corporation, a nonprofit organization established by Congress in 1974. See http://lsc.gov/about/what-is-lsc.

[17] A limitation to this study is that it did not interview DDS officials to identify potential differences in organization or administrative processes. Such differences might include disability examiner qualifications and workloads or likelihood of requesting a Consultative Examination to make a disability determination. Differences in DDS allowance rates influence cross-state variations in disability caseloads (see Social Security Advisory Board 2012; Wittenburg et al. 2015).

[18] Perrin et al (2014) discuss the growing prevalence of chronic health conditions and disabilities (e.g. asthma, obesity, attention-deficit/hyperactivity disorder (ADHD), autism) among children of all income levels in recent decades. The authors note that the increase for some of the conditions (e.g. asthma, obesity) reflects an increase in prevalence while for others (e.g. autism, ADHD), the increase is more likely due to better awareness and more accurate diagnosis. The authors note that these relatively common conditions amongst children are typically best treated by primary care providers, who are increasingly using medical home approaches involving chronic care management.

[19] An Institute of Medicine report on mental disabilities and disorders among low-income children (Boat and Wu, 2015) concludes that it is "likely that a sizeable number of families that include a child with a disabling mental disorder are not supported by SSI benefits." The report regards the state variation in child SSI program participation as "as a significant and concerning observation."

[20] Duggan and Kearney (2007) estimate that participation in the child SSI program increases total household income by an average of approximately $316 (or 20 percent) per month and that for every $100 in child SSI benefits, total household income increases by at least $72. They also estimate that participation in child SSI reduces the probability that a child lives in poverty by approximately 11 percent. A separate question regards the long-term effect of child SSI participation on recipient outcomes as young adults, such as poverty and employment. Better understanding of long-term effects would be valuable, recognizing the substantial legal, ethical and logistical challenges in answering this

question through a rigorous experiment. For discussion of the available evidence regarding long-term outcomes of child SSI recipients see Wittenburg (2011).

Appendix A. Summary of states and counties visited

Site characteristics	
State (county)	**Characteristics**
Kentucky (Breathitt County)	State has relatively high SSI-child low-income population ratio (6.1 percent) and TANF-child low-income population ratio (10.3 percent) Rural county with some of the highest unemployment and poverty rates in the United States
Oregon (Morrow and Polk Counties)	State has low SSI-child low-income population ratio (2.8 percent) and relatively high TANF-child low-income population ratio (19.6 percent) Populated counties that include Salem (the state capital) and Portland (the largest city in the state)
Pennsylvania (Philadelphia County)	State has relatively high SSI-child low-income population ratio (7.2 percent) and TANF-child low-income population ratio (12.0 percent) Urban area with a high concentration of children receiving SSI (22 percent of the population, including children, adults, and elderly adults, receive SSI)
Texas (Harris County)	State has close to national average SSI-child low-income population ratio (4.3 percent) and low TAN F-child low-income population ratio (2.3 percent) Urban area (that includes Houston) with a high concentration of SSI recipients

Notes: *High*, *low*, and *average* qualifiers are derived by comparing the state SSI-child low-income population and state TANF-child low-income population ratios to the national average for these programs. All ratios are shown in Exhibit 1.

SSI = Supplemental Security Income; TANF = Temporary Assistance for Needy Families.

Appendix B. Organizations and stakeholders interviewed during site visits

	Stakeholders consulted
All states	**Description**
SSA	Staff at the local SSA field office explained the SSI application process, referral sources for applicants, and relationships with other local agencies
State TANF, SNAP, and Medicaid/CHIP administrators	Administrators of safety net programs provided an overview of the state's public assistance environment, helped identify local offices to visit, and identified programs to link children with health conditions to the SSI program
Local TANF and other program administrators	Staff at local TANF offices explained the TANF application process, work and other requirements for adult applicants, and how they identify and refer TANF applicants or household members with disabilities to the SSI program
Legal Aid staff	Legal Aid staff explained how they refer households to SSI, how they assist households with the application and appeals processes, and the barriers households face in applying for SSI for children
State-specific topical interviews	**Description**
Health services providers	In Oregon, Pennsylvania, and Texas, health care providers, including staff of a clinic affiliated with a children's hospital, a visiting nurse, and a team administering special services for children with disabilities funded through Medicaid, described their referral processes to the SSI program and how they assist with appeals of eligibility denials
School teachers and personnel	In Oregon and Texas, school staff, including a school social worker and special education teachers, described their referral processes and the barriers households face in applying for child SSI

Note: Mathematica researchers interviewed stakeholders using a common set of protocols to allow for comparison across sites: one protocol for state program administrators, one for SSA field office officials, one for local TANF office staff, and one for staff of health care organizations and other service providers.

CHIP = Children's Health Insurance Program; LIHEAP = Low-Income Home Energy Assistance Program; SNAP = Supplemental Nutrition Assistance Program; SSA = Social Security Administration; TANF = Temporary Assistance for Needy Families.

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