Where to Turn...

Your Guide to Federal Disability Policies and Programs

Brain Injury Association
# Table of Contents

Chapter 1  
*An Overview of the U.S. Government*

Chapter 2  
*Americans with Disabilities Act (ADA)*

Chapter 3  
*The Rehabilitation Act of 1973*

Chapter 4  
*Disability Programs Under the Social Security Administration*

Chapter 5  
*Medicare*

Chapter 6  
*Health Care and Insurance*

Chapter 7  
*Welfare and Temporary Assistance for Needy Families (TANF)*

Chapter 8  
*Individual and Family Supports*

Chapter 9  
*The Fair Housing Act*

Chapter 10  
*Housing Assistance Options for Individuals with Disabilities*

Chapter 11  
*Employment*

Chapter 12  
*Family and Medical Leave Act (FMLA)*

Chapter 13  
*Special Education*

Chapter 14  
*Assistive Technology*

Chapter 15  
*Telecommunications*

Chapter 16  
*Voting Rights*

Chapter 17  
*Transportation and Travel*

Chapter 18  
*Older Americans Act of 1965 and Older Americans Act Amendments of 1999*

Appendices  
A: Ten Standardized Medigap Plans A Through J  
B: List of Addresses and Telephone Numbers for Offices of Public Housing  
C: State Vocational Rehabilitation Agencies  
D: Parent Training and Information Centers (PTI)

Index
Where to Turn...

An Overview of the U.S. Government
An Overview of the U.S. Government

About the U.S. Congress

When was the Congress created?

The Congress of the United States was created by the Constitution on September 17, 1787.

Who makes up the Congress?

There are two Houses in Congress. One is the House of Representatives and the other is the Senate.

The Senate has 100 members. There are two members from each state. They are elected for six year terms.

The House of Representatives has 435 members. The number representing each State is determined by how many people live in that state. Each state has at least one representative. Members are elected for two-year terms.

Why are there two Houses?

There are two reasons why the Congress has two Houses. The first reason is history. The people who wrote the Constitution were most familiar with the British Parliament, which had two Houses. The second is that a bicameral legislature (two Houses) offered a way of resolving a major conflict in the writing of the Constitution. Delegates to the Constitutional Convention from states with many people wanted a state’s representation in the new Congress to be based on population. Delegates from states with fewer people were afraid that the larger states would dominate the Congress if this were done. They wanted each state to have equal representation.
A legislature made up of two chambers (or Houses) supports the system of checks and balances that is built into the American form of government. Either House is able to block legislation approved by the other. Therefore, the two Houses often must cooperate with each other and compromise on their differences in writing the nation’s laws.

How do the House and Senate differ?

The two Houses differ in a number of ways. These include size and rules, terms of office, base of representation, requirements of office, and special powers under the Constitution.

The House of Representatives is more than four times the size of the Senate. The House of Representatives is led by the Speaker of the House, who is nominated by the majority political party in that chamber. The Vice-President of the United States leads the Senate.

Because of its larger size, the House is more formal and has stricter rules than the Senate. For example, a member of the House is recognized to speak during a debate for a limited period of time, often five minutes or less. Senators normally have no such time limits placed on them.

It is possible, therefore, as an extreme measure, for a senator or group of senators to use this privilege of unlimited debate to delay or defeat legislation. This delaying tactic is called a filibuster.

Members of the House are elected to two-year terms of office. Senators are elected to six-year terms.

Members of the House must seek re-election much more frequently than senators and may tend to pay especially close attention to the needs and opinions of their constituents—the people in the districts they represent. The Constitution also requires that one-third of the Senate is elected every two years. As a result,
the Senate is more of a continuing body than the House, because two-thirds of the Senate’s membership will remain unchanged, regardless of what happens in an election.

**Who makes Laws?**

The Congressional lawmaking process is complex. A proposed law, or bill, must pass through a series of steps before it is voted on the House and Senate floors. At any one of these steps, a bill can be delayed, defeated or amended. Most bills that are introduced do not survive this process and do not become law. Except for those concerning money, bills may be introduced in either House. They are referred then to an appropriate committee, where much of the important work of the Congress occurs.

**What happens to a bill on the floor?**

If a bill passes the House then it also must pass the Senate. If a bill starts in the Senate, then it needs to go the House. Because a bill rarely will pass both chambers of Congress in the same form, a Conference Committee is selected to work out differences between the Senate and House versions. Both chambers must approve any agreement reached by the Conference Committee. Then the legislation is sent to the President of the United States, who must sign it before it can become law. If the president vetoes (says no) a bill, it requires a two-thirds majority vote of members present in both Houses for passage.
What other responsibilities does Congress have?

Congress has a number of other responsibilities and powers under the Constitution. It can propose amendments to the Constitution, and it can declare war. The House of Representatives has the power to impeach, or bring charges against, federal officials for misconduct. If no candidate in a presidential election wins a majority in the Electoral College, the House of Representatives elects the president. The Congress also can determine if a president has a disability that makes him or her unable to continue in office.

What is the Congressional Record?

The work of Congress is published in the Congressional Record. The Daily Digest of the Congressional Record summarizes the proceedings of that day in each House, and before each of their committees and subcommittees. The Digest also presents the legislative program for each day and, at the end of the week, gives the program for the following week.

What is the committee system?

There are 19 committees in the House and 16 in the Senate. About 10,000 or more bills are introduced by Congress every two years. Each committee has its own special area of interest such as health, taxes or education. Committees only can handle a small number of the bills referred to them. Many bills simply “die” in committee. If a bill is of particular importance, the committee usually will schedule hearings to gather information about the bill and listen to the opinions of those who favor or oppose it. The committee then may proceed to further consideration of the bill and offer amendments to it. Only if the committee votes to approve the bill will it be scheduled for consideration by the chamber’s full membership.
## Standing Committees of the U.S. Congress

<table>
<thead>
<tr>
<th>House Committees</th>
<th>Senate Committees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture</td>
<td>Agriculture, Nutrition, and Forestry</td>
</tr>
<tr>
<td>Appropriations</td>
<td>Appropriations</td>
</tr>
<tr>
<td>Armed Services</td>
<td>Armed Services</td>
</tr>
<tr>
<td>Banking and Financial Services</td>
<td>Banking, Housing, and Urban Affairs</td>
</tr>
<tr>
<td>Budget</td>
<td>Budget</td>
</tr>
<tr>
<td>Commerce</td>
<td>Commerce, Science, and Transportation</td>
</tr>
<tr>
<td>Education and the Workforce</td>
<td>Energy and Natural Resources</td>
</tr>
<tr>
<td>Government Reform</td>
<td>Environment and Public Works</td>
</tr>
<tr>
<td>House Administration</td>
<td>Finance</td>
</tr>
<tr>
<td>International Relations</td>
<td>Foreign Relations</td>
</tr>
<tr>
<td>Judiciary</td>
<td>Governmental Affairs</td>
</tr>
<tr>
<td>Resources</td>
<td>Judiciary</td>
</tr>
<tr>
<td>Rules</td>
<td>Labor and Human Resources</td>
</tr>
<tr>
<td>Science</td>
<td>Rules and Administration</td>
</tr>
<tr>
<td>Small Business</td>
<td>Small Business</td>
</tr>
<tr>
<td>Standards of Official Conduct</td>
<td>Veterans' Affairs</td>
</tr>
<tr>
<td>Transportation and Infrastructure</td>
<td></td>
</tr>
<tr>
<td>Veterans' Affairs</td>
<td></td>
</tr>
<tr>
<td>Ways and Means</td>
<td></td>
</tr>
</tbody>
</table>

Where can I get Congressional Publications?

U.S. Goverment Agencies

General Accounting Office (GAO)

The U.S. General Accounting Office (GAO) is an agency that works for Congress and the American people. Congress asks GAO to study the programs and spending of the federal government. GAO often is called the investigative arm of Congress or the congressional watchdog. GAO is independent and nonpartisan. It studies how the federal government spends taxpayer dollars. GAO advises Congress and the heads of executive agencies (such as Health and Human Services) about ways to make government more effective and responsive. GAO evaluates federal programs, audits federal expenditures and issues legal opinions. When GAO reports its findings to Congress, it recommends actions. Its work leads to laws and acts that improve government operations and save billions of dollars.
**Congressional Budget Office (CBO)**

How does CBO help the Congress develop a plan for the Budget?

The House and Senate each have a budget committee. The CBO helps prepare the budget plan for Congress each year. A major part of CBO’s role in that process is to prepare an annual report that provides economic and budget projections for the next 10 years. That report includes a discussion of some current economic or budget policy issue, such as the effects of the federal deficit on economic growth or recent changes in the budget process.

How does CBO help the Congress stay within its budget plan?

Once the Congress adopts the annual budget resolution, the budget committees take the lead in enforcing its provisions. To help them, CBO offers their best guess about how much a bill might cost. CBO also prepares a series of reports that advise the Congress and the Administration on two things: whether they spent too much and whether the passage of any new bills has increased how much the government owes or how much they plan to spend.
What are the Major Responsibilities of the CBO?

**Helping the Congress Develop a Plan for the Budget**
- ☑ Make projections about the economy
- ☑ Review the president’s budget
- ☑ Look at long term budget issues

**Helping the Congress Stay within Its Budget Plan**
- ☑ Look at what a bill will cost
- ☑ Make sure Congress does not overspend

**Helping the Congress Consider Budget and Economic Policy Issues**
- ☑ Review the federal government budget
- ☑ Recommend policy about money and tax laws
The Department of Health and Human Services (HHS)

What is the Department of Health and Human Services?

The Department of Health and Human Services (HHS) is the United States government’s principal agency for protecting the health of all Americans and providing essential human services, especially those who are least able to help themselves.

What programs are included within HHS?

The department includes more than 300 programs, covering a wide spectrum of activities. Some highlights include:

- Medical and social science research
- Preventing outbreak of infectious disease, including immunization services
- Assuring food and drug safety
- Medicare (health insurance for elderly and disabled Americans) and Medicaid (health insurance for low-income people)
- Financial assistance for low-income families
- Child support enforcement
Improving infant, child, adolescent and family health

Head Start (pre-school education and services)

Preventing child abuse and domestic violence

Substance abuse treatment and prevention

Services for older Americans, including home-delivered meals

Comprehensive health services delivery for American Indians and Alaska Natives

Does HHS give grants?

HHS is the largest grant-making agency in the federal government, providing some 60,000 grants per year. HHS’ Medicare program is the nation’s largest health insurer, handling more than 900 million claims per year.

Where is the main office for HHS?

The Department’s Headquarters is in the Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C., 20201.

Which agencies within HHS provide funding to support TBI activities?

Health Resources and Services Administration (HRSA) — HRSA funds a significant program authorized by the Traumatic Brain Injury Act of 1996, the TBI State Grant Program administered by the Maternal and Child Health Bureau. State agencies may apply for grants to build a foundation within the State to determine needs and improve access to services for
individuals with TBI and their families. In addition, HRSA funds grants to national organizations such as the Brain Injury Association to develop guides like the one you are reading.

HRSA provides access to essential health services for people who are poor, uninsured, or who live in rural and urban neighborhoods where health care is scarce. HRSA-funded health centers provide comprehensive primary and preventive medical care to more than nine million patients each year at more than 3000 sites nationwide. Working in partnership with many state and community organizations, HRSA also supports programs that ensure healthy mothers and children, increase the number and diversity of health care professionals in underserved communities, and provide supportive services for people fighting HIV/AIDS through the Ryan White Care Act.

Centers for Disease Control and Prevention (CDC) — CDC is the lead federal agency responsible for protecting the health of the American public through monitoring disease trends, investigating outbreaks, as well as health and injury risks, fostering safe and healthful environments, and implementing illness and injury control and prevention interventions. Established in 1946, as the Communicable Disease Center. Headquarters: Atlanta, GA.

National Institutes of Health (NIH) — NIH is the world’s premier medical research organization, supporting some 35,000 research projects nationwide in diseases like cancer, Alzheimer’s, diabetes, arthritis, heart ailments and AIDS. NIH includes 18 separate health institutes, the National Center for Complementary and Alternative Medicine and the National Library of Medicine. Established in 1887, as the Hygienic Laboratory, Staten Island, N.Y. Headquarters: Bethesda, MD.
Substance Abuse and Mental Health Services Administration (SAMHSA) — SAMHSA works to improve the quality and availability of substance abuse prevention, addiction treatment and mental health services. It provides funding to the states to support and maintain substance abuse and mental health services through federal block grants. Targeted Capacity Expansion grants provide Mayors as well as town and county officials resources to address emerging drug abuse trends and mental health service needs and related public health problems, including HIV/AIDS, at the earliest possible stages. SAMHSA funds hundreds of programs nationwide to increase the use and improve prevention and treatment methods shown by research to be effective through “Knowledge Development and Application” grants. Established: 1992. (Predecessor agency, the Alcohol, Drug Abuse and Mental Health Administration, was established in 1974.) Headquarters: Rockville, MD.

Health Care Financing Administration (HCFA) — HCFA administers the Medicare and Medicaid programs, which provide health care to about one in every four Americans. Medicare provides health insurance for more than 44 million Americans who are over age 65 or who have disabilities. Medicaid, a joint federal-state program, provides health coverage for more than 34 million low-income persons, including nearly 18 million children and nursing home coverage for older Americans with low-income. HCFA also administers the Children’s Health Insurance Program (CHIP) through approved state plans that cover more than 2.2 million children. Established: 1977. Headquarters: Baltimore, MD.

Administration for Children and Families (ACF) — ACF is responsible for some 60 programs that promote the economic and social well-being of families, children, individuals and communities. ACF administers the state-federal welfare program, Temporary Assistance to Needy Families, providing assistance to an estimated 7.3 million persons, including 6.3 million children in September 1998. ACF administers the national child support enforcement system, collecting some
$15.5 billion in FY 1999 in payments from non-custodial parents and administers the Head Start program, serving more than 800,000 pre-school children. ACF provides funds to assist low-income families in paying for child care, and supports state programs to provide for foster care and adoption assistance. ACF funds programs to prevent child abuse and domestic violence. Established in 1991, bringing together several already-existing programs. Headquarters: Washington, D.C.

**Administration on Aging (AoA)** — The Administration on Aging (AoA) is the federal focal point and advocate agency for older persons and their concerns. The AoA administers key federal programs mandated under various titles of the Older Americans Act. These programs help vulnerable older persons remain in their own homes by providing supportive services, including nutrition programs such as home delivered meals (Meals-on-Wheels). Other programs offer opportunities for older Americans to enhance their health and be active contributors to their families, communities, and the Nation. The AoA works closely with its nationwide network of regional offices and State and Area Agencies on Aging to plan, coordinate and develop community-level systems of services that meet the unique needs of individual older persons and their caregivers. The AoA collaborates with federal agencies, national organizations and representatives of business to ensure that, whenever possible, their programs and resources are targeted to older persons and coordinated with those of the network on aging. Headquarters: Washington, D.C.
The Department of Housing and Urban Development

The Department of Housing and Urban Development (HUD) is the Federal agency responsible for national policy and programs that address America’s housing needs, improve and develop the Nation’s communities, and enforce fair housing laws. HUD’s business is helping create a decent home and suitable living environment for all Americans, and it has given America’s cities a strong national voice at the Cabinet level.

What is HUD’s mission?

HUD is the Federal agency that works to help the nation’s communities meet their development needs, spur economic growth in distressed neighborhoods, provide housing assistance for the poor, help rehabilitate and develop moderate and low-cost housing, and enforce the nation’s fair housing laws. HUD plays a major role in supporting homeownership by underwriting homeownership for lower- and moderate-income families through its mortgage insurance program.

What are HUD’s major programs?

The primary programs administered by HUD include:

- Community Development Block Grants (CDBG) to help communities with economic development, job opportunities and housing rehabilitation.
- Subsidized housing in the form of Section 8 certificates or vouchers for low-income households.
- Subsidized public housing for low-income individuals and families.
- Homeless assistance in a "continuum of care," through local communities and nonprofit organizations.
- Home Investment Partnership Act block grants to develop and support affordable housing for low-income residents.
- Fair housing public education and enforcement.
- Mortgage and loan insurance through the Federal Housing Administration.
What is the Community Development Block Grant program?

HUD’s Community Development Block Grant (CDBG) program was created in 1974 to help states and communities. CDBG funds may be used for a wide range of activities. Funds must be spent to meet one of three broad national goals:

- Aid low and moderate income persons;
- Prevent or eliminate slum or blight conditions; or
- Meet an urgent need that threatens health or safety
- At least 70 percent of the funds must be used for activities that benefit people who are poor. States decide how to spend the money through a strategic planning process. Communities and states are accountable to HUD for how funds are spent

CDBG funds have been used to renovate housing; construct or improve public facilities, such as water, sewers, streets and neighborhood centers; purchase real property; and assist private businesses in economic development activities.

What is “assisted” housing?

HUD “assists” low-income households with rental subsidies in the private sector, through Section 8 certificates and vouchers. Individuals looking for help apply through their local public housing agency. Under the voucher program, people have greater freedom of choice to select housing where they want to live within a standard rent range. Under the Section 8 certificate program, rent subsidies are used to pay owners the difference between what tenants can pay and contract rents.
Overall, more than three million households received Section 8 rental assistance in FY 1996. Congress gave about $400 million for relocation assistance in the form of Section 8 certificates and vouchers in FY 1996. It also provided $830 million for Section 202 housing grants and subsidies for elderly, and $258 million for grants and subsidies for Section 811 housing for the disabled.

The program goes beyond providing certificates and vouchers to individuals; it also renews Section 8 contracts with private owners. This is needed in order to keep enough housing in the country for low-income families.

HUD also administers a Housing Counseling Program which was funded with $12 million in FY 1996 to assist tenants and homeowners in property maintenance, financial management and other matters.

**HUD’s HOPE Program is being used to tear down dilapidated public housing developments. How does that work?**

HUD started a new housing program called HOPE. The HOPE VI (Homeownership and Opportunity for People Everywhere) program is run by the Office of Public and Indian Housing. It gives money to change the nation’s most distressed public housing into communities of hope.

The program is based on the principles of integration of services and resident contributions. It gives money to:

- Replace and rehabilitate neighborhood homes;
- Provide job training and encourage neighboring businesses to hire public housing residents;
Offer joint ventures on private multifamily housing financing for Section 8 rentals;

Wire selected units for computers and Internet communications; and

Develop mixed-income housing with rental and homeownership choices in public housing neighborhoods

How do the homeless get help from HUD?

HUD gives money to state and local governments and nonprofit organizations to help homeless individuals and families. The funds are used to help the homeless move from the streets, to temporary shelter, to supportive housing (with services, if necessary), and ultimately back to the mainstream of American life. The Assistant Secretary for Community Planning and Development administers most of HUD’s homeless assistance programs.

HUD’s homeless efforts began on a national level with the Stewart B. McKinney Homeless Assistance Act of 1987, which provided the first direct HUD programs to help communities deal with homelessness. More than $4.8 billion has been provided and more than 2 million homeless Americans have been assisted by these programs through FY 1996.

**Shelter Plus Care** - HUD provides grants for rental assistance to homeless persons with chronic disabilities under the Shelter Plus Care program. Eligible recipients are state and local government units, public housing agencies and Indian tribes.

To receive the funds each recipient must provide supportive services at least equal in value to the rental assistance. Supportive services would address mental illness, substance abuse and acquired immunodeficiency syndrome (AIDS) and related diseases.
Supportive Housing - Supportive Housing grants go to state and local governments, Indian tribes and nonprofit organizations to provide short-term transitional housing and services to deinstitutionalized homeless individuals, families with children, individuals with mental disabilities and others, including people with AIDS. States may receive funds for long-term housing projects for homeless persons with disabilities.

HUD provides grants for acquisition, rehabilitation, new construction and annual payments for operating costs and supportive services. HUD also provides technical assistance. Participants must match the acquisition, rehabilitation or new construction costs and provide a percentage of the operating costs.

Section 8 Moderate Rehabilitation (SRO) - Public and Indian housing agencies and private nonprofit organizations compete for Section 8 Moderate Rehabilitation grants based on local needs and their ability to provide single-room occupancy (SRO) housing for homeless persons.

Emergency Shelter Grants - Emergency Shelter Grants are distributed to states, entitlement cities and counties and territories on a formula basis, and Indian tribes. The funds may be used to renovate, rehabilitate or convert buildings to be used as shelters for homeless persons. The funds also may be used to operate emergency shelters, provide essential services to homeless individuals and prevent homelessness.
What is the HOME program? How is it different from other HUD low-income housing programs?

The HOME Investment Partnerships Program is administered by the Assistant Secretary for Community Planning and Development.

HOME funds are distributed on a formula basis, like the Community Development Block Grant (CDBG) program, and are administered locally through community development departments or housing finance agencies. Participating jurisdictions include states, large cities and urban counties, consortia, Indian tribes and territories.

Participating jurisdictions must provide a 25 percent match for housing activities funded by HOME.

Are any HUD housing programs available for persons who are not very low income?

The Federal Housing Administration (FHA) assists first-time buyers and others who might not be able to meet down payment requirements for conventional loans by providing mortgage insurance to private lenders. It also insures loans for home improvements and buying manufactured (mobile) homes.

This is done through the FHA, a branch of HUD which works through local mortgage lending institutions to provide Federal mortgage and loan insurance for homeownership and the construction or improvement of affordable housing.
There are approximately 10 mortgage insurance and loan programs administered by the Assistant Secretary for Housing-Federal Housing Commissioner. Interest rates on FHA loans generally are market rates, while down payment requirements are lower than for conventional loans. FHA loans cannot exceed the statutory limit.

When buyers become seriously delinquent on their loans, their mortgage companies usually foreclose and file insurance claims with HUD for the amount still owed on the loan. HUD pays the claim and becomes the owner of the property. The HUD Property Disposition staff across the nation and its contractors maintain and market these properties.

FHA also assists in providing affordable rental housing by insuring loans to developers and builders who construct or rehabilitate apartments and other multifamily housing developments.

FHA had insurance in force estimated at $48.6 billion on 15,935 multifamily developments with 2 million units as of September 30, 1996.
Endnotes:

www.Congress.gov

General Accounting Office
www.gao.gov

Congressional Budget Office
www.cbo.gov

U.S. Department of Health and Human Services
www.dhhs.gov

U.S. Department of Housing and Urban Development
www.hud.gov
Where to Turn...

Americans with Disabilities Act (ADA)
Americans with Disabilities Act (ADA)

The Americans with Disabilities Act (ADA) prohibits discrimination in employment, state and local government, public accommodations, commercial facilities, transportation and telecommunications, against a person with a disability.

Does the ADA protect me?

To be protected by the ADA, one must have:

☑ A disability, or
☑ A relationship or association with an individual with a disability

Do I have a disability?

The ADA defines an individual with a disability as:

☑ A person who has a physical or mental impairment that substantially limits one or more major life activities

OR

☑ A person who has a history or record of such an impairment

OR

☑ A person who is perceived by others as having such an impairment

What is a Major Life Activity?

Major life activities are activities that an average person can perform with little or no difficulty such as walking, breathing, seeing, hearing, speaking, learning and working.
Title I: Employment

What employers are covered by the ADA?

The following, if they employ 15 or more individuals:

☑ Private employers
☑ State and local governments
☑ Employment agencies
☑ Labor organizations
☑ Labor-management

If I have a disability, am I protected against not being hired for the job I want?

If you have a disability, you also must be qualified to perform the essential functions or duties of a job, with or without reasonable accommodation, in order to be protected from job discrimination by the ADA. This means two things: first, you must satisfy the employer’s requirements for the job, such as education, employment experience, skills or licenses. Second, you must be able to perform the essential functions of the job, with or without reasonable accommodation. Essential functions are the basic job duties that you must be able to perform, on your own or with the help of a reasonable accommodation. An employer cannot refuse to hire you because your disability prevents you from performing duties that are not essential to the job.
What is a Reasonable Accommodation?

A reasonable accommodation is any change or adjustment to a job or work environment that permits a qualified applicant or employee with a disability to participate in the job application process, perform the essential functions of a job, or enjoy benefits and privileges of employment equal to those enjoyed by employees without disabilities. For example, reasonable accommodation may include:

☑ Providing or modifying equipment or devices
☑ Job restructuring
☑ Part-time or modified work schedules
☑ Reassignment to a vacant position
☑ Adjusting or modifying examinations, training materials or policies
☑ Providing readers and interpreters
☑ Making the workplace readily accessible to and usable by people with disabilities

An employer is required to provide a reasonable accommodation to a qualified applicant or employee with a disability unless the employer can prove that the accommodation would be an “undue hardship” — that is, it would require significant difficulty or expense.

Discriminatory Practices

Under ADA, it is illegal to discriminate in any aspect of employment, including:

☑ Hiring and firing
☑ Compensation, assignment or classification of employees
Transfer, promotion, layoff or recall
Recruitment
Testing
Use of company facilities
Training and apprenticeship programs
Fringe benefits
Pay, retirement plans and disability leave
Other terms and conditions of employment.

It also is unlawful for an employer to retaliate against you for asserting your rights under the ADA. The Act also protects you if you are a victim of discrimination because of your family, business, social or other relationship or association with an individual with a disability.

Can an employer require medical examinations or ask questions about a disability?

If you are applying for a job, an employer cannot ask you if you are disabled or ask about the nature or severity of your disability. An employer can ask if you can perform the duties of the job with or without reasonable accommodation. An employer also can ask you to describe or demonstrate how, with or without reasonable accommodation, you will perform the duties of the job.

An employer cannot require you to take a medical examination before you are offered a job. Following a job offer, an employer can condition the offer on your passing a required medical examination, but only if all entering employees for that job category have to take the examination. An employer cannot reject you because of information about your disability revealed by the medical examination unless the reasons for rejection are
job-related and necessary for the conduct of the employer’s business. The employer cannot refuse to hire you because of your disability if you can perform the essential functions of the job with an accommodation.

Once you have been hired and started work, your employer cannot require that you take a medical examination or ask questions about your disability unless they are related to your job and necessary for the conduct of your employer’s business. Your employer may conduct voluntary medical examinations that are part of an employee health program, and may provide medical information required by state workers’ compensation laws to the agencies that administer such laws.

The results of all medical examinations must be kept confidential and maintained in separate medical files.

Do individuals who use drugs illegally have rights under the ADA?

Anyone who is currently using drugs illegally is not protected by the ADA and may be denied employment or fired on the basis of such use. The ADA does not prevent employers from testing applicants or employees for current illegal drug use.

What do I do if I think that I’m being discriminated against in the workplace?

You generally have 180 days from the time of the incident you think is discriminating to file a complaint with the U.S. Equal Employment Opportunity Commission (EEOC). That time may be extended to 300 days to file a charge if there is a state or local law that provides relief for discrimination on the basis of disability. However, it is probably in your best interest to contact the EEOC promptly if you suspect discrimination. You may contact any EEOC field office, located in cities throughout the United States. If you have been discriminated against, you are entitled to a remedy that will place you in the
position you would have been in if the discrimination had never occurred. You may be entitled to hiring, promotion, reinstatement, back pay or reasonable accommodation, including reassignment. If you have an attorney, you also may be entitled to payment of your attorney’s fees. Individuals may file a lawsuit in Federal court only after they receive a “right-to-sue” letter from the EEOC.

While the EEOC only can process ADA charges based on actions occurring on or after July 26, 1992, you may already be protected by state or local laws or other current federal laws. EEOC field offices can refer you to the agencies that enforce those laws.

To contact the EEOC, look in your telephone directory under “U.S. Government.” For information and instructions on reaching your local office, call:

☑️ (800) 669-4000 (Voice)
☑️ (800) 669-6820 (TDD)
☑️ (In the Washington, D.C. 202 Area Code, call 202-663-4900 (voice) or 202-663-4494 (TDD).)

If I am an employer, where can I get additional ADA information and assistance?

The EEOC conducts an active technical assistance program to promote voluntary compliance with the ADA. This program is designed to help people with disabilities understand their rights and help employers understand their responsibilities under the law.
In January 1992, EEOC published a *Technical Assistance Manual*, providing practical application of legal requirements to specific employment activities, with a directory of resources to aid compliance. EEOC publishes other educational materials, provides training on the law for people with disabilities and employers and participates in meetings and training programs of other organizations. EEOC staff also will respond to individual requests for information and assistance.

The Commission’s technical assistance program is separate from its enforcement responsibilities. Employers who seek information or assistance from the Commission will not be subject to any enforcement action because of such inquiries. The Commission also recognizes that differences and disputes about ADA requirements may arise between employers and people with disabilities as a result of misunderstandings. Such disputes frequently can be resolved more effectively through informal negotiation or mediation procedures, rather than through the formal enforcement process of the ADA.

Accordingly, the EEOC will encourage efforts of employers and individuals with disabilities to settle such differences through alternative methods of dispute resolution, providing that such efforts do not deprive any individual of legal rights provided by the statute.

### Frequently Asked Questions about Title I of the ADA

**Q.** Is an employer required to provide reasonable accommodation when I apply for a job?

**A.** Yes. Applicants, as well as employees, are entitled to reasonable accommodation. For example, an employer may be required to provide a sign language interpreter during a job interview for an applicant who is deaf or hearing impaired, unless to do so would impose an undue hardship.
Q. Should I tell my employer that I have a disability?

A. If you think you will need a reasonable accommodation in order to participate in the application process or perform essential job functions, you should inform the employer that an accommodation will be needed. Employers are required to provide reasonable accommodation only for the physical or mental limitations of a qualified individual with a disability of which they are aware. Generally, it is the responsibility of the employee to inform the employer that an accommodation is needed.

Q. Do I have to pay for a needed reasonable accommodation?

A. No. The ADA requires that the employer provide the accommodation unless to do so would impose an undue hardship on the operation of the employer’s business. If the cost of providing the needed accommodation would be an undue hardship, the employee must be given the choice of providing the accommodation or paying for the portion of the accommodation that causes the undue hardship.

Q. Can an employer lower my salary or pay me less than other employees doing the same job because I need a reasonable accommodation?

A. No. An employer cannot make up the cost of providing a reasonable accommodation by lowering your salary or paying you less than other employees in similar positions.
Q. **Does an employer have to make non-work areas used by employees, such as cafeterias, lounges or employer-provided transportation accessible to people with disabilities?**

A. **Yes.** The requirement to provide reasonable accommodation covers all services, programs and non-work facilities provided by the employer. If making an existing facility accessible would be an undue hardship, the employer must provide a comparable facility that will enable a person with a disability to enjoy benefits and privileges of employment similar to those enjoyed by other employees, unless to do so would be an undue hardship.

Q. **If an employer has several qualified applicants for a job, is the employer required to select a qualified applicant with a disability over other applicants without a disability?**

A. **No.** The ADA does not require that an employer hire an applicant with a disability over other applicants because the person has a disability. The ADA only prohibits discrimination on the basis of disability. It makes it unlawful to refuse to hire a qualified applicant with a disability because of the disability or because a reasonable accommodation is required to make it possible for the person to perform essential job functions.
Q. Can an employer refuse to hire me because he/she believes that it would be unsafe, because of my disability, for me to work with certain machinery required to perform the essential functions of the job?

A. The ADA permits an employer to refuse to hire an individual if he/she poses a direct threat to the health or safety of himself/herself or others. A “direct threat” means a “significant risk of substantial harm.” The determination that there is a direct threat must be based on objective, factual evidence regarding an individual’s present ability to perform the essential functions of a job. An employer cannot refuse to hire you because of a slightly increased risk or because of fears that there might be a significant risk sometime in the future. The employer also must consider whether a risk can be eliminated or reduced to an acceptable level with a reasonable accommodation.

Q. Can an employer offer a health insurance policy that excludes coverage for pre-existing conditions?

A. Yes. The ADA does not affect pre-existing condition clauses contained in health insurance policies, even though such clauses may affect employees with disabilities more adversely than other employees.
Q. If the health insurance offered by my employer does not cover all of the medical expenses related to my disability, does the company have to obtain additional coverage for me?

A. No. The ADA only requires that an employer provide employees with disabilities equal access to whatever health insurance coverage is offered to other employees.

Q. I think I was discriminated against because my wife is disabled. Can I file a charge with the EEOC?

A. Yes. The ADA makes it unlawful to discriminate against an individual, whether disabled or not, because of a relationship or association with an individual with a known disability.
Title II of the ADA prohibits discrimination against qualified individuals with disabilities in all programs, activities, and services of public entities. It applies to all state and local governments, their departments and agencies, and any other “instrumentalities or special purpose districts” of state or local governments. It clarifies the requirements of Section 504 of the Rehabilitation Act of 1973 for public transportation systems that receive federal financial assistance, and extends coverage to all public entities that provide public transportation, whether or not they receive federal financial assistance. It establishes detailed standards for the operation of public transit systems, including commuter and intercity rail (AMTRAK).
Q. *How does Title II affect my participation in a state or local government’s programs, activities and services?*

A. A state or local government must eliminate any eligibility criteria for participation in programs, activities and services that screen out or tend to screen out persons with disabilities, unless it can establish that the requirements are necessary for the provision of the service, program or activity. The state or local government may, however, adopt legitimate safety requirements necessary for safe operation if they are based on real risks, not on stereotypes or generalizations about individuals with disabilities. Finally, a public entity must modify its policies, practices, or procedures reasonably to avoid discrimination. If the public entity can demonstrate that a particular modification would alter the nature of its service, program, or activity, it is not required to make that modification.

Q. *Does Title II cover a public entity’s employment policies and practices?*

A. Yes. Title II prohibits all public entities, **regardless of the size of their work force**, from discriminating in employment against qualified individuals with disabilities. In addition to Title II’s employment coverage, Title I of the ADA and Section 504 of the Rehabilitation Act of 1973 prohibit employment discrimination by certain public entities against qualified individuals with disabilities.
Q. What changes must a public entity make to its existing facilities to make them accessible?

A. A public entity must ensure that individuals with disabilities are not excluded from services, programs and activities because existing buildings are inaccessible. A state or local government’s programs, when viewed in their entirety, must be readily accessible to and usable by individuals with disabilities. This standard, known as “program accessibility,” applies to any facilities of a public entity that existed on or after January 26, 1992. Public entities do not necessarily have to make each of their existing facilities accessible. They may provide program accessibility by a number of methods, including alteration of existing facilities, acquisition or construction of additional facilities, relocation of a service or program to an accessible facility or provision of services at alternate accessible sites.

Q. When must structural changes be made to attain program accessibility?

A. Structural changes needed for program accessibility must have been made no later than January 26, 1995.

Q. What is a self-evaluation?

A. A self-evaluation is a public entity’s assessment of its current policies and practices. The self-evaluation identifies and corrects those policies and practices inconsistent with Title II’s requirements. All public entities must have completed a self-evaluation by January 26, 1993. Though not a requirement, most should have these evaluations available.
Q. **What does Title II require for new construction and alterations?**

A. The ADA requires that all new buildings constructed by a state or local government be accessible. In addition, when a state or local government undertakes alterations to a building, it must make the altered portions accessible.

Q. **How will a state or local government know that a new building is accessible?**

A. A state or local government will be in compliance with the ADA for new construction and alterations if it follows either of two accessibility standards. It can choose either the Uniform Federal Accessibility Standards or the Americans with Disabilities Act Accessibility Guidelines for Buildings and Facilities, the standard that must be used for public accommodations and commercial facilities under Title III of the ADA. If the state or local government chooses the ADA Accessibility Guidelines, it is not entitled to the elevator exemption (which permits certain private buildings under three stories or 3,000 square feet per floor to be constructed without an elevator).

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**Places of accommodation include:**

- restaurants
- theaters
- pharmacies
- museums
- private schools
- libraries
- hotels
- doctors' offices
- retail stores
- day care centers
- parks
Q. What requirements apply to a public entity’s emergency telephone services, such as 911?

A. State and local agencies that provide emergency telephone services must provide “direct access” to individuals who rely on a TDD or computer modem for telephone communication. Telephone access through a third party or relay service does not satisfy the requirement for direct access. Where a public entity provides 911 telephone service, it may not substitute a separate seven-digit telephone line as the sole means for access to 911 services by nonvoice users. A public entity may, however, provide a separate seven-digit line for the exclusive use of nonvoice callers in addition to providing direct access for such calls to its 911 line.

Q. Does Title II require that telephone emergency service systems be compatible with all formats used for nonvoice communications?

A. No. At present, telephone emergency services must be compatible with the Baudot format only. Until it can be proven technically that communications in another format can operate in a reliable and compatible manner in a given telephone emergency environment, a public entity would not be required to provide direct access to computer modems using formats other than Baudot.
Q. How will the ADA’s requirements for state and local governments be enforced?

A. Private individuals may bring lawsuits to enforce their rights under Title II and receive the same remedies as those provided under Section 504 of the Rehabilitation Act of 1973, including reasonable attorney’s fees. Individuals also may file complaints with eight designated Federal agencies, including the Department of Justice and the Department of Transportation.
Title III: Public Accommodations

The ADA contains requirements for new construction, alterations or renovations to buildings and facilities, and improving access to existing facilities of private companies providing goods or services to the public. It also requires that state and local governments provide access to programs offered to the public. The ADA also covers effective communication with people with disabilities and eligibility criteria that may restrict or prevent access, and requires reasonable modifications of policies and practices that may be discriminatory.

The ADA gives the Department of Justice (DOJ) authority to issue regulations for Title II and III of the ADA and provide technical assistance and enforcement. The Department also has authority to certify that a state or local accessibility code is equivalent to the ADA’s requirements for new construction and alterations.

What are Public Accommodations?

A public accommodation is a private entity that owns, operates, leases from or leases to a place of public accommodation.

Private clubs and religious organizations are exempt from the ADA’s Title III requirements for public accommodations. Additionally, the ADA generally does not cover private residences. However, if a place of public accommodation, such as a doctor’s office or day care center, is located in a private residence, those portions of the residence used for that purpose are subject to the ADA’s requirements.
Public accommodations must comply with basic nondiscrimination requirements that prohibit exclusion, segregation and unequal treatment.

They also must comply with:

- Specific requirements related to architectural standards for new and altered buildings
- Reasonable modifications to policies, practices and procedures
- Effective communication with people with hearing, vision or speech disabilities
- Other access requirements

Additionally, public accommodations must remove barriers in existing buildings where it is easy to do so without much difficulty or expense, given the public accommodation’s resources.

Courses and examinations related to professional, educational or trade-related applications, licensing, certifications or credentialing must be provided in a place and manner accessible to people with disabilities, or alternative accessible arrangements must be offered.

Commercial facilities, such as factories and warehouses, must comply with the ADA’s architectural standards for new construction and alterations.

Complaints about Title III violations may be filed with the Department of Justice. In certain situations, cases may be referred to a mediation program sponsored by the Department. The Department is authorized to bring a lawsuit where there is a pattern or practice of discrimination in violation of Title III, or where an act of discrimination raises an issue of general public importance. Title III also may be enforced through private lawsuits. It is not necessary to file a complaint with the Department of Justice (or any Federal agency), or receive a “right-to-sue” letter, before going to court.
Under general rules governing lawsuits brought by the Federal Government, the Department of Justice may not sue a party unless negotiations to settle the dispute have failed.

The Department of Justice may file lawsuits in federal court to enforce the ADA, and courts may order compensatory damages and back pay to remedy discrimination if the Department prevails. Under Title III, the Department of Justice also may obtain civil penalties of up to $50,000 for the first violation and $100,000 for any subsequent violation.

For more information or to file a complain, contact:

Disability Rights Section
Civil Rights Division
U.S. Department of Justice
P.O. Box 66738
Washington, D.C. 20035-6738
You also may call for information at:
(800) 514-0301 (voice)
(800) 514-0383 (TDD)

Frequently Asked Questions about Title III of the ADA

Q. Will the ADA have any effect on the eligibility criteria used by public accommodations to determine who may receive services?

A. Yes. If a criterion screens out or tends to screen out individuals with disabilities, it only may be used if necessary for the provision of the services. For instance, it would be a violation for a retail store to have a rule excluding all deaf persons from entering the premises, or for a movie theater to exclude all individuals with cerebral palsy. More subtle forms of discrimination also are prohibited.
For example, requiring presentation of a driver’s license as the sole acceptable means of identification for purposes of paying by check could constitute discrimination against individuals with vision impairments. This would be true if such individuals are ineligible to receive licenses and the use of an alternative means of identification is feasible.

Q. Does the ADA allow public accommodations to take safety factors into consideration in providing services to individuals with disabilities?

A. The ADA expressly provides that a public accommodation may exclude an individual, if that individual poses a direct threat to the health or safety of others that cannot be mitigated by appropriate modifications in the public accommodation’s policies or procedures, or the provision of auxiliary aids. A public accommodation will be permitted to establish objective safety criteria for the operation of its business. Any safety standard, however, must be based on objective requirements rather than stereotypes or generalizations about the ability of persons with disabilities to participate in an activity.

Q. Are there any limits on the kinds of modifications in policies, practices and procedures required by the ADA?

A. Yes. The ADA does not require modifications that would “fundamentally alter” the nature of the services provided by the public accommodation. For example, it would not be discriminatory for a physician specialist who treats only burn patients to
refer a deaf individual to another physician for treatment of a broken limb or respiratory ailment. To require a physician to accept patients outside of his or her specialty would alter the nature of the medical practice fundamentally.

Q. What kinds of auxiliary aids and services are required by the ADA to ensure effective communication with individuals with hearing or vision impairments?

A. Appropriate auxiliary aids and services may include services and devices such as qualified interpreters, assistive listening devices, notetakers and written materials for individuals with hearing impairments; and qualified readers, taped texts, and braille or large print materials for individuals with vision impairments.

Q. Are there any limitations on the ADA’s auxiliary aids requirements?

A. Yes. The ADA does not require the provision of any auxiliary aid that would result in an undue burden or fundamental alteration in the nature of the goods or services provided by a public accommodation. However, the public accommodation is not relieved from the duty to furnish an alternative auxiliary aid, if available, that would not result in a fundamental alteration or undue burden. Both of these limitations are derived from existing regulations and caselaw under Section 504 of the Rehabilitation Act and determined on a case-by-case basis.
Q. Will restaurants be required to have braille menus?

A. No. Not if waiters or other employees are made available to read the menu to a blind customer.

Q. Will a clothing store be required to have braille price tags?

A. No. Sales personnel could provide price information orally upon request.

Q. Will a bookstore be required to maintain a sign language interpreter on its staff in order to communicate with deaf customers?

A. No. Not if employees communicate by pen and notepad when necessary.

Q. Are there any limitations on the ADA’s barrier removal requirements for existing facilities?

A. Yes. Barrier removal need be accomplished only when it is “readily achievable” to do so.

Q. What does the term “readily achievable” mean?

A. It means “easily accomplishable and able to be carried out without much difficulty or expense.”
Q. What are examples of the types of modifications that would be readily achievable in most cases?

A. Examples include the simple ramping of a few steps, installation of grab bars where only routine reinforcement of the wall is required, lowering of telephones and similar modest adjustments.

Q. Will businesses need to rearrange furniture and display racks?

A. **Possibly.** For example, restaurants may need to rearrange tables and department stores may need to adjust their layout of racks and shelves in order to permit wheelchair access.

Q. Will businesses need to install elevators?

A. Businesses are not required to retrofit their facilities to install elevators unless such installation is readily achievable.

Q. When barrier removal is not readily achievable, what kinds of alternative steps are required by the ADA?

A. Alternatives may include such measures as in-store assistance for removing articles from high shelves, home delivery of groceries or coming to the door to receive or return dry cleaning.
Q. Must alternative steps be taken without regard to cost?

A. No. Only readily achievable alternative steps must be undertaken.

Q. How is “readily achievable” determined in a multisite business?

A. In determining whether an action to make a public accommodation accessible would be “readily achievable,” the overall size of the parent corporation or entity is only one factor to be considered. The ADA also permits consideration of the financial resources of the particular facility or facilities involved and the administrative or fiscal relationship of the facility or facilities to the parent entity.

Q. Who has responsibility for ADA compliance in leased places of public accommodation, the landlord or the tenant?

A. The ADA places the legal obligation to remove barriers or provide auxiliary aids and services on both the landlord and the tenant. The landlord and the tenant may decide by lease who actually will make the changes and provide the aids and services, but both remain legally responsible.
Q. What does the ADA require in new construction?

A. The ADA requires that all new construction of places of public accommodation, as well as of “commercial facilities” such as office buildings, be accessible. Elevators generally are not required in facilities under three stories or with fewer than 3,000 square feet per floor, unless the building is a shopping center or mall; the professional office of a health care provider; a terminal, depot or other public transit station; or an airport passenger terminal.

Q. Is it expensive to make all newly constructed places of public accommodation and commercial facilities accessible?

A. The cost of incorporating accessibility features in new construction is less than one percent of construction costs. This generally is considered a small price in comparison to the economic benefits from full accessibility in the future, such as increased employment and consumer spending and a potential corresponding decreased dependency on government assistance.

Q. Must every feature of a new facility be accessible?

A. No. Only a specified number of elements such as parking spaces and drinking fountains must be made accessible in order for a facility to be “readily accessible.” Certain nonoccupiable spaces such as elevator pits, elevator penthouses, and piping or equipment catwalks need not be accessible.
Q. What are the ADA requirements for altering facilities?

A. All alterations that could affect the usability of a facility must be made in an accessible manner to the maximum extent feasible. For example, if during renovations a doorway is being relocated, the new doorway must be wide enough to meet the new construction standard for accessibility. When alterations are made to a primary function area, such as the lobby of a bank or dining area of a cafeteria, an accessible path of travel to the altered area also must be provided.

The bathrooms, telephones and drinking fountains serving that area also must be made accessible. These additional accessibility alterations only are required to the extent that the added accessibility costs do not exceed 20% of the cost of the original alteration. As in new construction, elevators generally are not required in facilities under three stories or with fewer than 3,000 square feet per floor, unless the building is a shopping center or mall; the professional office of a health care provider; a terminal, depot or other public transit station; or an airport passenger terminal.
Q. Does the ADA permit an individual with a disability to sue a business when that individual believes that discrimination is about to occur, or must the individual wait for the discrimination to occur?

A. The ADA public accommodations provisions permit an individual to allege discrimination based on a reasonable belief that discrimination is about to occur. This provision allows a person who uses a wheelchair to challenge the planned construction of a new place of public accommodation, such as a shopping mall, that would not be accessible to individuals who use wheelchairs. The resolution of such challenges prior to the construction of an inaccessible facility would enable any necessary remedial measures to be incorporated in the building at the planning stage, when such changes would be relatively inexpensive.

Q. How does the ADA affect existing state and local building codes?

A. Existing codes remain in effect. The ADA allows the Attorney General to certify that a state law, local building code or similar ordinance that establishes accessibility requirements meets or exceeds the minimum accessibility requirements for public accommodations and commercial facilities. Any state or local government may apply for certification of its code or ordinance. The Attorney General can certify a code or ordinance only after prior notice and a public hearing at which interested people, including individuals with disabilities, are provided an opportunity to testify against the certification.
Q. What is the effect of certification of a state or local code or ordinance?

A. Certification can be advantageous if an entity has constructed or altered a facility according to a certified code or ordinance. If someone later brings an enforcement proceeding against the entity, the certification is considered “rebuttable evidence” that the state law or local ordinance meets or exceeds the minimum requirements of the ADA. In other words, the entity can argue that the construction or alteration met the requirements of the ADA because it was done in compliance with the state or local code that had been certified.

Q. When are the public accommodations provisions effective?

A. In general, they became effective on January 26, 1992.

Q. How will the public accommodations provisions be enforced?

A. Private individuals may bring lawsuits in which they can obtain court orders to stop discrimination. Individuals also may file complaints with the Attorney General, who is authorized to bring lawsuits in cases of general public importance or where a “pattern or practice” of discrimination is alleged. In these cases, the Attorney General may seek monetary damages and civil penalties. Civil penalties may not exceed $50,000 for a first violation or $100,000 for any subsequent violation.
Title IV: Telecommunications

Title IV addresses telephone and television access for people with hearing and speech disabilities. It requires common carriers (telephone companies) to establish interstate and intrastate telecommunications relay services (TRS) 24 hours a day, seven days a week. TRS enables callers with hearing and speech disabilities who use text telephones (TTYs or TDDs), and callers who use voice telephones, to communicate with each other through a third party communications assistant. The Federal Communications Commission (FCC) has set minimum standards for TRS services. Title IV also requires closed captioning of Federally funded public service announcements.

For more information about TRS, contact the FCC at:

Federal Communications Commission
1919 M Street, N.W.
Washington, D.C. 20554
Documents and questions:
(202) 418-0190 (voice)
(202) 418-2555 (TDD)
Legal Questions:
(202) 418-2357 (voice)
(202) 418-0484 (TDD)
ADA Information Resources

Federal Agencies

**Department of Justice’s ADA Information Line and Technical Assistance**
http://www.usdoj.gov/crt/ada/adahom1.htm
Architectural and Transportation Barriers Compliance Board
1331 F Street, N.W.
Washington, D.C. 20004
(800) USA-ABLE (872-2253) (voice and TTY)
(202) 272-5447 (fax)
info@access-board.gov (e-mail)
*Provides technical assistance on architectural, transportation and communications accessibility issues. Issues specific ADA Accessibility Guidelines.*

**Equal Employment Opportunity Commission**
1801 L Street, N.W.
Washington, D.C. 20507
(202) 663-4900; (800) 669-4000
(800) 669-6820 (TTY)
(202) 663-4912 (fax)
http://www.eeoc.gov (website)
*Promulgates regulations and enforces ADA Title I provisions prohibiting discrimination in employment. Provides technical assistance to employers and persons with disabilities.*

**U.S. Department of Justice Civil Rights Division**
Public Access Section
P.O. Box 66738
Washington, D.C. 20035-6738
(202) 514-0301; (800) 514-0301; (800) 514-0383 (TTY)
http://www.usdoj.gov/crt/ada/adahom1.htm (website)
*Promulgates regulations and enforces anti-discrimination provisions under Title II involving public services and under Title III involving public accommodations. Also enforces employment provisions under Title II of the ADA affecting state and local government entities. Provides technical assistance on compliance with ADA Titles II and III.*
Internal Revenue Service
U.S. Department of the Treasury
1111 Constitution Avenue, N.W.
Washington, D.C. 20224
(800) 829-1040
Provides information on tax credits and tax deductions available to businesses for costs of providing reasonable accommodations, tax information for people with disabilities, and information on the Targeted Jobs Tax Credit Program, which offers incentives for hiring individuals with disabilities referred by state vocational rehabilitation or Veterans Administration programs.

National Institute on Disability and Rehabilitation Research
U.S. Department of Education
600 Independence Avenue, S.W.
Room 360, MES
Washington, D.C. 20202-2572
(202) 205-8134; (800) 346-2742
(202) 205-9136 (TTY)
(202) 205-8515 (fax)
james_doherty@ed.gov (e-mail)
Administers the principal federal disability research programs and ADA technical assistance centers. To reach the regional Disability and Business Technical Assistance Center (DBTAC) closest to you, call (800) 949-4ADA (voice and TTY). The DBTACs act as “one-stop” central sources of information, direct technical assistance, training and referral on ADA issues, and provide individualized responses to information requests, referrals to local sources of expertise and training on ADA provisions and disability awareness.
President’s Committee on Employment of People with Disabilities
1331 F Street, N.W.
Washington, D.C. 20004
(202) 376-6200
(202) 376-6205 (TTY)
(202) 376-6219 (fax)
info@pcepdp.gov (e-mail)
Provides information and technical assistance on employing people with disabilities. Works with state organizations to increase employment opportunities.

State Vocational Rehabilitation Services Program, Rehabilitation Services Administration
Department of Education
330 C Street, S.W., Room 3127
Washington, D.C. 20202
(202) 205-5482; (202) 205-9874 (fax)
Assists employers in recruiting, training, placing and accommodating people with disabilities. Offers information on state and local agencies providing rehabilitation services, training and job-related assistance to people with disabilities.

National Organizations and Associations

Disability Business and Technical Assistance Center
1-800-949-4232

Disability Rights Education and Defense Fund
2212 Sixth Street
Berkeley, CA 94710
(510) 644-2555
(800) 466-4ADA (voice/TTY)
(510) 644-2626 (TTY)
(510) 841-8645 (fax)
dredf@dredf.org (e-mail)
Operates a telephone information line to answer ADA questions. Provides technical assistance to businesses, state and local governments, persons with disabilities and their advocates.
Job Accommodation Network
918 Chestnut Ridge Road, Suite 1
P.O. Box 6080
Morgantown, WV 26506-6080
(800) 526-7234 (voice/TTY)
(800) 526-4698 (in West Virginia)
(800) 526-2262 (in Canada)
(304) 293-5407 (fax)
jan@jan.icdi.wvu.edu (e-mail)
Offers information network and free telephone consulting resource. Maintains database of successful accommodations. Helps employers and individuals with disabilities use public programs dealing with disabilities.

National Association of Protection and Advocacy Systems
900 Second Street, N.E., Suite 211
Washington, D.C. 20002
(202) 408-9514
(202) 408-9521 (TTY)
(202) 408-9520 (fax)
hn4537@handsnet.org (e-mail)
Represents federally funded protection and advocacy agencies and provides materials on the ADA to state programs. Can provide lists of state protection and advocacy agencies. Every state has such a program that, among other services, provides legal representation on a selective basis.

National Organization on Disability
910 16th Street, N.W., Suite 600
Washington, D.C. 20006
(202) 293-5960
(202) 293-5968 (TTY)
(202) 293-7999 (fax)
ability@nod.org (e-mail)
Mobilizes, supports, and involves citizens and groups in working partnerships at local, state and national levels. Publishes list of liaisons employed by state organizations on disability. Has information hotline.
World Institute on Disability
510 16th Street, Suite 100
Oakland, CA 94612
(510) 763-4100 (voice/TTY)
A cross-disability research, training and policy development center specializing in telecommunications issues.

Employment-related Resources

Ability Magazine Jobs Information Business Service
1682 Langley
Irvine, CA 92714
(714) 854-8700; (714) 251-7010 (TTY)
(714) 435-1971 (fax)
ability@pacbell.net (e-mail)
Publishes magazine for disabled persons. Provides an electronic “classified” system enabling employers to recruit qualified individuals with disabilities, and enable persons with disabilities to locate employment opportunities.

The Association for Persons in Supported Employment
1627 Monument Avenue, Room 301
Richmond, VA 23220
(804) 278-9187
(804) 278-9377 (fax)
apse@erols.com (e-mail)
Helps employers use subsidized “supported-employment” programs by matching persons with severe disabilities to employers. Provides ongoing support for such workers. Has state chapters.

National Center for Disability Services
201 I.U. Willets Road
Albertson, NY 11507-1599
(516) 747-5400
(516) 747-5355 (TTY)
(516) 746-3298 (fax)
Provides technical assistance to employers on policies and practices for integrating persons with disabilities into the workplace. Provides training and placement services for people with disabilities.
Washington Business Group on Health
777 North Capitol Street, N.E., Suite 800
Washington, D.C. 20002
(202) 408-9320
(202) 408-9333 (TTY)
(202) 408-9332 (fax)
http://www.wbgh.com (website)

Promotes the employment of people with disabilities. Its Institute for Rehabilitation and Disability Management disseminates information to employers to help them implement cost-effective practices. Acts as a national clearinghouse for employers on psychiatric disabilities.

Organizations for Persons with Alcohol and Drug Dependence

The National Clearinghouse for Alcohol and Drug Information Center for Substance Abuse Prevention
U.S. Department of Health and Human Services
P.O. Box 2345
Rockville, MD 20847-2345
(800) 729-6686
(800) 487-4889 (TTY)
(301) 468-6433 (fax)
info@health.org (e-mail)
http://www.health.org (website)

The clearinghouse responds to requests for information on alcoholism and drug dependency. The technical assistance staff conducts online searches in order to refer callers to appropriate resources and organizations. Most services and publications from the clearinghouse are available at no charge.

National Council on Alcoholism and Drug Dependence
The National Council focuses on education, prevention and treatment of affected persons and their families. Has state and local affiliates.
Endnotes

U.S. Department of Justice Civil Rights Division
www.usdoj.gov

U.S. Equal Employment Opportunity Commission
www.eeoc.gov
Where to Turn...

The Rehabilitation Act of 1973

Brain Injury Association

105 North Alfred Street . Alexandria, VA 22314
Family Helpline: 1-800-444-6443 . (703) 236-6000
www.biausa.org
The Rehabilitation Act of 1973

The Rehabilitation Act of 1973 prohibits discrimination based on disability, requires affirmative action and mandates accessibility with regard to Federal Government employment and provision of services. Four essential portions of the law focus on these issues: Sections 501, 502, 503 and 504.

Section 501: Mandates non-discrimination by the Federal Government in its own hiring practices and requires affirmative action in the hiring, placement and advancement of people with disabilities.

Section 502: Ensures accessibility of buildings constructed with federal funds.

Section 503: Mandates non-discrimination by federal contract recipients receiving $10,000 or more and requires affirmative action in hiring, placement and advancement of people with disabilities for contractors who have 50 or more employees and a contract of $50,000 or more.

Section 504: Prohibits discrimination against people with disabilities in programs or activities conducted with any amount of federal funds.

The Rehabilitation Act of 1973, as amended, makes it unlawful for the Federal Government and federal contract recipients with contracts that exceed $10,000 to discriminate in employment against a qualified individual with a disability. The Rehabilitation Act also prohibits discrimination against individuals with disabilities in any program or activity receiving federal financial assistance and ensures compliance with accessibility codes of buildings constructed with federal funds. Under the law, the federal government has an obligation to hire, place and advance individuals with disabilities and act as a model equal opportunity employer.

The current regulations governing non-discrimination in employment under the Rehabilitation Act have been patterned after Title I of the Americans with Disabilities Act (ADA) of 1990. The 1992 amendments to the Rehabilitation Act require that employment discrimination actions that take place under Section 501 of the Rehabilitation Act and Title I of the ADA be interpreted similarly.

The following information explains the part of the Rehabilitation Act that prohibits job discrimination. Federal Equal Employment Officers who work for federal agencies, the Equal Employment Opportunity Commission (EEOC) and the Office of Federal Contract Compliance (OFCCP) enforce this part of the law.
What employers are covered by the Rehabilitation Act?

Under section 501 of the Rehabilitation Act, federal employers may not discriminate against people with disabilities in hiring, placement or advancement practices. Federal agencies are required to establish affirmative action plans to make it clear that the Federal Government is an equal opportunity employer. This applies to each department, agency and instrumentality of the executive branch of the federal government.

Under Section 503 of the Rehabilitation Act, federal contractors and their subcontractors also must abide by the non-discrimination provision of the law. This applies to contractors receiving $10,000 or more in federal funds. Contract recipients having more than 50 employees, with a contract of $50,000 or more, also must abide by the affirmative action provision of the law.

Under Section 504 of the Rehabilitation Act, employment discrimination based on disability is prohibited for employers receiving federal funding. This applies to state agencies, institutions, organizations and instrumentalities that receive federal assistance, either directly or indirectly through another recipient.

The Rehabilitation Act applies to all federal employers regardless of the number of people employed with the agency. That is different from the ADA. Federal contractors also may have a second obligation to abide by the ADA based upon the number of employees.

The employment provisions of Section 501 of the Rehabilitation Act are enforced first by an Equal Opportunity Officer within the federal agency which engaged in the alleged violation of the law and second by the EEOC. The OFCCP is responsible for enforcing Section 503 of the Rehabilitation Act as it applies to federal contractors. Further enforcement information follows.
Am I protected by the Rehabilitation Act?

If you have a disability and are qualified to perform the essential functions of a job, the Rehabilitation Act protects you from job discrimination on the basis of your disability. To be considered a person with a disability under the Rehabilitation Act, you must have a physical or mental impairment that substantially limits one or more major life activities such as walking, seeing, hearing or talking. Similarly, if you have a record or history of such an impairment, you would be covered under the Rehabilitation Act. Also, if an employer treats you as though you have such an impairment but you do not, the law protects you.

To be considered a person with a disability, you must have a substantial impairment, as opposed to a minor impairment. A person must be restricted from performing a major life activity. A substantial impairment should be determined by considering the person, not just the impairment. One should address the number and type of jobs a person is disqualified from performing as a result of the impairment(s), the geographical area he or she has access to, and the job expectations and training of the individual. For purposes of Section 503, a person is limited substantially if he or she is likely to have difficulty in securing, retaining or advancing in employment because of his or her disability.

To be protected by the Rehabilitation Act, a person with a disability must be qualified to perform the essential functions or duties of a job, with or without a reasonable accommodation. One would determine essential functions by looking at whether a position exists to perform that function, whether there are a limited number of employees available to perform that function or whether the function is highly specialized, requiring special expertise to perform it. A qualified job applicant or employee is expected to meet the employer’s requirements for the particular job, such as proper education, experience and skills. Provided a person can perform all of the essential job duties, with or without reasonable accommodation, an employer cannot refuse to hire or advance a person because of his or her disability.
What is Reasonable Accommodation?

Reasonable accommodation is the key factor that allows many people with disabilities to achieve equal employment status in the workplace. A reasonable accommodation is a change or adjustment to a job or work environment that allows a person with a disability to participate in the job application process, perform essential job functions or enjoy benefits and privileges of employment equal to those enjoyed by employees without disabilities. A reasonable accommodation may include but is not limited to:

- Making a workplace readily accessible to and usable by people with disabilities
- Job restructuring
- Providing and modifying equipment and devices
- Providing readers and interpreters
- Part-time or modified work schedules and
- Reassignment to a vacant position

Reasonable accommodation should take place in an individual’s original position first. If no possible accommodation would allow the individual to perform the essential functions of that job, reassignment can be considered for accommodation purposes. In the past, courts have disagreed upon reassignment as reasonable accommodation under Section 501. Under the 1992 amendments, the EEOC regulations state that under Section 501, federal agencies must reassign employees who no longer can perform in their original position as a result of disability unless undue hardship would result. The reassignment provision for federal agencies is considered an affirmative action obligation rather than a reasonable accommodation obligation, as it would be considered under the ADA.
An employer is required to provide a reasonable accommodation to a qualified applicant or employee with a disability unless providing that accommodation would pose an undue hardship on the business. Undue hardship is determined by assessing the size, type and budget of the employer’s business and the nature of the cost of the accommodation. It must be determined whether or not the accommodation would require significant difficulty or expense to implement. A larger employer may be able to bear a more significant cost than a smaller employer based upon the number of employees and the employer’s budget.

**How do I request a reasonable accommodation?**

If you think you are covered by the Rehabilitation Act as a person with a disability, and you require an accommodation to perform the essential functions of your job, certain steps must be considered. An employer is not required to make an accommodation if he or she is not aware of a disability. In order to obtain an accommodation, a person with a disability must inform the employer of the need for accommodation. Some employers have a formal request policy that an employee should consider before making his or her request. Although the law does not require that a request be made in writing, a formal request is recommended in order to maintain a record for future reference. A request for accommodation should be addressed to a supervisor or the employer directly and may include the following key points:

- ✔ Identify yourself as a person with a disability
- ✔ State that you are requesting accommodation(s) under the Rehabilitation Act
- ✔ Identify your specific problematic job tasks
- ✔ Identify your accommodation ideas
- ✔ Request your employer’s accommodation ideas
Refer to medical documentation that may be attached to the letter of accommodation, or provide the employer with the option of obtaining the medical documentation.

*Note: An employer has the right to require a record of impairment when an accommodation is requested.*

Ask that the employer respond to your request in a reasonable amount of time.

Once a request for accommodation has been submitted, the employer has the obligation to consider the reasonableness of the request. If the employer is able to implement the accommodation without undue hardship, then the procedure should take place in a reasonable amount of time. This may depend upon the nature of the accommodation requested and the resources the employer can utilize to implement the accommodation.

It is unlawful for an employer to retaliate against a person with a disability who has asserted his or her rights under the Rehabilitation Act. A person who feels he or she has experienced retaliation from requesting accommodation may file a complaint with the proper enforcement agency.

**What employment practices are covered?**

Under Section 501 of the Rehabilitation Act, discrimination based on disability is prohibited in employment practices of the federal government. Federal contract recipients are also forbidden from discriminating in their employment practices under Section 503. Employment practices governed under the law include:

- Recruitment
- Firing
- Hiring
Can an employer require medical examinations or ask questions about a disability?

According to the 1992 amendments to the Rehabilitation Act, under Section 501, an employer is not permitted to ask an applicant if he or she is disabled or ask about the nature or severity of the disability. An employer can ask if an applicant can perform the duties of the job for which he or she is applying, with or without reasonable accommodation. An applicant also may be required to demonstrate to an employer how the duties would be performed, with or without reasonable accommodation. Federal employers and contractors that are covered by the affirmative action requirements of Sections 501 and 503 of the Rehabilitation Act, however, may invite individuals with disabilities to identify themselves on a job application form, or by some other pre-employment inquiry, to satisfy affirmative action requirements. Such an invitation is voluntary and maintains the applicant’s right to choose whether or not to disclose.

For certain positions, medical exams are necessary to determine an employee’s fitness for duty. Medical exams are forbidden until a conditional job offer is made to an applicant. Following a job offer, an employer may require an applicant to pass a required medical exam if all entering employees for that job category have to take the examination. An employer cannot reject a person with a disability based upon findings in a medical exam, unless the reasons for rejection are job-related and necessary for the conduct of the employer’s business.
After an individual has been hired, an employer cannot require a medical exam or ask questions about a disability unless they are related to the job and consistent with business necessity. An employer may conduct voluntary medical examinations and health screenings. The results of all medical examinations and disability-related inquiries must be kept confidential, and maintained in separate medical files.

How do I file a complaint of discrimination?

Under Section 501 of the Rehabilitation Act

A Federal Government employee who feels he or she has experienced discrimination in employment on the basis of disability should contact the Equal Employment Opportunity Officer (EEO Officer) of the agency which allegedly has violated the law. If the employee chooses to file a complaint, it must be filed within 45 days of the discriminatory act. The EEO Officer has 30 days in which to resolve the situation unless both parties have agreed to a 60-day extension. At the end of the extension, if a complainant is not satisfied with the decision, the EEO Officer can issue a notice of right to file a formal complaint with the EEOC that must be filed within 15 days. The EEOC then has 180 days to investigate the complaint with a possibility of a 90-day extension if needed. At that point, the complaint will be resolved or the complainant can proceed with a hearing in front of an administrative judge or go to court. If a decision is rendered which is not satisfactory to the parties, an appeal can be filed with the EEOC. A claim must go before the EEO Officer of the agency who allegedly violated the law first or it cannot go forward to the EEOC or the courts.

Note: This is the process in a nutshell. Some exceptions may apply. For more information, see the EEO Officer responsible for handling complaints at your agency.
EEOC field offices are located in cities throughout the United States. If an agency EEO Officer has been notified of the discrimination and a satisfactory decision has not been rendered, contact the EEOC by looking in your local telephone directory under U.S. Government. For information and instructions on reaching your local office, call:

U.S. Equal Employment Opportunity Commission (EEOC)
1801 L Street, N.W.
Washington, DC 20507
(202) 663-4519 (Voice) or (202) 663-4593 (TTY/TDD)

**Under Section 503 of the Rehabilitation Act**

A federal contract employee who feels he or she has been or is experiencing discrimination in employment on the basis of disability should contact the Office of Federal Contract Compliance Programs (OFCCP). According to the rules issued by the OFCCP designed to make Section 503 of the Rehabilitation Act consistent with Title I of the ADA, federal contract employees have 300 days to file a charge of employment discrimination based on disability. A written complaint must be filed with the OFCCP main office with one of their regional offices across the United States. The OFCCP will investigate the situation.

For further information and instruction on filing a complaint as a federal contract employee, contact:

U.S. Department of Labor
Office of Federal Contract Compliance Programs (OFCCP)
200 Constitution Ave., N.W.
Washington, DC 20210
(202) 401-8818 (Voice) or (202) 219-9471 (TTY/TDD)
Q. Is an employer required to provide reasonable accommodation when I apply for a job?

A. Yes. Applicants, as well as employees, are entitled to reasonable accommodation. An applicant may need an accommodation to complete the application and interview procedures. For example, an employer may be required to provide a sign language interpreter during an interview for an applicant who is deaf or hard of hearing, or perhaps an employer might have to consider providing additional time to take a skills test for an applicant who has a learning disability.

Q. Should I tell my employer that I have a disability?

A. An employee only is required to disclose his or her disability if a reasonable accommodation is required to participate in the application process or perform essential job functions. An employer is not required to provide an accommodation if there is no knowledge that a physical or mental limitation exists. Generally, it is the responsibility of the employee with the disability to inform the employer that an accommodation is needed.

Federal employers and contractors who are covered by the affirmative action requirements of Sections 501 and 503 of the Rehabilitation Act may invite individuals with disabilities to identify themselves to satisfy affirmative action requirements.
Q. Do I have to pay for a needed reasonable accommodation?

A. The Rehabilitation Act requires that the employer provide the accommodation unless to do so would impose an “undue hardship” on the operation of the employer’s business. When an accommodation would be too costly for the employer to provide, the employee can be given the choice of providing the accommodation. An employer and employee also can share the cost of accommodation.

Q. Can an employer lower my salary or pay me less than other employees doing the same job because I need reasonable accommodation?

A. The cost of reasonable accommodation cannot be recovered by lowering the salary of the person who needs the accommodation.

Q. Is an employer required to hire a qualified person with a disability over other applicants without disabilities?

A. Sections 501 and 503 of the Rehabilitation Act both include affirmative action responsibilities on the part of the Federal Government and federal contract recipients in their hiring practices. An employer, however, is expected to hire the most qualified person for a position, regardless of whether or not he or she has a disability. An employer cannot refuse to hire a person with a disability based upon that disability or the fact that reasonable accommodation may be necessary to perform essential job functions.
Q. **Does an employer have to provide me with the accommodation that I prefer?**

A. An employer is required to provide an effective accommodation that will allow a person with a disability to perform essential job duties and benefit from all employment-related privileges. The most effective accommodation may not always be the best, or the preferred accommodation. The employer has the right to choose between accommodation options.

Q. **Can an employer offer a health insurance policy that excludes coverage for pre-existing conditions?**

A. **Yes.** The Rehabilitation Act does not affect pre-existing condition clauses contained in health insurance policies.

Q. **Does an employer have to make non-work areas used by employees, such as cafeterias, lounges or employer-provided transportation, accessible to people with disabilities?**

A. **Yes.** The requirement to provide reasonable accommodation covers all services, programs and non-work facilities provided by the employer. Under section 502 of the Rehabilitation Act, buildings constructed with federal funds must be accessible. Not all federal facilities will have been constructed with federal funds, but the facilities must be made accessible to those employees who would need that accessibility.
For more specific information about the Rehabilitation Act requirements affecting employment contact:

Equal Employment Opportunity Commission (EEOC)
1801 L Street, NW
Washington, D.C. 20507
(202) 663-4519 (Voice)
(202) 663-4593 (TTY/TDD)

Office of Federal Contract Compliance Programs (OFCCP)
200 Constitution Ave., N.W.
Washington, D.C. 20210
(202) 401-8818 (Voice)
(202) 219-9471 (TTY/TDD)
Endnotes

President’s Committee on Employment of People with Disabilities
Job Accommodation Network (JAN)
918 Chestnut Ridge Road
Suite 1
P.O. Box 6080
Morgantown, WV 26505-6080
(800) 526-7234
(800) ADA-WORK
JAN on the web: http://janweb.icdi.wvu.edu
e-mail: jan@jan.icdi.wvu.edu
Where to Turn...

Disability Programs Under the Social Security Administration

Brain Injury Association

105 North Alfred Street  .  Alexandria, VA 22314
Family Helpline: 1-800-444-6443  .  (703) 236-6000
www.biausa.org
DISABILITY PROGRAMS UNDER THE SOCIAL SECURITY ADMINISTRATION

What are the two disability programs administered by the Social Security Administration?

The Social Security Administration administers two disability programs: the Social Security Disability Insurance (SSDI) program and the Supplemental Security Income (SSI) program. SSDI and SSI are the largest of several Federal programs that provide assistance to people with disabilities. People who have severe disabilities and meet strict medical rules may qualify for benefits under either program.

What is the difference between the SSDI and SSI programs?

Generally, the medical requirements for disability eligibility are the same under both programs. But, SSDI eligibility is based on your prior work experience, while SSI eligibility is based on your financial need. SSI may be considered the "low income" component of the Social Security Administration. Also, SSDI and SSI are funded differently.

Where does the SSDI and SSI money come from?

The SSDI program is funded by the Social Security taxes a working person pays. When a working person becomes disabled or retires, that person (and his or her family members) may collect monthly benefits from Social Security, based on the money the person paid in taxes. When that working person dies, his or her family may collect survivor's benefits.

The SSI program is funded by general tax revenues. The SSI program pays benefits to people who have limited income and assets.
How does the Social Security Administration define "disability"?

Under the SSDI and SSI programs, the word "disability" does not mean "disability" in the way that most of us think of the word. It is important to understand how the Social Security Administration defines "disability," because it is a very strict definition. Other Federal programs have different definitions for disability. For example, some programs may pay for a person's partial disability or a person's short-term disability. Social Security does not recognize partial or short-term disability.

The decision about a person's possible disability under the Social Security Administration is based strictly on that person's inability to work. This is because the Social Security Administration assumes that working families have access to other resources that will provide support during periods of short-term disabilities, including workers' compensation, insurance, savings and investments.

The Social Security rules for disability don't seem very fair. The Worker's Compensation Commission says I am partially disabled, so why doesn't Social Security say the same thing?

The ultimate decision on your disability status is a legal conclusion based on the Social Security regulations and related Federal court decisions. The findings from another government agency, such as the Worker's Compensation Commission, or from an insurance company, are not considered by Social Security.
What does "disabled" mean under the SSDI rules?

"Disabled" under the SSDI rules means that you have a physical or mental condition(s) that prevents you from working, and the condition(s) is expected to last at least a year, or result in death.

Do I qualify for SSDI?

To qualify for Social Security Disability Insurance (SSDI) benefits, you must be disabled under the Social Security Administration's definition, and you must have worked long enough and recently enough under the Social Security Administration's rules. To put it another way, SSDI benefits are based on how much money you have "paid into the system" by paying taxes. A working person who pays taxes earns what the Social Security Administration calls "work credits." To be eligible for SSDI benefits, a person must have earned a certain number of work credits.

You qualify if...

- you have worked long enough and recently enough
- you have "paid into the system" by paying taxes

How many work credits can I earn per year?

You can earn no more than four work credits in one year. The amount of earnings required for one work credit increases each year as the general wage levels rise.
How many work credits do I need to earn to be eligible for SSDI benefits?

The number of work credits you need to be eligible for SSDI benefits depends partly on the age you were when you became disabled, and on how recently you earned these credits. Generally, you need to have earned 20 work credits in the last 10 years, ending with the year you became disabled. Your age makes the difference. For example, younger workers may qualify for SSDI benefits with fewer credits.

The credit rules are very complicated. Most people are very confused by these rules. The Social Security Administration keeps track of how many work credits a person has earned, so you don't need to know how to calculate work credits. These are the rules:

- **Before age 24**—you may qualify for SSDI benefits if you have earned six credits in the three-year period ending when your disability started.

- **Age 24 to 31**—you may qualify for SSDI benefits if you have earned credit for having worked half the time between age 21 and the time you became disabled. For example, if you became disabled at age 27, you would need credit for three years of work (12 credits) out of the past six years (between age 21 and age 27).

- **Age 31 or older**—in general, you will need to have the number of work credits shown in the chart below. Unless you are blind, at least 20 of the credits must have been earned in the 10 years immediately before you became disabled.
How long can I receive SSDI benefits?

You can receive SSDI benefits until age 65. When you reach age 65, the SSDI benefits automatically convert to Social Security retirement benefits, but the payment amount remains the same.

Can my family members qualify for SSDI benefits?

Certain family members may qualify for benefits. These family members include:

☑️ A **spouse** who is age 62 or older, or a spouse who is any age if he or she is caring for your child under age 16 or a **child with a disability** who also is receiving disability payments.

☑️ A **widow or widower with a disability** who is age 50 or older. The disability must have started before your death or within seven years after your death. (If your widow or widower caring for your children receives Social Security checks, he or she is eligible if he or she becomes disabled before those payments end, or within seven years after they end).
☑ An unmarried son or daughter, including an adopted child, or, in some cases, a stepchild or grandchild. The child must be under age 18 or, if in high school full-time, under age 19.

☑ Your unmarried son or daughter, age 18 or older, if he or she has a disability that started before age 22. He/she must meet the adult definition of disability. (If a child with a disability under age 18 is receiving benefits as the dependent of a worker who is retired, deceased or disabled, someone should contact Social Security to have his or her checks continued at age 18 on the basis of disability).
How do I qualify for SSI benefits?

Supplemental Security Income (SSI) is for people who don't own many assets or have a low income. People who receive SSI benefits usually receive food stamps and Medicaid as well. SSI is for people who are **65 or older, blind or who have a disability** (including children who are blind or who have a disability).

It is important to know that SSI benefits are intended only as a **supplement**. The amount of SSI money can increase every year based on cost-of-living adjustments. The level varies from one state to another, so check with your local Social Security office to find out more about SSI benefit levels in your state.

People receiving SSI benefits **must** have limited income and assets. Generally, people with assets worth less than $2,000, or couples with assets worth less than $3,000, can qualify for SSI benefits. The Social Security Administration usually does not count items like your home or car (unless it's an expensive one) as an "asset."

What does "disabled" mean under the SSI rules?

"Disabled" means that you have a physical or mental condition(s) that prevents you from working and is expected to last **at least one year or result in death**.
How does the Social Security Administration decide if I am "disabled" under the SSDI or SSI programs?

The Social Security Administration applies a five-step test to determine if you are disabled, as follows:

1. **Are you working (conducting substantial gainful activity)?**

   If you are working, and your earnings average more than $700 a month, you will not be considered disabled. If you are working, and your earnings are less than $700 a month, your ability to do work may make your case more difficult to prove. The Social Security Administration calls work "substantial gainful activity," or "SGA." Social Security defines SGA as: *any significant and productive physical or mental activity that is done or intended for pay or profit.* If you are not engaged in SGA, go to step #2.

2. **Do you have a "severe impairment" or "combination of impairments" that is expected to last for at least 12 months or result in death?**

   Your physical or mental condition(s) must be "severe" so that it interferes with basic work-related activities. It also must be expected to last for at least 12 months, or result in death. If not, you will not be considered to have a disability. If you think your condition meets these requirements, go to step #3.
3. **Is your condition found on the Social Security Administration's list of disabling impairments?**

The Social Security Administration maintains a list of physical and mental impairments covering each of the major body systems. This list is known as "the medical listings." The impairments on this list are considered to be so severe that they automatically entitle a person to a finding of disability. If your impairment is not a "listed impairment," you must prove that your impairment is of equal severity to an impairment on the list. Therefore, the test is whether your impairment "meets or equals a listing." If your impairment is on the list, you will be found to have a disability. If your condition equals a listed impairment, go to step #4.

4. **Can you do the work you did previously?**

If your condition is severe, but not one of the listed impairments, then you must show that your condition interferes with your ability to do the work you did previously (i.e., the work you have performed in previous jobs). If your condition does not interfere with your ability to do the work you did previously, your claim will be denied. If it does, go to step #5.
5. _Can you do any other type of work?_

If you cannot do the work you did in the past, the Social Security examiners will look to see if you can perform any other work "that exists in the national economy." The examiners might determine that you are able to adjust to other work. In making this determination, the Social Security examiners will consider the following factors:

- ✓ Your medical condition(s)
- ✓ Your age
- ✓ Your education
- ✓ Your prior job training
- ✓ Your daily activities before and after you became disabled
- ✓ Your attempts to work or do work activities (e.g., doing the laundry, caring for young children) since you became disabled
- ✓ Your ability to perform certain job-related activities, including: standing, stooping, carrying, lifting, pushing/pulling, hand manipulation, memory, judgment, seeing and hearing
What if the Social Security Administration decides that I can do work that I don't want to do (because it is below my training level, boring, not enjoyable, pays less money than I used to earn etc.)?

Unfortunately, these factors are irrelevant under the Social Security rules. If there is a job available in the national economy that you can perform, then you will not be considered disabled. For example, a heart surgeon may be able to work as a cashier, or do some other type of "sitting" job. If so, the heart surgeon will not be found disabled.

What is "Substantial Medical Proof" and why do I need it?

**Substantial medical proof** is the evidence Social Security requires from your treating doctors or hospitals to prove that you are disabled. It includes your medical records, doctor reports, laboratory test results, signs and symptoms of a disability.

It is crucial that you get treatment from your own doctor(s). Your own doctor(s) can support and document your disability before you apply for disability benefits. Your own doctor(s) also can examine and treat you over time. This will allow your doctor(s) to gain a better understanding of your physical/mental condition(s).

My doctor is willing to write a letter saying that I am totally and permanently disabled; is this enough substantial medical proof?

No. Social Security is looking for a complete medical report. This report should include such things as your medical history, clinical findings, laboratory findings, diagnoses, treatment, medical assessment, prescription medications, etc. It is up to the Social Security Administration to determine if you are disabled. It is not up to your doctor to make this decision.
Social Security sent me to one of their doctors. Is this enough for substantial medical proof?

Not really. When you apply for disability benefits, Social Security may send you to a doctor for a medical examination (sometimes called a "consultative exam"). These doctors have been hired by Social Security. They will examine you once, and they will not provide you any treatment or medications. Also, they will not be able to discuss the history of your disability, nor your history of treatment and medications.

What if I can't afford a doctor?

If you can't afford a doctor, you should contact your local Department of Health and Human Services office to obtain medical assistance. Ideally, you should have been getting treatment from your own doctor before you apply for disability benefits.

Are there special rules for people who are blind?

Yes. You will be considered "blind" under the Social Security rules if your vision cannot be corrected to better than 20/200 in your better eye, or if your visual field is 20 degrees or less, even with a corrective lens.

There are a number of special rules for persons who are blind. The rules recognize the severe impact of blindness on a person's ability to work. For example, the earnings limit for people who are blind generally is higher than the $700 limit that applies to workers who are not blind, but who are workers with other disabilities. This amount changes each year. You can contact the Social Security Administration for the current figures and other information on special rules for persons who are blind. Ask for the leaflet entitled: If You Are Blind...How We Can Help (Publication No. 05-10052).
Are there special rules for children who have a disability?

Yes. There are three ways a child may be eligible for benefits from the Social Security Administration:

- **SSI Benefits For Children** - These are benefits payable to children with disabilities under age 18 who have limited income and resources, or come from homes with limited income and resources.

- **Social Security Dependents** - These are benefits payable to children under the age of 18 who are on the record of a parent who is collecting retirement or disability benefits from Social Security, or survivors benefits payable to children under the age of 18 on the record of a parent who has died.

Although children under age 18 who are eligible for these benefits might have a disability, the Social Security Administration does not need to consider their disability to qualify them for benefits, since these children are getting benefits in a different way.

*Note: A child can continue receiving dependents or survivors benefits until age 19 if he or she is a full-time student in elementary or high school.*

- **Social Security Benefits for Adults Disabled Since Childhood** - Childhood disability benefits normally stop when a child reaches age 18 (or 19 if the child is a full-time student). But those benefits can continue to be paid into adulthood if
the child has a disability. To qualify for these benefits, you must be eligible as the child of someone who is getting Social Security retirement or disability benefits, or of someone who has died. Also, the child must have a disability that began prior to age 22.

Although most of the people getting these benefits are in their 20s and 30s (some are even older), the benefit is called a "child's" benefit because of the eligibility rules.

What are the rules for children under 18?

Most children do not have their own income and do not have many assets. However, when children under age 18 live at home (or are away at school but return home occasionally and are subject to parental control), Social Security considers the parents' income and assets when deciding if the child qualifies. Social Security calls this process "deeming" of income and assets.

You should check with your local Social Security office for information about your child's specific situation and for a full explanation of the "deeming" process.

What are the rules for children 18 and older?

When a child turns 18, Social Security will no longer consider a parent's income and assets when deciding if the child can get SSI. A child who was not eligible for SSI before his or her 18th birthday because a parent's income or assets were too high may become eligible at 18. On the other hand, if a child with a disability who is getting SSI turns 18 and continues to live with his or her parent(s), but does not pay for food or shelter, that child may qualify for less money.
How does Social Security decide if a child is disabled?

This is what the law says: A child will be considered disabled if he or she has a physical or mental condition (or a combination of conditions) that results in "marked and severe functional limitations." The condition must last or be expected to last at least 12 months or result in the child's death. Also, the child must not be working.

Just like with adult disability, Social Security first will check to see if the child's disability can be found in a special "list of impairments," or if the condition is equal to an impairment on the list. The list includes symptoms, signs or laboratory findings of more than 100 physical and mental problems, such as cerebral palsy, mental retardation or muscular dystrophy, that are severe enough to disable a child (Social Security calls these symptoms, signs or laboratory findings "objective evidence"). The child will be considered disabled if his or her resulting difficulties (Social Security calls these "functional limitations") are the same as the functional limitations of any impairment on the list. Social Security also says that the child's difficulties must be "marked and severe."

I think I have a disability. How do I apply?

You should apply as soon as you have a disability. It is important, however, to know that your Social Security disability benefits will not begin until the sixth full month of disability. This waiting period begins with the first full month after the date Social Security decides that your disability began.

You can apply for benefits by calling a toll-free number: 1-800-772-1213, between 7:00 a.m. and 7:00 p.m., Monday through Friday. People who are deaf or hard of hearing may call a toll-free TTY number, 1-800-325-0778, between 7:00 a.m. and 7:00 p.m., Monday through Friday.
When you call Social Security, a representative can make an appointment for you to apply by telephone. You also may visit your nearest Social Security Office to file for disability benefits. The Social Security representatives can tell you over the phone where your nearest Social Security Office is, if you tell them your zip code.

How long will it take for Social Security to make a decision about my disability?

The claims process for disability benefits generally takes a long time. Often, the decision process can last from 60 to 90 days.

Can I make the decision process go faster?

You can help shorten the process by bringing certain documents with you when you apply for benefits. These documents include:

- **Social Security number**
- **Birth certificate** or other evidence of your date of birth
- **Military discharge papers**, if you were in the military service
- **Spouse's birth certificate** and Social Security number if he or she is applying for benefits
- **Children's birth certificates** and Social Security numbers if they are applying for benefits
- **Checking or savings account information**, so your benefits can be deposited directly
Names, addresses and phone numbers of doctors, hospitals, clinics and institutions that treated you and dates of treatment

Names of all medications you are taking

Medical records from your doctors, therapists, hospitals, clinics and caseworkers

Laboratory and test results

Work summary: a list of where you have worked in the past 15 years and the kind of work you did

Copy of your W-2 Form (Wage and Tax Statement), or if you are self-employed, your federal tax return for the past year

Dates of prior marriages if your spouse is applying

* If you are applying for SSI benefits you also need to provide Social Security with the following documents:

Information about the home where you live, such as your mortgage and lease information, and your landlord's name

Payroll slips, bank books, insurance policies, car registration, burial fund records and other information about your income and the things you own

* The documents you submit must be originals or certified copies from the issuing agency. The Social Security office will not accept uncertified photocopies as evidence.
Should I wait until I have all the necessary documents before I file for disability?

**No.** You should not delay filing for benefits just because you do not have all the information you need. You can turn in necessary documents as you receive them.

What do I do if I have been denied disability benefits?

First, you should know that the **majority** of people filing for disability benefits will have their initial application **denied**. There are a series of appeals that you may file so that the Social Security Administration is required to take a closer look at your case.

The entire appeals process can take a long time, from several months to a year or more. This is normal. There is a large backlog of pending disability cases at the Social Security Administration. As you go through the appeals process, try not to become discouraged.

Also, make sure that you follow the proper appeals process when you get denied. The biggest mistake people make when they receive a denial letter is either to give up, or reapply for benefits, instead of appealing the denial. **You should think of your first denial as the BEGINNING of the disability claim process, not the end.**
How do I appeal a denial of benefits from my first application?

When you receive a denial letter in the mail, you should file your first appeal immediately. This is called a Request for Reconsideration. You have 60 days to file the Request from Reconsideration from the date you receive the denial letter. Just as you did to apply for benefits, you can call Social Security to file a Request for Reconsideration, or you can file it at your local Social Security office. If you do not file your Request for Reconsideration within 60 days, your case may be dismissed. If your case is dismissed, you will have to start the process over again.

What do I do if my Request for Reconsideration (first appeal) is denied?

Some cases are approved at the Reconsideration level but many of them are denied. When you receive your denial letter in the mail, you should file your second appeal immediately. This second appeal is called a Request for Hearing. You have 60 days to file a Request for Hearing from the date you receive the denial letter in the mail. If you do not file your Request for Hearing within 60 days, your case may be dismissed. If your case is dismissed, you will have to start the process over again.

What happens at a disability hearing?

The hearing will be held in front of an Administrative Law Judge. The hearing is closed and private. Although the hearing is held in a courtroom, it is an informal proceeding. Your success at the hearing depends partly on any new or additional evidence you bring to the judge. You have a better chance of getting your disability benefits approved at this level than you do at the "paper" level.
Do I need to be represented by an attorney at the disability hearing?

The administrative process surrounding the application for disability benefits is complicated, but there is no requirement that you hire an attorney to represent you. You are allowed to represent yourself at the hearing, to "appear pro se." In fact, you may choose any person to represent you, such as a family member, friend or social worker. Most people choose to hire an attorney once they have been denied disability benefits.

How can an attorney help me?

Often, a disability claim is denied because of procedural or administrative problems (i.e., reasons not even related to your disability). Some disability claims become lost due to the huge backlog of cases at the Social Security Administration. In many cases, your disability claim may not be adequate or complete, resulting in the ongoing denial of your claim no matter how many times you apply. It often is difficult for a person to understand why a claim is denied continually.

A qualified attorney or practitioner can help you prepare and present clear, concise and complete factual and legal arguments that address relevant regulations and rulings in your case.
What if I can't afford an attorney? How can I avoid being overcharged by an attorney?

The Social Security Administration regulates attorney fees, so you will know ahead of time how much your attorney will be paid. The fees are awarded on a "contingency fee" basis. That means that the attorney only will be paid if you are approved for disability benefits. **You will not have to pay the attorney if you are not approved for disability benefits.** Some attorneys may charge you for certain out-of-pocket costs such as the cost for copying medical records. You should talk to your attorney about these costs at your first meeting and ask him or her for a cost estimate. In most cases, these costs should be minimal.

If you are a successful SSDI applicant, the Social Security Administration will pay your attorney directly with a government-issued check. If you are a successful SSI applicant, you will be responsible for paying your attorney out of the funds you are awarded.

Where can I find a Social Security Disability attorney?

Most states have a "lawyer referral" number serviced by the local bar association. You also may contact the **National Organization of Social Security Claimants' Representatives (NOSSCR) at 1-800-431-2804**, or online, at [www.nossr.org](http://www.nossr.org).
How can I locate my local Social Security Office?

There are three ways to locate your local Social Security Office:

1. Use Social Security's Field Office Locator at: https://s3abaca.ssa.gov/pro/fol-home.html
2. Call 1-800-772-1213 and ask for the office nearest you
3. Check your phone book; look in blue pages under U.S. government
Resources

National Organization of Social Security Claimants' Representatives (NOSSCR)
www.nosscr.org
1-800-431-2804
Where to Turn...

Medicare
What is Medicare?

Medicare is a federal health insurance program for people 65 years or older and many other individuals with disabilities.

Medicare has two parts: Part A and Part B. Part A covers hospital services. Most people do not have to pay for Part A. Part B covers physician services, outpatient hospital care and laboratory services. A monthly premium is deducted from a beneficiary’s Social Security check. In addition, you pay an annual deductible of $100 and 20% of the amount Medicare approves for your medical bills.

Am I Eligible for Medicare?

Generally, you are eligible for Medicare if you or your spouse worked for at least 10 years in Medicare-covered employment and you are at least 65 years old and a citizen or permanent resident of the United States. If you are under 65, you still may qualify for Medicare if you are a person with a disability or chronic kidney disease.

You qualify for Medicare if:

☑️ You are 65 years or older, or
☑️ If you are under 65, have a disability, or
☑️ Have chronic kidney disease
What are my choices in getting my health care through Medicare?

You have two health care delivery options through Medicare:

1. **The Original Medicare Plan:** Under this plan, a beneficiary can go to any doctor, specialist or hospital that accepts Medicare. Medicare pays a share of your health care costs and the beneficiary pays a portion. Although this is the means by which most beneficiaries receive their Medicare Part A and Part B benefits, certain options, like prescription drugs, are not covered.

2. **Medicare Managed Care Plans:** Otherwise known as Medicare+Choice, these managed care plans are available in some areas of the country. Like many managed care organizations, beneficiaries may only go to the plan’s doctors, specialists or hospitals. All participating plans are required to cover all Medicare Part A and Part B benefits. Some plans even cover prescription drugs.

Do I have to pay a premium?

You can get Part A at 65 without having to pay premiums if:

- You already are receiving retirement benefits from Social Security or the Railroad Retirement Board

  OR

- You are eligible to receive Social Security or Railroad benefits but have not yet filed for them

  OR

- You or your spouse had Medicare-covered government employment
While you do not have to pay a premium for Part A if you meet one of those conditions, you must pay for Part B if you want it. In 2000, the monthly premium for Part B is $45.50. This amount is deducted from your Social Security, Railroad Retirement, or Civil Service Retirement check.
What Does Medicare Part A Cover?

Medicare Part A covers much of the cost of:

- Inpatient hospital care
- Skilled nursing facility care
- Home health care
- Hospital care

Inpatient Hospital Care

Part A covers hospital stays, including psychiatric hospital stays. You are covered for up to 90 days of hospital care per benefit period. A “benefit period” begins when you have been admitted to the hospital and ends when you have been out of the hospital or skilled nursing facility for 60 days in a row. A new benefit period begins with your next hospital admission.

Part A also includes partial coverage for 60 additional hospital days in your lifetime, which are called “lifetime reserve” days. Medicare pays for lifetime reserve days only after you’ve used your Medicare hospital coverage through day 90. You do not have to use your 60 lifetime reserve days all at once. For inpatient psychiatric services in a psychiatric hospital, there is a 190-day lifetime reserve limit.

<table>
<thead>
<tr>
<th>Inpatient Hospital Care per benefit period: 2000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>You pay:</strong></td>
</tr>
<tr>
<td>Days 1-60</td>
</tr>
<tr>
<td>Days 61-90</td>
</tr>
<tr>
<td>Days 91-150</td>
</tr>
<tr>
<td>All additional days</td>
</tr>
</tbody>
</table>
Skilled Nursing Facility Care

While in a Skilled Nursing Facility (SNF) setting, you are offered a semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies.

Part A covers up to 100 days of care in a Medicare-certified skilled nursing facility per benefit period.

You must meet three conditions:

- You must need daily skilled nursing or rehabilitation services. “Daily” is defined as seven days per week for skilled nursing services and five days per week for skilled rehabilitation services.

- The services you need must be services that, as a practical matter, can be provided only in an inpatient facility.
The skilled nursing facility care begins within 30 days of your discharge from a hospital after a stay of at least three days.

If the skilled nursing facility claims that Medicare won’t pay for your care and makes you sign documentation agreeing to pay for your nursing care yourself, you can demand that the facility bill Medicare directly. The facility cannot charge you unless and until Medicare denies coverage.

### Skilled Nursing Facility Care Per Benefit Period: 2000

<table>
<thead>
<tr>
<th>You pay:</th>
<th>Medicare Pays:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days 1-20</td>
<td>Nothing</td>
</tr>
<tr>
<td>Days 21-100</td>
<td>$97 per day</td>
</tr>
<tr>
<td>All additional days</td>
<td>Everything</td>
</tr>
</tbody>
</table>

### Home Health Care

Home Health Care services consists of intermittent skilled nursing care, physical therapy, speech language pathology services, home health aide services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and supplies, and other services.

### Home Health Care Services Per Benefit Period: 2000

<table>
<thead>
<tr>
<th>You pay:</th>
<th>Medicare Pays:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days 1-20</td>
<td>Nothing</td>
</tr>
<tr>
<td>Days 21-100</td>
<td>$97 per day</td>
</tr>
<tr>
<td>All additional days</td>
<td>Everything</td>
</tr>
</tbody>
</table>
Part A covers up to 100 home health care visits if you need care at home within 14 days after a hospital stay of at least three days. (Part B covers home health care if you don’t meet the hospital stay requirement or if you need more than 100 visits.) To be eligible for the home health benefits (Part A or Part B), you must meet all three of these conditions:

- **You must be considered homebound.** This means that you must have a condition resulting from illness or injury that makes it very hard to leave home.

- **You must get care** from a Medicare-certified home health agency.

- **You must need the services of a skilled nurse** or a speech, physical or occupational therapist on an intermittent or part-time basis. Intermittent care is skilled care provided fewer than seven days per week or daily for a finite, predictable time. Part-time care is fewer than eight hours per day, usually for periods of 21 days or less.

**What is covered?**

Part A (or B) will cover skilled nursing and home health aide services on an intermittent or part-time basis; that is, up to seven days per week as long as services don’t exceed eight hours per day and 28 hours per week (sometimes up to 35 hours per week). They also will cover needed home health aide services, physical, speech and occupational therapy, as well as medical social services and supplies.

**What is your contribution?**

The home health benefit is available at no cost to those who are eligible (as described above). However, patients must pay the 20% coinsurance for durable medical equipment.
Hospice Care

Hospice care includes pain and symptom relief, and supportive services for the management of a terminal illness.

What is covered?

Part A covers hospice services if you’re expected to die within six months. Hospice services can be provided for two 90-day periods and an unlimited number of additional 60-day periods. You or your health care guardian must indicate in writing your decision to receive hospice care instead of other Medicare benefits.

What is your contribution?

Deductibles and coinsurance don’t apply to hospice care. You must pay 5% of the charge for outpatient prescription drugs (up to $5 per prescription) and 5% of the cost of inpatient respite care (up to a maximum of $768). Inpatient respite care is time you spend in a hospice facility to allow your caregiver to rest. Medicare covers no more than five respite days in a row.
What Does Medicare Part B Cover?

Part B covers the following:

- physician services,
- outpatient hospital care, and
- laboratory services

Remember, if you don't enroll in Part B when first eligible and you don't qualify for an exemption or a special enrollment period, you must pay a 10% premium penalty for each year you wait to enroll.

What must you pay?

A monthly premium is ordinarily deducted from your Social Security check.

You also must pay an annual deductible of $100 and 20% of the amount Medicare approves for your medical bills.

<table>
<thead>
<tr>
<th>Services:</th>
<th>Part B pays for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>80% of the approved charge for most reasonable and necessary doctors' services, except routine checkup</td>
</tr>
</tbody>
</table>
| Home Health Services       | ☑ 100% of the cost for up to 35 hours per week of skilled nursing and home health aide services  
                              ☑ skilled therapy services if you're homebound and require skilled nursing or skilled therapy on a part-time or intermittent basis |
| Preventive Services | ✓ **annual shots** to prevent flu and pneumonia  
| | ✓ **annual mammograms** if you're female and over age 40 (the Part B deductible is waived)  
| | ✓ **annual pap smears** for high-risk women, one every three years for others (the Part B deductible is waived)  
| | ✓ **bone density measurement**  
| | ✓ **colorectal cancer** screening if you're over age 50  
| | ✓ **diabetes self-management**: training for patients, glucose monitors and test strips  
| Durable Medical Equipment | **80% of the approved charge** for most reasonable and necessary medical equipment you buy from Medicare-certified suppliers (includes wheelchairs, walkers, hospital beds, oxygen, etc.)  
| Outpatient Hospital Services | **80% of the actual charge** - typically higher than the approved Medicare charge  
| Physical Therapy Services | **80% of the approved charge** for services provided by Medicare-certified independent physical therapists, up to a total of $1,500 a year  
<p>| Laboratory Tests and X-rays | <strong>100% of the approved charge</strong> for many reasonable and necessary laboratory tests, and 80% of the approved charge for X-rays required for medical diagnosis |</p>
<table>
<thead>
<tr>
<th>Mental Health Services</th>
<th>50% of the approved charge for most outpatient mental health services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services</td>
<td>80% of the approved charge when an ambulance is needed to take you to or from a hospital or skilled nursing facility because any other method of transportation would be dangerous to your health</td>
</tr>
<tr>
<td>Blood</td>
<td>80% of the approved charge for any additional blood after you pay for the first three pints</td>
</tr>
</tbody>
</table>

Part B also helps pay for:

- X-rays
- Emergency care
- Speech language pathology services
- Artificial limbs/eyes
- One pair of eyeglasses following cataract surgery
- Breast prostheses following a mastectomy
- Arm, leg, back and neck braces
- Ostomy bags, surgical dressings
- Kidney dialysis and transplants
How do I get Part B?

You are automatically eligible for Part B if you are eligible for premium-free Part A. You also are eligible if you are a United States citizen or permanent resident, who is age 65 or older.

Just before you turn 65 years old, you have to decide whether or not to receive Part B. You should keep in mind that the cost of Part B may increase 10% for each 12-month period that you could have had Part B but did not take it, except in special cases (see “Special Enrollment Period”). **You will have to pay this extra 10% for the rest of your life.** If you choose to get Part B, the monthly premium is taken out of your Social Security, Railroad Retirement or Civil Service Retirement payment. If you don’t get any of these payments, you are billed by Medicare every three months.

If you didn’t take Part B when you were first eligible, you can sign up during two enrollment periods. The two enrollment periods are:

1. **General Enrollment Period:** The General Enrollment Period is from January 1 through March 31 of each year. You can sign up for Part A or Part B at your local Social Security Administration office. Your Part B coverage will start on July 1 of that year.

2. **Special Enrollment Period:** If you didn’t take Part B when you first were eligible because you or your spouse were working and had group health plan coverage through your or your spouse’s employer or union, you can sign up for Part B during a Special Enrollment Period.
You can sign up:

☑️ Any time you still are covered by the employer or union group health plan through your or your spouse’s current or active employment, or

☑️ Within eight months of the date when the employer or union group health plan coverage ends, or when the employment ends (whichever is first).

If you are disabled and working (or you have coverage from a working family member), the Special Enrollment Period rules also apply. Most people who sign up for Part B during a Special Enrollment Period do not pay higher premiums. However, if you are eligible, but do not sign up for Part B during the Special Enrollment Period, the cost of Part B may increase.
What Can Doctors Charge Me?

Accepting Assignment

Doctors are called “participating providers” if they “accept assignment,” which means they always accept the Medicare-approved charge as payment in full. They aren’t allowed to charge you more than Medicare’s approved charge for their services. It’s always a good idea to ask doctors in advance whether they’ll take assignment. Medicare will pay the doctor 80% of the approved amount and you’re responsible for the remaining 20%. Doctors who treat Medicare beneficiaries who also are eligible for Medicaid (dual-eligibles) must accept Medicare assignment.

Doctors who don’t accept assignment can charge no more than 15% above Medicare’s approved amount. This means you pay no more than the extra 15%, plus any required deductible and coinsurance. Some states have stricter limits on doctors’ charges.

Who Pays the Doctor?

<table>
<thead>
<tr>
<th>Who Pays the Doctor?</th>
<th>You pay:</th>
<th>Medicare Pays:</th>
</tr>
</thead>
<tbody>
<tr>
<td>When doctors accept assignment</td>
<td>20% coinsurance</td>
<td>80% of approved charge</td>
</tr>
<tr>
<td>When doctors don’t accept assignment</td>
<td>20% coinsurance plus up to 15% extra</td>
<td>80% of approved charge</td>
</tr>
</tbody>
</table>
Does Medicare pay for Prescription Drugs?

Generally, Original Medicare does not cover prescription drugs. However, Medicare does cover some drugs in certain cases such as immunosuppressive drugs (for transplant patients) and oral anti-cancer drugs. You should call your Durable Medical Equipment Regional Carrier for more information. Check out www.medicare.gov to find the phone number for your Durable Medical Equipment Regional Carrier.

There are some Medicare Health Plans that cover prescription drugs. You also can check into getting a Medigap or supplemental insurance policy for prescription drug coverage. Medicaid also may help pay for prescription drugs for people who are eligible.

What is a “Medigap” policy and how does it work?

A Medigap policy is sold by private insurance companies to fill the “gaps” in Original Medicare Plan coverage. The front of the Medigap policy must clearly identify it as “Medicare Supplement Insurance.” In all but three states (Minnesota, Massachusetts and Wisconsin), there are 10 standardized Medigap plans called “A” through “J.”

Each plan has a different set of standard benefits. Medicare SELECT is a type of Medigap insurance policy. If you buy a Medicare SELECT policy, you are buying one of the 10 standardized Medigap plans A through J (see page 23).

When you buy a Medigap policy you pay a premium to the insurance company. As long as you pay your premium, policies bought after 1990 are renewed automatically each year. This means that your coverage continues year after year as long as you pay your premium. You still must pay your monthly Medicare Part B premium.

What is not covered by Medigap policies?

- Long-term care
- Vision or dental care
- Hearing aids
- Private-duty nursing
- Unlimited prescription drug
What do Medigap policies cover?

Each standardized Medigap policy must cover basic benefits (see core benefit section). Medigap policies pay most, if not all, of the Original Medicare Plan coinsurance amounts. These policies also may cover the Original Medicare Plan deductibles. Some of the policies cover extra benefits to fill more of the gaps in your coverage, like prescription drugs. See Chart of Ten Standardized Medigap Plans A through J in Appendix A.

Do any Medigap policies cover prescription drugs?

Yes. Plans H and I offer the “basic” prescription drug benefit. Plan J offers the “extended” prescription drug benefit (see chart below).

<table>
<thead>
<tr>
<th>Plans H and I</th>
<th>After you pay...</th>
<th>The plan pays...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Prescription Drug Benefit</td>
<td>$250 per year deductible</td>
<td>50% of prescription drug costs up to a maximum of $1,250 per year</td>
</tr>
<tr>
<td>Plan J</td>
<td>Extended Prescription Drug Benefit</td>
<td>$250 per year deductible</td>
</tr>
</tbody>
</table>

What is a “high deductible option” and how does it affect my costs?

Insurance companies may offer a “high deductible option” on Plans F and J. If you choose this option, you must pay a $1,530 deductible for the year 2000 before the plan pays anything. This is an increase for all high deductible plans that were bought before 2000. This amount can increase each year.
High deductible option policies often cost less but, if you get sick, your out-of-pocket costs will be higher and you may not be able to change plans.

In addition to the $1,530 deductible that you must pay for the high deductible option on plans F and J, you also must pay deductibles for prescription drugs ($250 per year for Plan J) and foreign travel emergency ($250 per year for Plans F and J).

**How can I get information on Medigap policies in my state?**

You can get information about Medigap policies in your state by calling:

- Your State Insurance Department to find out what Medigap policies are available in your state and which companies sell them; or

- Your State Health Insurance Assistance Program to get free counseling to help you decide which policy is best for you.

You also can use a computer to find information on and compare Medigap policies offered in your state.

- Look on the Internet at www.medicare.gov and click on “Medigap Compare.” This website has information on:

  - Which Medigap policies are sold in your state.
  - How to shop for a Medigap policy.
What the policies must cover.

How insurance companies decide what to charge you for a Medigap policy premium.

Your Medigap rights and protections.

Are There Programs to Help Low-Income Beneficiaries?

There are several programs that help pay Medicare costs. Through the Qualified Medicare Beneficiary (QMB) program, the Specified Low-Income Medicare Beneficiary (SLMB) program and the Qualifying Individuals (QI1 and QI2) programs, low-income people with Medicare may receive state assistance to pay Medicare premiums, deductibles or coinsurance. For more information, contact your local Department of Social Services, State Health Insurance Assistance Program or Area Agency on Aging.

People struggling to pay for Medicare may qualify for benefits through the following programs:

- Qualified Medicare Beneficiary (QMB)
- Specified, Low-income Medicare Beneficiary (SLMB)
- Qualifying Individuals 1 (QI-1)

These federal government programs help people on fixed incomes pay for Medicare coverage. They are administered by the Health Care Financing Administration (HCFA). You can apply for these benefits at your local Medicaid office.
What You Should Know

To qualify for QMB, SLMB or QI-1, individuals or couples must meet certain income and resources guidelines.

**QMB may cover the cost of Medicare premiums**, deductibles and coinsurance for Medicare Part A (hospital insurance) beneficiaries whose monthly income is less than:

- $716 for an individual
- $958 for a couple

**SLMB benefits may be available to individuals or couples** whose income is too high to qualify for QMB. SLMB will pay the monthly Medicare Part B premium of $45.50, but only for those whose monthly income is less than:

- $855 for an individual
- $1,145 for a couple

**If income is too high for SLMB**, QI-1 may help pay the monthly Medicare Part B premium for some whose monthly income is less than:

- $960 for an individual
- $1,286 for a couple

**However, funds for the QI-1 program are limited.** Applications are approved on a first-come, first-served basis until the funds for a given year run out.

**For all three programs discussed above**, savings must be less than:

- $4,000 for an individual
- $6,000 for a couple
For More Information

If you think you might be eligible for one of these programs, apply at your county’s Department of Human or Social Services. Their phone number is in the blue government section of your local phone directory. You can also call the Health Care Financing Administration’s hotline at 1-800-633-4227.
What if Medicare Says No?

If Medicare denies a claim for payment or services, you can ask Medicare to reconsider its decision. When you receive a written denial, you’ll receive information on how to appeal as well.

Before you start your appeal, call your State Health Insurance Assistance Program for free information and assistance. In hospital cases, if you think you’re being asked to leave the hospital early, contact your state’s Peer Review Organization (PRO) for an initial review. If the PRO agrees that you don’t need to stay in the hospital, it will tell you how to appeal further.

1. **DENIAL NOTICE**
   - You get a notice of denial of payment or service, and you disagree with it.
   - (Always request a written denial. You will get instructions on how to appeal.)

2. **RECONSIDERATION**
   - Send the denial notice back to Medicare with a "please review" note.
   - Try to add supporting information from your doctor.

3. **FAIR HEARING (PART B ONLY)**
   - Request a fair hearing if you don’t agree with the Reconsideration decision.
   - At least $100 must be in dispute.

4. **ADMINISTRATIVE LAW JUDGE (ALJ) HEARING**
   - At least $100 must be in dispute (Part A).
   - At least $500 must be in dispute (Part B).

5. **DEPARTMENT APPEALS BOARD (DAB)**
   - You can appeal to the DAB if you disagree with the ALJ.

6. **APPEAL TO FEDERAL COURT**
   - To appeal to federal court:
     - At least $1,000 must be in dispute.

7. **Final Decision**
Resources

Telephone and Web Resources

For more free information on your Medicare rights, options and the Medicare program:

1-800-MEDICARE (1-800-633-4227)
The Medicare hotline can provide general information about Medicare and detailed comparisons of the Medicare health plan options in your community. These options include Original Medicare and, where available, Medicare managed care plans, such as Medicare HMOs. You also can get information about the quality of care and member satisfaction in Medicare managed care plans, such as Medicare HMOs.

Medicare
This official U.S. Government site for Medicare provides up-to-date information about Medicare, Medicare health plans, wellness, fraud and abuse, nursing homes and consumer publications. View the Medicare handbook, Medicare and You and the 1999 Guide to Health Insurance for People with Medicare or order by calling 1-800-MEDICARE (1-800-633-4227).
URL: http://www.medicare.gov

Medicare Compare
Medicare Compare provides the costs and benefits of the Medicare health plan options in your community, which you can compare side by side. This site also contains information about the quality of care and member satisfaction in Medicare managed care plans, such as Medicare HMOs.
URL: http://www.medicare.gov/comparison/

Medicare Important Contacts
Find the important Medicare contacts in your state and local community. These contacts include your State Health Insurance Assistance Program (SHIP) and Peer Review Organization.
URL: http://www.medicare.gov/Contacts/Overview.asp
**Medicare Rights Center**
The Medicare Rights Center, a national, not-for-profit organization, represents the interests of Medicare beneficiaries and provides a free counseling service to Medicare beneficiaries. Order a wide range of consumer publications covering Medicare basics, Medicare HMOs, Medicare appeal rights, home and hospice benefits and supplemental insurance by calling 212-869-3850, Ext. 10.
URL: [http://www.medicarerights.org](http://www.medicarerights.org)

**Agency for Health Care Policy and Research (AHCPR)**
AHCPR is the lead federal agency supporting research designed to improve the quality of health care, reduce its cost and broaden access to essential services. View AHCPR’s publication, Your Guide to Choosing Quality Health Care or order by calling 1-800-358-9295.
URL: [http://www.ahcpr.gov](http://www.ahcpr.gov)

**National Committee on Quality Assurance (NCQA)**
NCQA, a private, not-for-profit organization, assesses and reports on the quality of managed care plans. Check online to find out if the HMO you are in or considering has been accredited by NCQA. You also can call NCQA at 1-888-275-7585 for this information. Order NCQA’s publication, Choosing Quality: Finding the Health Care Plan That’s Right For You by using the online order form or by calling 1-800-839-6487.
URL: [http://www.ncqa.org/Pages/Main/consumers.html](http://www.ncqa.org/Pages/Main/consumers.html)

**State Insurance Departments**
Links to your state insurance department Websites, if available, from the National Association of Insurance Commissioners (NAIC) Website. NAIC also provides a list of the health contacts in state insurance departments. State insurance departments are responsible for licensing and regulating insurance companies doing business in their state and approving their Medigap policies. They often have consumer information and can help with complaints.
URL: [http://www.naic.org/consumer/state/commlist.html](http://www.naic.org/consumer/state/commlist.html)
**Department of Labor, Pension and Welfare Benefits Administration (PWBA)**

PWBA is responsible for administering and enforcing standards to protect the health and pension benefits of many workers, retirees and dependents. Its Consumer Information on Health Plans Website provides information and publications on how life and work events, such as retiring, affect employees’ health benefit choices. Several brochures can be viewed on-line or ordered by calling 1-800-998-7542.

Endnotes

Official Government site for Medicare
www.medicare.gov

2000 Guide to Health Insurance for People with Medicare,
HCFA, Department of Health and Human Services,

American Association of Retired Persons
www.aarp.org
Where to Turn...

Health Care and Insurance

Brain Injury Association

105 North Alfred Street . Alexandria, VA 22314
Family Helpline: 1-800-444-6443 . (703) 236-6000
www.biausa.org
Your Guide to Federal Disability Policies and Programs

Authors
Patrice Drew, Esq.
Cathy Ficker Terrill
Anne C. Parrette, Esq.

Project Coordinator
Janna Starr

Graphic Designer
Tina Radenberg

Editors
Larry H. Hoffer
Lisa Ward
Monique Marino
Health Care and Insurance

Medicaid Waivers - Freedom of Choice Waivers

I am a Medicaid recipient. I want to be able to pick my own doctors. Do I have any options?

Yes. Your state may be granted a Freedom of Choice (FOC) waiver.

What is a Freedom of Choice (FOC) Waiver?

FOC or “1915(b)” waivers are authorized under section 1915(b) of the Social Security Act. Through this section, states are allowed to waive certain provisions of section 1902 of the Act.

What can an FOC waiver do?

An FOC waiver allows states to place beneficiaries in primary care case management (PCCM) programs. FOC waiver programs must ensure that Medicaid beneficiaries have a choice of at least two or more providers.

What are PCCM Programs?

PCCM programs are fee-for-service programs that are managed by a gatekeeper or a prepaid capitated program such as a health maintenance organization (HMO) or a prepaid health plan (PHP).
What is the purpose of an FOC waiver?

FOC waivers improve beneficiaries’ access to health care through enrollment in a guaranteed provider network. FOC waivers also monitor beneficiaries’ quality of care. Frequently, beneficiaries in these waiver programs are placed in health care systems focused on health education and preventive medicine.

What federal requirements are “waived” under the FOC program?

HCFA may waive certain provisions in section 1902 of the Social Security Act including:

- Beneficiaries’ right to select their own Medicaid providers
- Comparability of services, and
- The requirement to provide any service statewide

How does a state receive approval for a FOC waiver?

State Medicaid agencies must assure HCFA that beneficiaries in FOC waiver programs have a choice of at least two or more providers. Not all managed care programs require FOC waivers. Programs that allow beneficiaries to choose between fee-for-service and managed care without restricting a choice of providers do not require FOC waivers. FOC waivers are approved for two years and may be renewed for two-year periods.

Who approves FOC waivers?

The Medicaid Managed Care Team in HCFA’s Office of Managed Care approves FOC waivers.
If my state is approved for an FOC waiver, how long will approval last?

FOC waivers are approved for 2-year periods and may be renewed at 2-year intervals.

How can I find out more information about my state’s FOC waiver program?

You should contact your State Medicaid Agency. For a list of the State Medicaid Agency offices, go to the HCFA website, at: www.hcfa.gov/medicaid. You also will find the number for your State Medicaid Agency in the blue section of your local phone book.
I have some great, creative ideas for my state’s Medicaid program. How can I implement some of these ideas to improve my state’s current Medicaid program?

You may want to see whether your state has been granted a section 1115 waiver.

What is a section 1115 waiver?

Under section 1115 of the Social Security Act, a state can deviate from a great many standard Medicaid requirements in order to test new ideas. In return for greater flexibility, states must commit to a policy experiment that can be evaluated formally. These waivers are also known as “research and demonstration” waivers.

What is the purpose of a section 1115 waiver?

States are using section 1115 waivers more and more to enact a broad variety of initiatives. Approved waiver programs range from small-scale pilot projects that test new benefits or financing mechanisms to major restructurings of State Medicaid programs. States are also using section 1115 waivers for welfare reform projects.
What have states done with a Section 1115 waiver?

Upon receiving a section 1115 waiver, a state may do the following:

- Cover new services
- Offer different service packages
- Offer different combinations of services in different parts of the state
- Test new reimbursement methods
- Change Medicaid eligibility criteria in order to offer coverage to new or expanded groups

What does a state have to show to get a section 1115 waiver?

A state’s 1115 demonstration waiver must be budget neutral. This means that the programs cannot cost more over their duration than the Medicaid program would have spent without the demonstration project.

Is there any federal requirement a state CANNOT waive under a section 1115 waiver?

Yes. States may not use 1115 demonstration waivers to waive all Medicaid policies or program requirements. Some of the federal requirements a state cannot legally waive are:

- Services for pregnant women and children
- Co-payment and other cost sharing requirements for current categorically needy eligible people
Federal matching Medicaid (FMAP) rates
Requirements for maintaining appropriate levels of access to and quality of care
Current HCFA contract approval authority
Applicable requirements of the Employee Retirement and Income Security Act (ERISA)

If my state is approved for a section 1115 waiver, how long will approval last?

Section 1115 waiver authority normally can be granted for up to five years at a time. This authority allows states to try out a far greater range of policies than would otherwise be permissible in ordinary FOC programs (see FOC section above).

How can I find out more information about my state’s 1115 waiver program?

You should contact your State Medicaid Agency. For a list of the State Medicaid Agency offices, go to the HCFA website, at: www.hcfa.gov/medicaid. You also will find the number for your State Medicaid Agency in the blue section of your local phone book.
What is the Employment Retirement Income Security Act?

The Employment Retirement Income Security Act (ERISA) is a law that regulates broadly private-sector benefit plans sponsored by employers or unions. Despite its name, ERISA protections are not limited to pension or retirement savings plans. ERISA also regulates private-sector health and medical benefit plans sponsored by employers or unions.

What benefit plans does ERISA regulate?

ERISA regulates any “employee benefit plan” established or maintained by an employer or an employee organization that is engaged in interstate commerce.

Important: The law says that a plan will fall under ERISA protections if the plan meets the ERISA definition, even if ERISA coverage is not intended or desired by the employer/employee.

What does ERISA NOT cover?

ERISA does not cover plans maintained by federal, state, or local governments, certain church-affiliated plans, and workers’ compensation plans.
Are there different types of ERISA benefit plans?

Yes. There are three types of ERISA plans. These plans differ in how they are funded:

1. **Fully-insured Plan:** the employer purchases insurance to provide benefits to the employees

2. **Self-funded Plan:** the employer pays benefits from a trust or from the employer’s corporate assets

3. **Partially Self-funded Plan:** the employer pays benefits from a trust or from the employer’s corporate assets, up to a certain dollar threshold, and the employer purchases insurance to cover losses above that threshold amount (this is called the employer’s “reinsurance.”)

What does ERISA regulate, exactly?

ERISA regulates employer-sponsored benefit plans in the following areas only:

- Reporting and disclosure
- Fiduciary duty or responsibility
- Remedies for denied claims
What is “fiduciary duty?”

“Fiduciary duty” is a legal term that describes a person’s duty to act as a trustee when dealing with another person’s money. The fiduciary relationship involves trust, confidence, good faith, and honesty. A person is said to be acting in a “fiduciary capacity” when he or she handles money or business transactions that are not his or her own, for the benefit of another person.

Why is fiduciary duty important in connection with ERISA?

Fiduciary duty is important under ERISA because employers, plan administrators, and even insurance brokers maintain a fiduciary duty to plan beneficiaries (i.e., they are responsible for an employee’s money and benefits).

How do I know if a person has a fiduciary duty to me?

A person has a fiduciary duty to you if her or she performs the following activities:

- Exercises discretionary responsibility in the administration of management of your benefit plan
- Provides investment advice for a fee regarding your plan assets
- Exercises any authority or control over the management or disposition of your plan assets
What are the duties of a fiduciary?

A fiduciary must:

☑️ Act solely in the interest of the benefit plan and in the interest of the plan participants and beneficiaries
☑️ Act prudently in dealing with a benefit plan
☑️ Follow lawful terms of plan documents

My State has laws that cover employee benefit plans. Do those laws apply to my plan or does ERISA apply to my plan?

The answer to this question is complicated. ERISA preempts (overrides) a state law when the state law relates to an employee benefit plan. A state law is said to relate to an employee benefit plan if it is specifically designed to affect employee benefit plans or if the state law singles out certain employee benefit plans for special treatment.

There is an exception to this rule under the Savings and Deemer Clauses of ERISA.

What are the Savings and Deemer Clauses?

The Savings Clause provides that ERISA does not relieve any person from any state laws that regulate insurance. Courts have interpreted this to mean that only fully-insured ERISA plans are subject to state laws.

The Deemer Clause provides that an ERISA plan shall not be deemed to be an “insurance company” or to be engaged in the business of insurance for the purposes of any state law that regulates insurance. Courts have interpreted this to mean that self-insured and partially-insured benefit plans are NOT subject to ERISA.
How does ERISA preemption of state laws work?

If a state law relates to the administration of a benefits plan, the processing of claims under a benefits plan, or the remedies for denied claims under a benefits plan, and the plan is fully-insured, then state law will apply.

If a state law relates to the above areas, and the plan is self-insured, then ERISA regulations will apply, not state law.

My insurance plan says that I have a pre-existing condition and will not insure me for that condition. Does ERISA cover pre-existing conditions?

Yes. ERISA does cover the “pre-existing condition” issue, in connection with the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

What is HIPAA and how does it affect me?

HIPAA created new and important protections for working Americans and their families. HIPAA especially protects working families whose members may move from one job to another, and have pre-existing medical conditions. HIPAA limits plan exclusions for pre-existing conditions, and prohibits discrimination against employees and dependents based on their health status. See below for more information on HIPAA.

How exactly did HIPAA change the pre-existing condition rules?

Under HIPAA, and in connection with ERISA, pregnancy may never be treated as a “pre-existing condition.” Also, a patient’s genetic information may not be treated as pre-existing.
My plan does have a pre-existing condition period, is this legal?

Yes, with limitations. A pre-existing condition exclusion may not last for more than 12 months (18 months for late enrollees) after a person’s enrollment date. A “late enrollee” is a person who enrolls in a plan after the first date on which he or she was eligible to enroll.

A new employer is required to give a person credit for the length of time he or she had continuous health coverage. This will reduce the 12-month exclusion or waiting period in a new plan.

What is continuous coverage?

Continuous coverage or “credible coverage” is credit a beneficiary receives for his or her previous health insurance coverage. To receive credit toward a 12-month exclusion period in a new plan, the previous coverage must have occurred without a break in coverage for 63 days or more.

E.g., Sally began employment with her current employer 45 days after her previous group health plan coverage terminated. Under her previous employer’s group health plan, Sally had 24 months of continuous coverage. A 45-day break in coverage is not considered to be a “significant break” in coverage, so Sally’s previous coverage will be credited toward the 12-month exclusion period under her new employer’s plan. Also, since Sally had over 12 months of creditable coverage, she will not be subject to any pre-existing condition exclusion period.

How can I prove that I had continuous coverage?

The employee’s former group health plan and/or insurer are required to provide a certificate to the employee upon termination from the health plan stating when the employee was covered under the health plan.
What is considered a “pre-existing” condition?

A pre-existing condition under HIPAA is defined as a condition for which “medical advice, diagnosis, care or treatment was recommended or received within the 6-month period prior to the enrollment date.” This means that if you had a certain condition, but you did not go to the doctor for it or receive care for it within the 6-months before your enrollment date with your medical insurance, a pre-existing condition cannot be said to apply. Some health plans, however, do have a waiting period.

What is a “waiting period?”

A health plan may have an eligibility waiting period. If it does, the enrollment date begins on the first day of the waiting period. If the health plan does not have an eligibility waiting period, then the enrollment date begins on the first day of coverage.

Remember, enrollment dates are important when you are looking to see whether a pre-existing condition exclusion is valid in a policy (see above).

When did HIPAA go into effect?

HIPAA went into effect on July 1, 1997. Prior to July 1, 1997, a plan definition of pre-existing conditions could be as broad as the drafter of the policy wanted it to be. All health plans were required to be in compliance by January 1, 1998.
Can ERISA help me with the processing of my medical claims?

Yes. ERISA can help ensure that your claims are processed within a reasonable period of time. ERISA states claims must be paid or denied within 90 days. Unfortunately, ERISA does not provide a specific time within which a claim must be paid before penalties may be applied.

Can ERISA help me with medical claim denials?

Yes. under ERISA, a claimant must be given 60 days from the date of the claim denial notice to appeal. ERISA also states that a denial notice must meet certain requirements. A claims denial must:

- Provide a written explanation of the specific reasons of the denial
- Contain specific reasons for the denial, with specific references to pertinent plan provisions

Important: You should know that under ERISA, you are entitled to request and receive your entire claims file from your plan, including all notes, memoranda, and reports contained in your file that may have been considered by the plan in denying your claim. You are also entitled to “full and fair” claims review under ERISA.

What is “full and fair” claims review?

Under ERISA, when a claim is denied, the claimant is entitled to a full and fair review of the claim denial by a named fiduciary of the plan. Claimants must exhaust all remedies under this procedure prior to filing suit in court.
What happens after I appeal a claims denial?

Your plan has 60 days to review your appeal. Your plan also must respond to your appeal within 120 days.
Tell me more—What else should I know about HIPAA?

HIPAA made the following important changes to employee health coverage plans:

- Limits exclusions for pre-existing conditions
- Prohibits discrimination against employees and dependents based on their health status
- Guarantees renewability and availability of health coverage by providing better access to individual health insurance coverage
- Protects many workers who lose health coverage by providing better access to individual health insurance coverage

What does HIPAA apply to?

HIPAA applies to any group health plan and its insurer.

What does HIPAA NOT apply to?

HIPAA does not apply to small group health plans that, on the first day of the plan year, have less than two participants who are current employees.

HIPAA does not apply to governmental and church plans.
If HIPAA is a Federal program, why has my state modified HIPAA laws?

States can enact laws that modify HIPAA, but only if those laws impose stricter obligations on health insurance issuers.

Does HIPAA only affect employed, adult people?

No, HIPAA also provides special rules for newborns, adopted children, or children newly placed for adoption. Newborns, adopted children, and children newly placed for adoption cannot be subject to a pre-existing condition exclusion or limitation if they are enrolled within 30 days of birth, adoption, or placement for adoption.
For the last two years, I have been covered by a health insurance plan offered by my employer. I recently quit my job so that I could better care for my child with a disability for a few months. What can I do about health insurance for my child and me?

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), employers must offer continuation of health insurance coverage to qualified beneficiaries who lose coverage due to a qualifying event.

Tell me more about COBRA.

COBRA was passed in 1985 to provide employees, former employees, their spouses and dependents with a temporary extension of group health insurance coverage when their health insurance coverage is lost due to certain qualifying events.

The COBRA coverage must be identical to the coverage provided to similarly-situated employees. COBRA coverage must be offered for 18 months following the employee’s qualifying event.
What are “qualifying events” under COBRA?

The following “qualifying” events will provide health insurance coverage to an employee, spouse of an employee, dependent child of an employee, or child placed for adoption with an employee during the 18-month COBRA period. The employer is responsible for knowing when any of these qualifying events have occurred:

☑ Voluntary termination (e.g., an employee quits his or her job)
☑ Involuntary termination (e.g., an employee is fired for a reason other than “gross misconduct”)
☑ Reduction of hours (e.g., an employee experiences a strike, layoff, leave of absence, or moves from full-time to part-time work)

Does the employee have any responsibilities under COBRA?

Yes. The employee must inform the employer or the plan administrator of the occurrence of the following qualifying events within 60 days from the date of the event:

☑ Divorce
☑ Legal Separation
☑ Dependent child ceasing to be a dependent
How will I know if I am eligible for COBRA benefits?

Employers are required to notify an employee of their COBRA rights within 14 days from the date they learn of the qualifying event. If the employer and the plan administrator are one in the same, then the plan administrator only has 14 days from the date of the occurrence of the qualifying event to notify the employee.

The notice should inform the employee that they have certain rights to continue their group health coverage under COBRA. Notice to the employee must be sent via first class mail to all qualified beneficiaries at the last known address. Handing a notice to an employee during an exit interview is not sufficient notice.

How long do I have to decide whether I wish to elect COBRA coverage?

You have 60 days to elect COBRA coverage from the date you received notice of COBRA eligibility or from the date you lost your health insurance coverage, whichever event is later.

Does my employer continue to pay for my coverage when I elect COBRA?

No. The COBRA-eligible employee is responsible for paying COBRA premiums. Once an employee elects COBRA coverage, he or she has 45 days from the date of the election to pay the health coverage premiums. Note that the COBRA-eligible employee must pay retroactive premiums as well. The retroactive premium is the amount due from the loss of coverage date to the date of COBRA election.
What if I am late paying my COBRA premiums, do I lose coverage immediately?

It is important to pay your COBRA premiums on time. If you are paying monthly premiums, you are allowed a minimum 30-day grace period each and every month to pay.

Can my employer or former employer take away my COBRA coverage?

Yes. But only under limited circumstances. An employer can cancel COBRA coverage and still be in compliance with the law when the following situations occur:

- Payment of a premium is not made timely
- The beneficiary becomes covered under another group health plan that does not contain an exclusion or limitation regarding a pre-existing condition
- The beneficiary becomes eligible for Medicare
- The employer ceases to maintain any group health plan for any of its employees

Who enforces COBRA?

The COBRA law is enforced by different governmental entities. For example, if an employer fails to comply with COBRA, the Internal Revenue Service (IRS) can levy excise taxes; and the Department of Labor can file a lawsuit against the employer. Finally, an affected beneficiary can sue the employer in court.
Will an employer incur penalties for failing to comply with COBRA laws?

Yes. The IRS can levy a nondeductible excise tax of $100 a day, per COBRA violation. Since COBRA’s requirements are part of ERISA, failing to comply with COBRA can subject an employer to an ERISA penalty of up to $100 per day, per COBRA violation.

An employer who fails to comply with COBRA laws is required to pay beneficiary claims. Courts have held employers violating COBRA laws responsible for payment of damages and attorney fees.
Where to Turn...

Welfare and Temporary Assistance for Needy Families (TANF)

Brain Injury Association

U.S. Department of Health and Human Services

105 North Alfred Street  .  Alexandria, VA 22314
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Your Guide to Federal Disability Policies and Programs

Authors
Patrice Drew, Esq.
Cathy Ficker Terrill
Anne C. Parrette, Esq.

Project Coordinator
Janna Starr

Graphic Designer
Tina Radenberg

Editors
Larry H. Hoffer
Lisa Ward
Monique Marino
Welfare and Temporary Assistance for Needy Families (TANF)

What is the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996?

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) was passed by Congress in 1996 and is a comprehensive bipartisan welfare reform plan that dramatically changed the nation’s welfare system into one that requires work in exchange for time-limited assistance. The law contains strong work requirements, a performance bonus to reward states for moving welfare recipients into jobs, state maintenance of effort requirements, comprehensive child support enforcement, and supports for families moving from welfare to work — including increased funding for child care and guaranteed medical coverage.

What is Welfare-to-Work?

Under PRWORA, recipients must work after two years on assistance, with few exceptions. In 1998, states were required to have 30 percent of all single parent families, and 75 percent of all two-parent families, engaged in a work activity for a minimum of 20 hours per week for single parents and 35 hours per week for two-parent families. The rates for all families started at 25 percent in 1997 and increase 5 percent each year, to 50 percent in 2002.

<table>
<thead>
<tr>
<th>Work Requirements:</th>
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<tr>
<td>☑ Recipients must work after two years on assistance</td>
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<tr>
<td>☑ Single parents must work for at least 20 hours per week</td>
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<tr>
<td>☑ Two-parent families must work 35 hours per week</td>
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Are child care and medical assistance available?

PRWORA provides over $14 billion over five years in child care funding to help more mothers move into and stay in jobs. PRWORA also guarantees that individuals who meet pre-welfare reform welfare-eligibility criteria continue to be eligible to receive Medicaid, including at least six months of Transitional Medicaid Assistance (TMA) when they leave welfare-for-work. Families leaving welfare because of increased income from work are entitled to TMA for six months. For the next six months, they remain eligible for TMA if their income is below 185% of poverty. In addition, families who qualified for Medicaid under Section 1931 but are not on welfare also are entitled to TMA if they become ineligible because of increased income from work. States should make clear to families that they should remain in contact with the welfare office—even if they find a job or get a pay raise—in order to get TMA.

What kind of work is required?

To count toward state work requirements, recipients are required to participate in unsubsidized or subsidized employment, on-the-job training, work experience, community service, up to 12 months of vocational training or provide child care services to individuals participating in community service. Up to six weeks of job search (no more than four consecutive weeks) can count toward the work requirement. States can count no more than 30 percent of work participants toward meeting the work requirement based on their participation in vocational training. Single parents with a child under age six who cannot find child care cannot be penalized for failure to meet the work requirements. States can exempt from the work requirement single parents with children under age one and disregard these individuals in the calculation of participation rates for up to 12 months.
Is there a time limit on receiving assistance?

Families who have received assistance for five cumulative years (or less at state option) will be ineligible for federally funded cash aid under the welfare reform law. States are permitted to exempt up to 20 percent of their caseload from the federal time limit, and have the option to provide state-funded assistance, non-cash assistance or vouchers to families who reach the time limit using Social Services Block Grants or state funds. States also can lower the time limit for receipt of assistance in their state.

How can I determine what job I am best suited for?

Under PRWORA, states are required to make an initial assessment of recipients’ skills. States also can develop personal responsibility plans for recipients to receive the education, training and job placement services needed to move them into the workforce.

Are there any subsidies or incentives available to employers?

The law allows states to create jobs by taking money now used for welfare checks and using it to create community service jobs or provide income subsidies or hiring incentives for potential employers.

A welfare-to-work tax credit. This provision gives employers an added incentive to hire long-term welfare recipients by providing a credit equal to 35 percent of the first $10,000 in wages in the first year of employment, and 50 percent of the first $10,000 in the second year, paid to new hires who have received welfare for an extended period. The credit is for two years per worker, to encourage not only hiring but job retention.
How does PRWORA promote responsibility?

PRWORA includes the child support enforcement measures President Clinton proposed in 1994 — the most sweeping crackdown on non-paying parents in history. Collections rose to a record high of $14.4 billion in 1998, an 80 percent increase since 1992. Under PRWORA, to be eligible for Temporary Assistance to Needy Families (TANF) block grants, each state must operate a child support enforcement program that meets federal requirements. Provisions include:

**National new hire reporting system.** The law establishes a Federal Case Registry and National Directory of New Hires to track delinquent parents across state lines. It also requires that employers report all new hires to state agencies for transmittal of new hire information to the National Directory of New Hires. Approximately 2.8 million parents delinquent in child support payments were found last year by the National Directory of New Hires, which matches all employees, both newly hired and those already holding jobs, with a list of parents who owe child support. This builds on President Clinton’s June 1996 executive action to track delinquent parents across state lines. The law also expands and streamlines procedures for direct withholding of child support from wages.

**Streamlined paternity establishment.** PRWORA streamlines the legal process for paternity establishment, making it easier and faster. It also expands the voluntary in-hospital paternity establishment program, started by the Clinton Administration in 1993, and requires a state form for voluntary paternity acknowledgment. In addition, the law requires states to publicize the availability and encourage the use of voluntary paternity establishment processes. Welfare recipients who fail to cooperate with paternity establishment will have their monthly cash assistance reduced by at least 25 percent. Paternity establishments rose to more than 1.4 million in 1998, an increase of over 300 percent since 1992.
Uniform interstate child support laws. PRWORA provides for uniform rules, procedures and forms for interstate cases.

Computerized state-wide collections. PRWORA requires states to establish central registries of child support orders and centralized collection and disbursement units. It also requires expedited state procedures for child support enforcement.

Tough new penalties. Under PRWORA, states can implement tough child support enforcement techniques. PRWORA expands wage garnishment, allows states to seize assets, allows states to require community service in some cases, and enables states to revoke drivers and professional licenses for parents who owe delinquent child support.

“Families First.” Under a new “Families First” policy, families no longer receiving assistance will have priority in the distribution of child support arrears. This new policy will bring families who have left welfare for work about $1 billion in support over the first six years.

Access and visitation programs. In an effort to increase non-custodial parents’ involvement in their children’s lives, PRWORA includes grants to help states establish programs that support and facilitate non-custodial parents’ visitation with and access to their children.

Are there any provisions that address teenagers?

Under PRWORA, unmarried minor parents must live with a responsible adult or in an adult-supervised setting and participate in educational and training activities to receive assistance. States are responsible for locating or assisting in locating adult-supervised settings for teens. In addition to requiring unmarried minor parents to stay in school and live at home or in a supervised setting, the law encourages “second chance homes” to provide teen parents with the skills and support they need and provides $50 million a year in new funding for state abstinence education activities.
What are the potential barriers to accessing aid?

The enactment of PRWORA and the Balanced Budget Act of 1997 (BBA) has had a profound effect on the Medicaid program. There have been problems facing TANF/Medicaid recipients in many states.

**Delinking Medicaid** — One perplexing and disturbing problem is the failure to “delink” Medicaid from TANF. To preserve Medicaid eligibility for families formerly eligible for Aid to Families with Dependent Children (AFDC), the new welfare law delinked eligibility for Medicaid from the receipt of cash assistance. Specifically, a new section, Section 1931, the so-called Medicaid savings clause, requires that families who meet the AFDC income, resource, and family composition rules in effect on July 16, 1996, continue to be eligible for Medicaid even if they do not meet their state’s new cash assistance requirements. The “delinking” of Medicaid eligibility from TANF eligibility was intended to ensure that poor families with dependent children would continue to have access to medical assistance. Yet reports from the field indicate that eligible families and their children are losing Medicaid coverage.

Although section 1931 requires states to establish a new, separate category of Medicaid eligibility based on pre-welfare reform eligibility criteria, states are continuing to link Medicaid eligibility to eligibility for cash assistance. Many states report using a consolidated application form for both TANF and Medicaid. States also are aligning eligibility rules for their TANF and Medicaid programs to minimize administrative burden and complexity and foster coordination. However, absent a clearly established alternate route to Medicaid, these policies and procedures are endangering Medicaid eligibility for recipients who do not want to receive TANF benefits or are no longer eligible to receive them due to a time limit or sanction.
Sanction for Refusal to Work — Another problem is the use of sanctions. The PRWORA gives states the option to terminate the Medicaid coverage of an adult who loses cash assistance provided under the state’s TANF-funded program because he or she refused to work. The Health Care Financing Administration (HCFA) has interpreted this provision to mean that a state may terminate Medicaid coverage of an individual whose “cash assistance funded under TANF is terminated for failure to meet a work requirement (as defined by TANF).”

The federal statute explicitly prohibits states from terminating the Medicaid coverage of a pregnant woman who fails to comply with a work requirement, or from terminating a child’s Medicaid coverage because the child’s parents’ refuse to work. Preliminary results from a nationwide survey revealed that 16 states report opting to terminate Medicaid coverage as a sanction for violating TANF work requirements.

Reports from the field, however, indicate that states are applying sanction policies more broadly than permitted under the law. Many states require TANF recipients to sign a personal responsibility agreement that requires recipients to agree to certain conditions in order to receive their benefits, such as ensuring that their children receive age-appropriate immunizations and are raised in a home free from violence. The agreement explicitly provides that the failure to comply with any of its provisions may result in the imposition of sanctions, including the loss of cash benefits and Medicaid.

Sanction for Alcohol and Substance Abuse — In certain states, some applicants for public assistance and Medicaid who fail to participate in mandatory screening and assessment for alcohol and/or substance abuse are becoming ineligible for both public assistance and Medicaid. Even in states with a policy of not sanctioning Medicaid for TANF-related violations, recipients are losing their Medicaid benefits.
Sanction for Failure to Obtain Medical Support for a Child — Recipients also may be losing Medicaid benefits due to the inappropriate application of sanctions for failing to cooperate in obtaining medical support. The new welfare law left intact the provisions of prior law allowing states to terminate the Medicaid benefits of a custodial parent who fails to cooperate in obtaining medical support. States, however, no longer are permitted to impose a Medicaid sanction for a failure to cooperate with child support enforcement unless that failure is simultaneously a failure to cooperate in obtaining medical support.

Work Diversion — Another major problem is diversion into work programs. A number of states have implemented or are implementing work first (or job diversion) programs, which divert recipients from applying for or receiving cash assistance when they first seek assistance from the county welfare office. Recipients may be diverted to an employment security office for a job referral or be asked to participate in “up front” job search activities before receiving any assistance. Such programs run the risk of denying recipients Medicaid benefits because they are diverted from even applying for cash assistance.

Lack of access to Medicaid in these circumstances violates the PRWORA provisions that make recipients eligible for Medicaid based on the July 16, 1996, requirements. Such a rule also likely violates the Medicaid Act provisions allowing recipients the right to apply for benefits. Moreover, delaying the Medicaid application pending work program requirements that apply only to AFDC would violate Medicaid recipients’ rights to have their applications processed in a timely manner.

To find out how to apply for assistance in your state, contact your local social services department.
Endnotes

Families USA
www.familiesusa.org

Children's Defense Fund
www.cdf.org

Administration for Families and Children, Department for Health and Human Services
www.acf.dhhs.gov

Family Resource Coalition of America:
www.frca.org
Where to Turn...

Individual and Family Supports
Individual and Family Supports

Home and community-based waivers

My family member has disabilities and is Medicaid-eligible, but I want him to be able to live at home, not in a nursing home facility or other institution. Do I have any options?

Your family member may be able to get services at home through a “home and community-based waiver” (1915(c) waiver) through your state’s Medicaid program.

What are Home and Community-Based Waivers?

Medicaid home and community-based service (HCBS) waivers grant exceptions to certain Medicaid rules. While federal funding streams and regulations have traditionally favored congregate, institution-based services, waivers can be granted by the federal government to states to develop and implement creative community alternatives to placing/or leaving Medicaid-eligible people in hospitals, nursing facilities or Intermediate Care Facilities for People with Mental Retardation (ICFs-MR). Waivers allow programs designed by states to be supported with a match of federal funds.

What is the purpose of the HCBS waivers?

The HCBS waiver program recognizes that many people with disabilities are at risk of being placed inappropriately in an institutionalized setting, when they may be better off receiving services at home and in their communities.
Why would a home or community setting be better?

A person who receives services and supports at home in his or her community is often better able to preserve his or her independence, productivity, ties to family and friends and mental and physical health at a cost no higher than that of institutional care.

Where does the HCBS waiver program get its authority?

The HCBS waiver program is found under section 1915(c) of the Social Security Act. Under this section, states may request waivers of certain federal requirements in order to develop Medicaid-financed community-based treatment alternatives.

What federal requirements may states request to be waived?

There are three requirements that the states may request to be waived. They are found in section 1902 of the Social Security Act. The requirements deal with:

- ✔ Statewideness: A state can design a service for a specific geographic locale, rather than being bound by the general Medicaid rule that any services provided must be provided in all parts of the state.

- ✔ Comparability of services and community income: States have more flexibility in offering a range of services.

- ✔ Resource rules for people who are “medically needy”: States can set rules for how Medicaid will consider the assets of people who have extremely high medical costs.
What can be included in HCBS waiver programs?

The Social Security Act specifically lists seven services that may be provided in HCBS waiver programs:

1. Case management
2. Homemaker health aide services
3. Home health aide services
4. Personal care services
5. Adult day health
6. Rehabilitation
7. Respite care

What else can be included in HCBS waiver programs?

Other services may be requested by a state because they are needed by waiver participants to avoid being placed in a medical facility. Some examples are of these other services are:

- Non-medical transportation
- In-home support services
- Special communication services
- Minor home modifications
- Adult day care
- Treatment for people with chronic mental illness, including day treatment, partial hospitalization services and psychosocial rehabilitation services
What about room and board? Is it included?

No. Room and board is excluded from coverage, except under certain limited circumstances.

Who designs a state waiver program?

States have flexibility to select and design the mix of waiver services that best meet the needs of the population they wish to serve, to select eligibility characteristics of the population to be served and to provide services statewide or in specific geographic locations.

What groups of people can the HCBS waiver programs serve?

Under federal regulations, HCBS waivers are permitted to serve the following groups of people:

- People who are elderly
- People with physical disabilities
- People with developmental disabilities
- People with mental retardation
- People with mental illness
- People with traumatic brain injury or other specified conditions
- People with specified services needs, such as technology-dependent children
These HCBS waivers sound great. How can a state get one?

In general, states have one or more Medicaid waivers in place already. States must obtain HCBS waivers with the cooperation of State Medicaid Agencies even though other state agencies, such as the ones that serve seniors or people with disabilities, may administer the program. To receive approval to implement HCBS waivers, the State Medicaid Agency must assure the Health Care Financing Administration (HCFA) that, on an average per capita basis, the cost of providing home and community-based services will not exceed the cost of services for the identical population in an institution. The State Medicaid Agency also must document that there are safeguards in place to protect the health and welfare of beneficiaries.

If my state is granted an HCBS waiver, how long will it last?

HCBS waiver programs initially are approved for 3 years. They may be renewed perpetually at 5-year intervals.

How can I find out more information about my state’s home and community-based services waiver program(s)?

You may check with your State Medicaid Agency or another state or local agency that oversees or provides services for people with disabilities. For a list of the State Medicaid Agency offices, go to the HCFA website at: www.hcfa.gov/medicaid. You also will find the number for your State Medicaid Agency in the blue section of your local phone book.
I’ve heard a lot recently about the famous Olmstead case. What is it and how can it help my family?

In the Supreme Court’s 1999 Olmstead decision, the Court ruled that under the Americans with Disabilities Act (ADA), people cannot be placed or retained in institutions or nursing homes if the placement or retention is unjustified and if the placement would severely limit the person’s exposure to the outside community. One of the most important outcomes of the Olmstead decision is the strong message that the unjustified placement of a person in an institution potentially constitutes discrimination against people with disabilities under the ADA and should not be supported by any state.

What problems did the Olmstead decision address?

The Olmstead decision addressed:

- The lack of access and availability of home and community-based services and supports for people with disabilities
- Violations of the ADA’s integration mandate due to the unjustified placement of people with disabilities in an institutional setting
What did the Court tell states to do to comply with Olmstead?

There are several things the states must do to comply with Olmstead:

- States must operate publicly-supported programs in a non-discriminatory manner.
- States must offer services in the most integrated settings possible.
- States must provide community-based services for people with disabilities who would otherwise be entitled to institutional care.

Under what circumstances are community-based services required under Olmstead?

Community-based services are required when:

- A treatment professional decides that community placement is appropriate.
- The person affected by the placement or the person’s main caregiver do not oppose the placement.
- The placement of the person can be reasonably accommodated, taking into consideration the resources available to the state and the needs of others who are receiving state-supported disability services.
What does “reasonably accommodated” mean for the states?

The Supreme Court has said that under the ADA, the states must make “reasonable accommodations in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability,” UNLESS…

Unless what?

Unless “making the modifications would fundamentally alter the nature of the [state’s] service, program, or activity.”

So, how does the state decide whether a modification would alter a state’s program?

The Supreme Court said to look at 3 factors:

1. Cost
2. State resources
3. Effect on the state’s ability to meet the needs of other people with disabilities

What else do the states have to do?

Under Olmstead, a state must prove that its programs are “even-handed” and that the programs ensure a “full range” of services.
How does a state show it is in compliance with Olmstead and Title II of the ADA?

A state must demonstrate that it has:

- An effective working plan for placing qualified people with disabilities in less restrictive settings
- A waiting list that moves at a reasonable pace and is not influenced by the state’s interest in keeping its institutions fully occupied.

How close are most states to complying with Olmstead?

Most states have a long way to go.

- A full range of services currently does not exist in most states.
- The Medicaid funding and payment systems still favor institutional placement.
- Available community services and supports are often “cookie-cutter” and unimaginative.

How is the Department of Health and Human Services (HHS) monitoring state compliance with Olmstead?

On January 14, 2000, HHS sent a letter to all Medicaid State Directors, encouraging states to develop equitable plans and to involve actively people with disabilities and their representatives in the design, development and implementation of a comprehensive working plan.
Endnotes

Health Care Financing Administration
www.hcfa.gov
Where to Turn...

The Fair Housing Act

105 North Alfred Street  .  Alexandria, VA 22314
Family Helpline: 1-800-444-6443 . (703) 236-6000
www.biausa.org
Your Guide to Federal Disability Policies and Programs

Authors
Patrice Drew, Esq.
Cathy Ficker Terrill
Anne C. Parrette, Esq.

Project Coordinator
Janna Starr

Graphic Designer
Tina Radenberg

Editors
Larry H. Hoffer
Lisa Ward
Monique Marino

Brain Injury Association

U.S. Department of Health and Human Services
Health Resources and Services Administration
Maternal and Child Health Bureau
The Fair Housing Act

The Fair Housing Act prohibits discrimination in housing, including discrimination against a person with a disability.

Which Types of Housing are Covered by the Law?

Most housing is covered by the Fair Housing Act.

However, the Act exempts the following types of housing:

- Owner-occupied buildings with no more than four units
- Single-family housing sold or rented without the use of a broker
- Housing operated by organizations and private clubs that limit occupancy to members

What Is Prohibited under the Act?

Under the Fair Housing Act, no one may take any of the following actions in the sale and rental of housing based on disability:

- Refuse to rent or sell housing
- Refuse to negotiate for housing
- Make housing unavailable
- Deny a dwelling
Set different terms, conditions or privileges for sale or rental

Provide different housing services or facilities

Falsely deny that housing is available for inspection, sale or rental

For profit, persuade owners to sell or rent

Deny anyone access to or membership in a facility or service related to the sale or rental of housing

Under the Fair Housing Act, no one may take any of the following actions in mortgage lending based on disability:

Refuse to make a mortgage loan

Refuse to provide information regarding loans

Impose different terms or conditions on a loan, such as different interest rates, points or fees

Discriminate in appraising property

Refuse to purchase a loan

Set different terms or conditions for purchasing a loan
In addition, it is illegal for anyone to:

☑ Threaten, coerce, intimidate or interfere with anyone exercising a fair housing right assisting others who exercise that right

☑ Advertise or make any statement that indicates a limitation or preference based on disability. This prohibition against discriminatory advertising applies to single-family and owner-occupied housing that is otherwise exempt from the Fair Housing Act

What are New Buildings Required to Have?

If a building is ready for first occupancy after March 13, 1991, and have an elevator and four or more units:

☑ Public and common areas that are accessible to persons with disabilities

☑ Doors and hallways wide enough for disabilities

Each unit must have:

☑ An accessible route into and through the unit

☑ Accessible light switches, electrical outlet, thermostats and other environment controls

☑ Reinforced bathroom walls to allow later installation of grab bars
Kitchens and bathrooms that can be used by people in wheelchairs

If a building with four or more units has no elevator and was ready for first occupancy after March 13, 1991, these standards apply to ground floor units

What do I do if I believe my rights have been violated?

You may report any problems with housing discrimination to the Department of Housing and Urban Development (HUD). You can download the Housing Discrimination Complaint Form at http://www.hud.gov/hdiscrim.html. This form can be downloaded, completed and returned, or completed online and submitted.

You may also write HUD a letter. Your letter must contain the following information:

- Your name and address
- The name and address of the person your complaint is against (the respondent)
- The address or other identification of the housing involved
- A short description of the alleged violation (the event that caused you to believe your rights were violated)
- The date(s) of the alleged violation
Where to write or call:

Send the Housing Discrimination Complaint form or a letter to the National HUD office or the HUD Office nearest you. You also may call that office directly.

Office of Fair Housing and Equal Opportunity
Department of Housing and Urban Development
Room 5204
451 Seventh Street SW
Washington, DC 20410-2000

See Appendix B for a list of local HUD offices.

What Happens When I File a Complaint?

You have one year after an alleged violation to file a complaint with HUD. Once you have filed a complaint, HUD will notify the alleged violator of your complaint and permit that person to submit an answer. Your complaint will be investigated by HUD investigators and it will be determined whether there is reasonable cause to believe the Fair Housing Act has been violated. If HUD decides that it cannot complete an investigation within 100 days of receiving your complaint, it will notify you.

HUD will try to reach an agreement with the person your complaint is against (the respondent). If you sign a conciliation agreement with the alleged violator, HUD will take no further action on your complaint. However, if HUD had reasonable cause to believe that a conciliation agreement is breached, HUD will recommend that the Attorney General file suit.

If HUD had determined that your state or local agency has the same fair housing powers as HUD, HUD will refer your complaint to that agency for investigation and notify you of the referral. That agency must begin work on your complaint within 30 days or HUD may take it back.
What If You Need Help Quickly?

If you need immediate help to stop a serious problem that is being caused by a Fair Housing Act violation, HUD may be able to assist you as soon as you file a complaint. HUD may authorize the Attorney General to go to court to seek temporary or preliminary relief, pending the outcome of your complaint, if:

✔ Irreparable harm is likely to occur without HUD’s intervention

✔ There is substantial evidence that a violation of the Fair Housing Act occurred

*Example:* A builder agrees to sell a house but after learning the buyer is black, fails to keep the agreement. The buyer files a complaint with HUD. HUD may authorize the Attorney General to go to court to prevent a sale to any other buyer until HUD investigates the complaint.

What Happens after a Complaint Investigation?

If, after investigating your complaint, HUD finds reasonable cause to believe that discrimination occurred, it will inform you. Your case will be heard in an administrative hearing within 120 days, unless you or the respondent want the case to be heard in Federal district court. Either way, there is no cost to you.
The Administrative Hearing

If your case goes to an administrative hearing, HUD attorneys will litigate the case on your behalf. You may intervene in the case and be represented by your own attorney if you wish. An Administrative Law Judge (ALJ) will consider evidence from you and the respondent. If the ALJ decides that discrimination occurred, the respondent can be ordered to:

☑ Compensate you for actual damages, including humiliation, pain and suffering.
☑ Provide injunctive or other equitable relief; for example, to make the housing available to you.
☑ Pay the Federal Government a civil penalty to vindicate the public interest. The maximum penalties are $10,000 for a first violation and $50,000 for a third violation within seven years.
☑ Pay reasonable attorney’s fees and costs.

Federal District Court

If you or the respondent chooses to have your case decided in Federal District Court, the Attorney General will file a suit and litigate it on your behalf. Like the ALJ, the District Court can order relief, and award actual damages, attorney’s fees and costs. In addition, the court can award punitive damages.
In Addition

You May File Suit

You may file suit, at your expense, in Federal District Court or State Court within two years of an alleged violation. If you cannot afford an attorney, the Court may appoint one for you. You may bring suit even after filing a complaint, if you have not signed a conciliation agreement and an Administrative Law Judge has not started a hearing. A court may award actual and punitive damages and attorney’s fees and costs.

Other Tools to Combat Housing Discrimination:

If there is noncompliance with the order of an Administrative Law Judge, HUD may seek temporary relief, enforcement of the order or a restraining order in a United States Court of Appeals.

The Attorney General may file a suit in a Federal District Court if there is reasonable cause to believe a pattern or practice of housing discrimination is occurring.
Endnotes

U.S. Department of Housing and Urban Development
www.hud.gov

Consortium for Citizens with Disabilities
www.c-c-d.org

The Technical Assistance Collaborative, Inc
www.tacinc.org
Housing Assistance Options for Individuals with Disabilities
Your Guide to Federal Disability Policies and Programs

Authors
Patrice Drew, Esq.
Cathy Ficker Terrill
Anne C. Parrette, Esq.

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Brain Injury Association

U.S. Department of Health and Human Services
Health Resources and Services Administration
Maternal and Child Health Bureau
Housing Assistance Options for Individuals with Disabilities

What kind of housing assistance is available to persons with disabilities?

In most communities, there are three basic kinds of housing assistance available:

- **Public Housing**, a low-income housing program operated by your local housing authority

- **“Section 8 housing”** in which the housing authority gives you a certificate or voucher that says that the government will subsidize your rent payments under this program and help you locate your own housing

- **Privately owned subsidized housing**, in which the government provides subsidies directly to the owner or landlord, who then applies these subsidies to the rents he/she charges low-income tenants

What is a Public Housing Authority?

A Public Housing Authority (PHA) is a local government agency that develops and coordinates housing assistance for individuals in need.
What is the difference between Public Housing and Section 8 Certificates/Vouchers?

**Public Housing** is development-based assistance. This means that the housing assistance is “attached” to a specific housing development, owned and managed by a PHA. When a vacancy occurs in that development, the PHA offers you the apartment. If you accept, you agree to live in that apartment in that public housing development. As long as you live in the apartment, you should receive the benefit of rental assistance. If you move out of the development, the assistance “stays” with the apartment, and the next family to move in will receive the assistance.

**Section 8 Certificates and Vouchers** are tenant-based assistance. This means that assistance is “attached” to you and your family, in the form of a certificate or voucher issued to you by the PHA. With the certificate or voucher, you find rental housing on the private housing market and the PHA agrees to assist you with your rent in that house or apartment. The housing must meet certain basic quality standards, the rent must be reasonable and the owner must be willing to participate in the Section 8 program. When you leave that housing, you can take the assistance with you to a different house or apartment on the private market, and receive assistance there.

**What is “Public Housing”?**

Public housing was established to provide decent and safe rental housing for eligible low-income families, the elderly and persons with disabilities. Public housing comes in all sizes and types, from scattered single family houses to high-rise apartments for elderly families. There are approximately 1.3 million households living in public housing units, managed by some 3,300 PHAs. The U.S. Department of Housing and Urban Development (HUD) administers Federal aid to local housing agencies that manage the housing for low-income residents at rents they can afford. HUD furnishes technical and professional assistance in planning, developing and managing these developments.
Am I eligible for Public Housing?

Public housing is limited to low-income families and individuals. A PHA determines your eligibility based on: 1) annual gross income; 2) whether you qualify as elderly, a person with a disability or as a family; and 3) U.S. citizenship or eligible immigration status. If you are eligible, the PHA will check your references to make sure you and your family will be good tenants. PHAs will deny admission to any applicant whose habits and practices may be expected to have a detrimental effect on other tenants or the project’s environment.

PHAs use income limits developed by HUD. HUD sets the lower income limits at 80% and very low income limits at 50% of the median income for the county or metropolitan area in which you choose to live. Income limits vary from area to area so you may be eligible at one PHA but not at another. The PHA service in your community can provide you with the income levels for your area and family size, or you also can find the income limits on the internet at www.huduser.org.

How do I apply for Public Housing?

If you are interested in applying for public housing, contact your local PHA. If you have trouble contacting the PHA, contact the local HUD Field Office.
How does the application process work?

The application must be written. Either you or the PHA representative will fill it out. A PHA usually needs to collect the following information to determine eligibility:

1. Names of all persons who would be living in the unit, their sex, date of birth and relationship to the family head;

2. Your present address and telephone number;

3. Family characteristics (e.g., veteran) or circumstances (e.g., living in substandard housing) that might qualify the family for tenant selection preferences;

4. Names and addresses of your current and previous landlords for information about you or your family’s suitability as a tenant;

5. An estimate of your family’s anticipated income for the next 12 months and the sources of that income;

6. The names and addresses of employers, banks and any other information the PHA would need to verify your income and deductions, as well as the family composition; and

7. The PHA also may visit you in your home to interview you and your family members to see how you manage the upkeep of your current home.

After obtaining this information, the PHA representative should describe the public housing program and its requirements, and answer any questions you might have.
Will I need to produce any documentation?

Yes. The PHA representative will request whatever documentation is needed (e.g., birth certificates, tax returns) to verify the information given on your application. The PHA also will rely on direct verification from your employer, etc. You will be asked to sign a form to authorize release of pertinent information to the PHA.

When will I be notified?

A PHA has to provide written notification. If the PHA determines that you are eligible, your name will be put on a waiting list, unless the PHA is able to assist you immediately. Once your name is reached on the waiting list, the PHA will contact you. If it is determined that you are ineligible, the PHA must say why and, if you wish, you can request an informal hearing.

Will I have to sign a lease?

If you are offered a house or apartment and accept it, you will have to sign a lease with the PHA. You may have to give the PHA a security deposit. You and the PHA representative should go over the lease together. This will give you a better understanding of your responsibilities as a tenant and the PHA’s responsibilities as a landlord.

Are there any selection preferences?

Sometimes there are. Giving preference to specific groups of families enables a PHA to direct their limited housing resources to the families with the greatest housing needs. Since the demand for housing assistance often exceeds the limited resources available to HUD and the local PHAs, long waiting periods are common. In fact, a PHA may close its waiting list when there are more families on the list than can be assisted in the near future.
Each PHA has the discretion to establish preferences to reflect needs in its own community. These preferences will be included in the PHA’s written policy manual. You should ask what preferences they honor so you will know whether you qualify for a preference.

How is rent determined?

Your rent, Total Tenant Payment (TTP), is based on your family’s anticipated gross annual income, less deductions, if any. HUD regulations allow PHAs to exclude from annual income the following allowances: $480 for each dependent; $400 for any elderly family members, or a person with a disability; and some medical deductions for families headed by an elderly person or a person with disabilities. Based on your application, the PHA representative will determine if any of the allowable deductions should be subtracted from your annual income. Annual income is the anticipated total income from all sources received from the family head, spouse and each additional family member over the age of 18.

The formula used in determining the TTP is the highest of the following, rounded to the nearest dollar:

- 30 percent of the monthly adjusted income. (Monthly Adjusted Income is annual income less deductions allowed by the regulations)
- 10 percent of monthly income
- Welfare rent, if applicable or
- A $25 minimum rent or higher amount (up to $50) set by a PHA
What is the role of the PHA?

A PHA is responsible for the management and operation of its local public housing program. They also may operate other types of housing programs.

Your PHA will:

☑ Ensure compliance with leases
☑ Set other charges (e.g., security deposit, excess utility consumption and damages to unit)
☑ Transfer families from one unit to another in order to correct over/under crowding
☑ Repair or renovate a dwelling
☑ Terminate leases when necessary
☑ Maintain the development in a decent, safe and sanitary condition

How long can I stay in public housing?

In general, you may stay in public housing as long as you comply with the lease. If, at reexamination, your family’s income is sufficient to obtain housing on the private market, the PHA may determine whether your family should stay in public housing. You will not be required to move unless there is affordable housing available for you on the private market.
What is “Section 8” Housing?

Section 8 Certificates and Vouchers are tenant-based assistance. This means that assistance is “attached” to you and your family, in the form of a certificate or voucher issued to you by the PHA. With the certificate or voucher, you find rental housing on the private housing market and the PHA agrees to assist you with your rent in that house or apartment. The housing must meet certain basic quality standards, the rent must be reasonable, and the owner must be willing to participate in the Section. 8 program. When you leave that housing, you can take the assistance with you to a different house or apartment on the private market, and receive assistance there.

How do I apply for Section 8 assistance?

The Public Housing program and the Section 8 Certificate/Voucher programs are administered by local Public Housing Agencies (PHAs). Because PHAs are responsible for all aspects of day-to-day management of these programs, including accepting and processing applications, you must apply directly to the PHA in the jurisdiction (usually a city or county) in which you wish to live.

All PHAs handle the application and intake process differently. When you contact the PHA, they can provide information on how, where and when to apply, as well as information on waiting lists and available housing.

See Appendix B for a list of Public Housing Agencies.
Am I eligible for Section 8 assistance?

Basic eligibility requirements for Public Housing and Section 8 assistance are virtually identical. To be eligible for admission to either program, an applicant must meet two basic criteria:

- Applicants must qualify as a Family or qualify under certain categories of eligible single individuals. Generally, a Family includes two or more people. Local PHAs have discretion in defining the circumstances where two or more people constitute a family. Eligible categories of single individuals include individuals who are either age 62 or over, disabled or displaced.

- Applicants’ gross annual income must fall below certain Income Limits. Income Limits are established for each locality in the state. Income Limits also vary based on the number of people in the family. There are two Income Limits: “Low” and “Very Low.” The “Low” Income Limit is established at 80% of the median income for the area. The “Very Low” Income Limit is established at 50% of the median income for the area. Usually, a family’s income must fall below the Low Income Limit to be eligible for public housing. To be eligible for admission to some developments, however, a family’s income must fall below the Very Low Income Limit.

Is there a list of apartments or complexes that accept Section 8 Certificates or Vouchers?

HUD does not maintain a list of all of the private owners, managers and landlords in a jurisdiction who would be willing to lease a unit to a family with a Section 8 Certificate or Voucher. Such a list would be extremely large and very difficult for anyone to create and maintain with accuracy and timeliness.
The best source of information on private owners and landlords in any area is the PHA that operates the Section 8 program in that area. Local PHAs are most familiar with private owners and landlords in their jurisdiction, including owners that currently rent to Section 8 families, owners that formerly rented to Section 8 families and owners that don’t currently rent to Section 8 families but have expressed an interest.

HUD does maintain a listing of privately-owned and managed apartment complexes in the state, where the Section 8 assistance is attached to the apartment complex itself (i.e., “project-based” Section 8). This is similar to Public Housing where the assistance stays with the apartment, not the family, and the family receives the assistance as long as they live in that apartment.

I own a house that I’d like to rent out to a family with a Section 8 Certificate or Voucher. How can I do this?

Whenever you advertise your house or apartment for rent, whether in the newspaper, in flyers, posters, bulletin boards, etc., you should indicate that you are willing to accept Section 8 families. This easily “flags” your rental unit for any Section 8 family out there who might be looking for a place to rent.

You should contact the PHA that operates the Section 8 program in your community and tell them of your willingness to accept Section 8 families. While PHAs cannot “steer” a family to any particular unit, they can inform the family of housing opportunities in the community, including any owners who have expressed an interest.
I have a Section 8 Certificate or Voucher. I’ve looked everywhere and can’t find an apartment or house to take my Certificate / Voucher. What can I do?

Families with a Section 8 Certificate or Voucher have an initial term of 60 days to find a suitable apartment or house to rent (with an owner willing to take a Section 8 family), and submit a Request for Lease Approval to the PHA. If the Certificate or Voucher is about to “expire,” the family may submit a request for an extension to the PHA. The PHA may grant one or more extensions, not to exceed a total of an additional 60 days, if it believes the family may be able to find a suitable apartment or house in that time.

Talk to the PHA that issued you the Certificate or Voucher and keep them informed of your efforts, particularly if you’re having difficulty. The PHA might be able to help by offering you advice on how to search for a place and where you might look, giving you leads on possible vacancies and landlords willing to rent to Section 8 families, and giving you an extension of your Certificate or Voucher. You also might talk with local social service agencies, public assistance agencies, churches, local real estate agencies or any other local organization with the expertise to help. Don’t confine your search to newspaper ads alone.

Keep in mind that the ultimate responsibility for finding a place to rent rests with you, the family with the Certificate or Voucher. PHAs and other organizations may be able to help, but they cannot find a place for you. A Certificate or Voucher is a golden opportunity for housing assistance. As long as the Certificate or Voucher is available, you should be diligent, assertive and tireless in your search.
More questions about Public Housing and Section 8 Housing

Can I be denied housing based on bad credit or a criminal record?

In the Public Housing program, a PHA can deny an applicant based on reasonable criteria related to an applicant’s potential “suitability” as a tenant.

These criteria include, but are not limited to:

☑ Past performance in meeting financial obligations (especially rent)

☑ History of disturbance of neighbors, destruction of property or living/housekeeping habits that might adversely affect the health, safety and welfare of other tenants

☑ A history of criminal activity involving crimes of physical violence to persons or property, and other criminal acts which would adversely affect the health, safety and welfare of other tenants

Basically, a PHA is the owner and manager of public housing. Like any other landlord in the community, PHAs screen potential tenants to determine if the family can be expected to fulfill the obligations of the lease reasonably. And, like any other landlord, the PHA is subject to the rights and obligations established in state “landlord/tenant” law.
In the Section 8 Certificate and Voucher programs, the PHA is not the “landlord” of the housing, so the PHA does not screen applicants for “suitability” as tenants. The PHA screens the applicant to determine his or her eligibility for housing assistance. When it comes time for the family actually to rent a house or apartment from a private landlord on the private market, this landlord does have the right to screen the family for “suitability.” Again, the private landlord is subject to the rights and responsibilities established in state “landlord/tenant” law.

There are circumstances, however, where a PHA may deny assistance to a Section 8 applicant family based on the family’s history, behavior, actions or inactions. These include, but are not limited to:

☐ Violation of a required obligation under the program (such as failing to provide necessary info to the PHA, committing fraud or bribery, receiving duplicate housing assistance under any other program, etc.)

☐ Past history of eviction from public housing or termination of Section 8 assistance

☐ History of engaging in drug-related criminal activity or violent criminal activity

☐ The family owes rent or other amounts to the PHA or to another PHA

☐ Abusive or violent behavior toward PHA personnel

In all of these and other circumstances, the PHA may consider extenuating circumstances before denying assistance. Your local PHA is the best source of information on program rules and requirements regarding eligibility for assistance.
Can I get a priority to get into housing?

PHAs have the option under the law to establish a system of preferences for applicant families having certain characteristics. Preferences establish an order of priority for applicant families to be selected from the waiting list. A PHA’s system must be based on local housing needs, priorities and objectives, as determined by the PHA.

Local housing priorities and objectives may include, for example, giving preference to families who are:

- ✔ currently living in substandard housing;
- ✔ involuntarily displaced from their most recent housing;
- ✔ paying more than 50% of their income for rent in their current housing; or
- ✔ currently homeless

It is the option of each individual PHA to decide whether and to what extent a system of preferences will be used when selecting applicants for assistance at that particular PHA. A system of preferences may apply to the Public Housing program only, the Section 8 Certificate and Voucher programs only, or all programs. In addition, a PHA may adopt a different system of preferences for the Public Housing program than the system used (if any) for the Section 8 Certificate and Voucher programs.

Because PHAs have this discretion and responsibility, each PHA may take a different approach for its community. There is no one answer. It’s important to contact the PHA directly in the area where you wish to live to find out about the specific selection priorities used and whether you might qualify for a priority.
I’ve applied for Public Housing or Section 8 Certificate / Voucher assistance. How long will it take and how do I find out where I am on the waiting list?

Local PHAs are responsible for all aspects of day-to-day management of the Public Housing and the Section 8 programs including accepting and processing applications, determining eligibility, managing the waiting list and offering assistance. PHAs also have wide discretion on the type of preferences and priorities they may use in selecting applicants for housing.

Only the PHA where you applied for assistance can give you any specific information about your place on its waiting list, your eligibility for housing or any other information about your status.

What documentation will I need when I go to apply for Section 8/Public Housing assistance?

Each PHA will have different rules about what documentation is required. You can expect to provide some of the following documentation:

☑ **Picture Identification**: Valid picture identification (driver license, military, state, school, etc) for the head of household regardless of age as well as all other persons living in the household who are eighteen (18) years of age or older

☑ **Social Security**: A valid social security card for all persons to be living in the residence who are six (6) years of age or older
markdown

- **Current/Previous Landlord**: The names and addresses of current/previous landlords for the past five (5) years

- **Citizenship**: A visa, alien card, etc. if not a citizen of the U.S.

You also may be required to show proof of your income and expenses.

**Do you have any of the following incomes or expenses?**

- **Department of Human Services**: Temporary Assistance for Needy Families (TANF), Aid to Disabled (AD), Old Age Assistance (OAA), Aid to the Blind (AB), etc. Make sure you bring your case number/medical card with you.

- **Employment**: Bring the name and mailing address of your employer.

- **Unemployment Benefits**: Make sure you bring any relevant documentation of the benefits you received during any period of unemployment.

- **Retirement Benefits**: (Veterans Administration, Civil Service, railroad company, etc.), bring the claim numbers and mailing address for the source of your benefits.

✅ **Bank Accounts:** Bring the most recent bank statement for all checking/saving accounts.

✅ **Interest/Annuities:** Bring statements for the last four (4) quarters or a statement from the bank or company from which you are receiving income. This statement must include account number, current balance and amount of interest or percentage rate earned during the past four (4) quarters. If you receive an annuity, provide a letter from the company from which you receive the income stating the current balance and amount paid to you each month.

✅ **Stock:** Bring statements for the year or a letter from the company showing income, number of shares owned and type of stock (common or preferred).

✅ **Rental Incomes:** Bring information on any rental income received.

✅ **Property:** Bring verification of market value for all real estate properties owned.

✅ **Child Support/Alimony:** Bring a letter from the source (Department of Human Services/Child Support Enforcement, mother/father/guardian) verifying the monthly amount.

✅ **Medical Allowance Information:** Bring in bills, reimbursements received and proof of payment for medical expenses during the last twelve (12) months.

✅ **Child Care Allowance Information:** Bring actual childcare expenses for the care of children, including foster children, age 12 and younger. They may be deducted from annual income if requirements are met under the guidelines. Also bring the name and address of the childcare center and/or sitter(s) caring for your child/children.
Disability Assistance Allowance: Bring in verification of care being provided for a disabled family member who is over the age of 12.
Endnotes

U.S. Department of Housing and Urban Development
www.hud.gov

Consortium for Citizens with Disabilities
www.c-c-d.org

The Technical Assistance Collaborative, Inc.
www.tacinc.org
Where to Turn...

Employment

105 North Alfred Street, Alexandria, VA 22314
Family Helpline: 1-800-444-6443  (703) 236-6000
www.biausa.org
Where to Turn...

Your Guide to Federal Disability Policies and Programs

Authors
Patrice Drew, Esq.
Cathy Ficker Terrill
Anne C. Parrette, Esq.

Project Coordinator
Janna Starr

Graphic Designer
Tina Radenberg

Editors
Larry H. Hoffer
Lisa Ward
Monique Marino
I have a disability and am looking for employment. What laws will protect me from discrimination and assist me in finding employment?

There are several laws that deal with employment for individuals with disabilities, including the American with Disabilities Act, the Rehabilitation Act of 1973 and the Social Security Act. For an in-depth look at how each law contributes to the complex mosaic created to protect individuals with disabilities, please refer to Chapter 2 (ADA), Chapter 3 (Rehab. Act) and Chapter 4 (Social Security).

What are the work disincentives under the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs?

Many people with disabilities want to work. However, due to the stringent rules promulgated by the Social Security Administration (SSA) regarding employment, many people fear loss of cash benefits, loss of health insurance coverage and—should a work attempt fail—the time-consuming reapplication process.

The general rule is that average earnings of $700 per month or more amount to substantial gainful activity (SGA). Absent the application of one of the rules discussed below, a person earning an average of $700 per month would be denied benefits as an applicant for SSDI or SSI, or be terminated from the SSDI program if receiving benefits already. Under these rules, average earnings of less than $300 per month will not amount to SGA and will not affect entitlement. If earnings are between $300 and $700 per month, SSA is required to individually evaluate the person’s work to see if it indicates that he or she is performing SGA. Typically, SSA does not terminate benefits under the SGA rule unless earnings are more than $700 per month.
For the SSDI applicant or recipient who is legally blind, $1,170 in monthly earnings is considered to be SGA in 2000. That amount increases each year, as the SGA test for persons who are blind is adjusted annually. There is no SGA rule in the SSI program for persons who are blind. The United States Court of Appeals for the 10th Circuit has held that Social Security’s statutes and regulations allowing persons who are blind a higher SGA threshold than those allowed for persons with other disabilities does not violate the U.S. Constitution’s equal protection clause.

People with disabilities and those who have worked as disability advocates know how harsh the $700 rule can be. Monthly earnings in the $700 to $1000 range will seldom, if ever, duplicate the combination of cash and medical benefits of a mere subsistence existence. When one factors in the difficulties in finding permanent gainful employment, many individuals with disabilities have chosen not to seek competitive employment.

The Continuing Disability Review (CDR) can be another major disincentive to work. Many justifiably fear that work activity in one’s record increases the likelihood that a CDR will result in a termination of benefits. Indeed, many advocates have discouraged work activity for this very reason. Advocates should not discourage work activity. Instead, the advocate’s role is to ensure that the person with a disability understands the potential impact of work on benefits so that he or she can make informed choices about work and use of the work incentives.

There are three categories of SSDI or SSI beneficiaries for CDR purposes. Individuals in each category will have SSA review their cases more or less frequently, depending upon where they fit. These are referred to as “diaried” CDRs and will occur whether or not the individual is working. The three categories are:

- Medical Improvement Not Expected: Reviewed every five to seven years
- Medical Improvement Possible: Reviewed once every three years
- Medical Improvement Expected: Reviewed six to 18 months after initial entitlement
Under current law, when can my disability benefits be terminated if I have a medical improvement?

Generally, disability benefits will be terminated only if there is medical improvement that enables the person to engage in substantial gainful activity. There are several exceptions to the medical improvement standard, allowing for termination of benefits when there has been no medical improvement. Three of these exceptions are noteworthy:

- Where there is no real medical improvement, but the person is now able to engage in SGA because he or she is a beneficiary of advances in medical or vocational therapy or technology.
- Where new or improved diagnostic techniques or evaluations show that the person’s impairment or combination of impairments is not as disabling as it was considered to be when the person’s case was reviewed most recently.
- Where substantial evidence shows that a prior determination was in error.
- When any of the listed criteria are determined to be present, a person can be terminated from SSDI or SSI, despite the absence of medical improvement.

I am a recipient of SSDI or SSI and I work, how can I avoid the implication of medical improvement?

The only “safe” cases, where it is clear that a disability has not improved, are those in which a person’s disability continues to meet the criteria of a “listing.” The Listing of Impairments contains 14 different categories of disability and specific criteria under each category that will support a finding of disability without further analysis of the person’s ability to perform work.
activity. Primary candidates for the listings include persons with mental retardation, legal blindness, deafness or severe physical disabilities, particularly those that render a person quadriplegic. Since meeting a listing results in an automatic finding of disability, a medical improvement termination could not occur. More problematic cases are those involving mental illness or pain as the primary disability. Since mental illness and pain symptoms cannot be objectified or quantified as easily, the work activity might be viewed as evidence of improvement.

Are there any work incentives?

SSDI Work Incentives provide support over several years to allow you to test your ability to work and gradually become self-supporting and independent. In general, you have at least four years to test your ability to work. This includes full cash payments during the first 12 months and a 36-month period in which SSA can start your cash benefits again without a new application. You will continue to have Medicare coverage during this time.

<table>
<thead>
<tr>
<th>The SSDI work incentives are:</th>
<th>The SSI work incentives are:</th>
</tr>
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<tbody>
<tr>
<td>✓ Impairment-Related Work Expenses</td>
<td>✓ Impairment-Related Work Expenses</td>
</tr>
<tr>
<td>✓ Subsidies and Special Conditions</td>
<td>✓ Earned Income Exclusion</td>
</tr>
<tr>
<td>✓ Unincurred Business Expenses (Self-Employed Only)</td>
<td>✓ Student Earned Income Exclusion</td>
</tr>
<tr>
<td>✓ Unsuccessful work attempts</td>
<td>✓ Blind Work Expenses</td>
</tr>
<tr>
<td>✓ Trial Work Period</td>
<td>✓ Plan for Achieving Self-Support (PASS)</td>
</tr>
<tr>
<td>✓ Extended Period of Eligibility</td>
<td>✓ Property Essential to Self-Support</td>
</tr>
<tr>
<td>✓ Continuation of Medicare coverage</td>
<td>✓ Special SSI Payments for People Who Work -- section 1619(a)</td>
</tr>
<tr>
<td>✓ Medicare for People With Disabilities Who Work</td>
<td>✓ Reinstating eligibility without a new application</td>
</tr>
<tr>
<td>✓ Continued payment under a Vocational Rehabilitation program</td>
<td>✓ Continued payment under a Vocational Rehabilitation Program</td>
</tr>
<tr>
<td></td>
<td>✓ Special Benefits for People Eligible Under Section 1619 (a) or (b) who Enter a Medical Treatment Facility</td>
</tr>
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SSDI and SSI Work Incentives

Impairment-Related Work Expenses (IRWE)

How can IRWE help?

SSA considers the cost of certain impairment-related items and services that you need to work as a deduction from your gross earnings when it decides if your “countable earnings” demonstrate performance of SGA. It does not matter if you also use these items and services for non-work activities. IRWE also is excluded from your earned income when SSA figures your monthly SSI payment amount.

IRWE are deductible for SGA purposes when:

- The item or service enables you to work
- You need the item or service because of your disability
- You pay the cost yourself and are not reimbursed by another source (e.g., Medicare, Medicaid, private insurance)
- The expense is “reasonable”—that is, it represents the standard charge for the item or service in your community
- You paid the expense in a month in which you are or were working (occasionally, an impairment-related work expense may be used before the first or after the last month of work activity)
### Examples of expenses likely and not likely to be deductible

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Not Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical devices such as wheelchairs, hemodialysis equipment, pacemakers, respirators, traction equipment and braces (arm, leg, neck, back, etc.)</td>
<td>Any medical device you do not use for a medical purpose</td>
</tr>
<tr>
<td>Attendant Care Services Performed in the work setting</td>
<td>Attendant Care Services performed on non-workdays or helping you with shopping or general homemaking (e.g., cleaning, laundry)</td>
</tr>
<tr>
<td>The cost of structural or operational modifications to your vehicle that you need in order to travel to work, even if you also use the vehicle for non-work purposes</td>
<td>The cost of modification to your vehicle not related directly to your impairment or critical to your operation of the vehicle (e.g., paint or décor preferences)</td>
</tr>
<tr>
<td>Artificial hip or artificial replacement of an arm, leg or other parts of the body</td>
<td>Any prosthetic device that is primarily for cosmetic purposes</td>
</tr>
</tbody>
</table>

### Subsidies and Special Conditions

“Subsidies” and “special conditions” are names for support you receive on the job that could result in your receiving more pay than the actual value of the services you perform. “Subsidies” are items provided by your employer. “Special conditions” are items provided by someone other than your employer (e.g., a vocational rehabilitation agency).

SSA deducts the value of subsidies and special conditions from your earnings when it makes an SGA decision. SSA does not deduct subsidies or special conditions when it figures your SSI payment amount.

Examples of subsidies and special conditions are:

- ✓ You receive more supervision than other workers doing the same or similar job for the same pay
- ✓ You have fewer or simpler tasks to complete than other workers doing the same job for the same pay
- ✓ You have a job coach or mentor who helps you perform some of your work
SSA only uses earnings that represent the real value of the work you perform to decide if your work is at the SGA level. If your employer and/or other involved parties have difficulty setting the real value of your work or the amount of the subsidy or special conditions, SSA will decide the value of your work.

**Unincurred Business Expenses**
**(Self-Employed Only)**

“Unincurred business expenses” is SSA’s name for self-employment business support that someone else gives to you without cost. Because someone gives you these items or services, the Internal Revenue Service (IRS) does not allow you to deduct their cost for income tax purposes. Examples include the State Vocational Rehabilitation agency giving you a computer for your business or a friend working for your business as unpaid help.

If you are self-employed, SSA generally follows the IRS rules to figure your net earnings from self-employment. However, when it makes an SGA decision it also deducts unincurred business expenses from your net earnings to gain a more accurate measure of the value of your work.

SSA does not deduct unincurred business expenses from earnings when it figures your SSI payment amount.

For an item or service to qualify as an unincurred business expense:

- It must be an item or service that the IRS would allow as a legitimate business expense if you had paid for it, and
- Someone other than you must have paid for it.
Unsuccessful Work Attempts

An unsuccessful work attempt is an effort to do substantial work (in employment or self-employment) that you stopped or reduced to below the SGA level after a short time (six months or less) because of your impairment or the removal of special conditions which are related to your impairment and essential to the further performance of your work.

SSA does not count earnings during an unsuccessful work attempt when SSA makes an SGA decision for initial eligibility (for SSDI or SSI); or, when it decides (for SSDI only) if disability continues or ceases because of work.

SSA does not take into account unsuccessful work attempts when it figures your SSI payment amount.

Continued Payment Under a Vocational Rehabilitation Program

If SSA finds you no longer have a disabling impairment due to medical improvement, your benefit payments usually stop. If you participate in a vocational rehabilitation program, however, your benefits may continue until the vocational rehabilitation program ends.

To qualify:

- You must have started the vocational rehabilitation program before your disability ceased; and

- SSA must review the situation and decide that your continued participation in the vocational rehabilitation program would increase the likelihood of your permanent removal from the disability benefit rolls.
**Trial Work Period (TWP)**

**How does the TWP help people?**

The TWP allows you to test your ability to work for at least nine months. During your TWP, you will receive full SSDI benefits, regardless of how high your earnings might be so long as you have a disabling impairment.

**When does the TWP start?**

Your TWP starts with the first month you are eligible for SSDI benefits and are working.

**How long does the TWP last?**

The TWP continues until you accumulate nine months (not necessarily consecutive) of “services” that you performed within a 60-consecutive-month period. SSA uses this “services” rule only to control when the TWP stops.

“Services” means any activity you do in employment or self-employment for pay or profit, or of the kind normally done for pay or profit (whether or not it is SGA). SSA currently considers your work to be services if you earn more than $200 a month (or work more than 40 self-employed hours in a month).
What else do I need to know about the TWP?

You are not eligible for disability benefits or a TWP if you work at SGA level within 12 months of the onset of your impairment(s) or before SSA approves your claim for disability benefits. This is because your impairment does not meet SSA’s definition of disability. SSA can consider medical evidence that might demonstrate your medical recovery at any time. It is possible, therefore, for your benefits to stop because of your medical recovery before the end of your TWP.

SSA allows only one TWP in any one period of disability.

*Note: Unsuccessful work attempts do not apply to the TWP.*

What happens when I complete my TWP?

SSA considers your work and earnings after the end of the trial work period to decide if you can work at SGA level. It also considers whether any of the work incentive provisions may affect your situation.

If SSA decides that you cannot work at the SGA level, your SSDI benefits continue.

If SSA decides that you can work at the SGA level:

- It pays your SSDI benefits for the month your disability ceased (either resulting from medical improvement or your work at GA level) plus the next two months (this is called the “grace period”).

- If your benefits stopped because you worked at SGA level, you are now in the extended period of eligibility (see next section).
Extended Period of Eligibility (EPE)

How does the EPE help me?

If SSA ceased your disability benefits because you worked at SGA level, it can automatically reinstate your benefit payments automatically. No new application and/or disability determination is required.

When can SSA reinstate my benefits?

The earliest it can reinstate your benefits is the first month following the end of the trial work period. (Note that the extended period of eligibility and the grace period may overlap.)

The latest SSA can reinstate your benefits is the 36th consecutive month following the end of the trial work period. (If your earnings change significantly from month-to-month, it is possible that SSA could reinstate your benefits up to 18 times during this period.)

How do I qualify for reinstatement of my benefits?

You qualify for any month in the period described above in which:

- You continue to have a disabling impairment, and
- Your earnings in that month fall below SGA level.
Can I receive reinstated benefits after the 36th month?

Yes. If you are eligible for a reinstated benefit payment for the 36th month, you will continue to be eligible for benefits until you:

- Work a month at SGA level, or
- Medically recover.

Note: Unsuccessful work attempts do not apply to people who receive reinstated benefits under the EPE because SSA already has made the decision that their disability ceased.
Continuation of Medicare Coverage

How does this rule help me?

Although cash benefits may cease as a result of work, you have the assurance of continued health insurance.

You can receive up to 39 consecutive months of Medicare hospital and medical insurance after the trial work period. This provision allows your health insurance to continue when you go to work and are engaging in SGA. You pay no premium.
Medicare for People with Disabilities who work

Is there any way I can buy Medicare coverage?

Yes. After premium-free Medicare coverage ends because of work, some people who have returned to work may buy continued Medicare coverage, as long as they remain medically disabled. (Some people with low incomes and limited resources may be eligible for state assistance with these expenses.)

Who is eligible to buy Medicare Coverage?

You are eligible to buy Medicare coverage if you:

☑ Are not yet age 65
☑ Have a disabling impairment, and
☑ Your Medicare coverage stopped because of work

What kind of Medicare coverage can I buy if I’m eligible?

☑ You can buy Premium Hospital Insurance (HI Part A) at the same monthly cost which uninsured eligible retired beneficiaries pay ($309 per month for 1999), and

☑ You can buy Premium Supplemental Medical Insurance (SMI Part B) at the same monthly cost which uninsured eligible retired beneficiaries pay ($45.50 per month for 1999), or

☑ You can buy Hospital Insurance separately without Supplemental Medical Insurance.

Note: You can buy Supplemental Medical Insurance only if you also buy Hospital Insurance.
If I’m eligible, when can I enroll?

You may enroll:

- During your initial enrollment period (the month you are notified about the end of your premium-free health insurance and for the following seven months)
- During the annual general enrollment period (January 1 through March 31 of each year)
- During a special enrollment period if you are covered under an employer group health plan

Does the state ever pay Medicare premiums for people?

States are required to pay Hospital Insurance premiums for some working individuals with disabilities. You qualify if you:

- Are eligible to enroll in premium Hospital Insurance for people with disabilities who work
- Meet certain income and resource standards, and
- Are not eligible for Medicare on any other basis
- Earned Income Exclusion

How can the Earned Income Exclusion help me?

SSA does not count all of your earned income when it figures your SSI payment amount. In fact, SSA counts less than one-half of your earnings when figuring your SSI payment amount.

The first $65 of your earnings in any given month, plus one-half of the remainder, are not counted. This is in addition to the $20 general income exclusion that is applied to any unearned income that you may receive.
Who does the Student Earned Income Exclusion help?

If you are under age 22, not married or the head of your household and regularly attending school, SSA does not count up to $400 of earned income per month when figuring your SSI payment amount. The most they will exclude in a single year is $1,620.

What is SSA’s definition of “regularly attending school”?

“Regularly attending school” means that you take one or more courses of study and attend classes:

- In a college or university for at least eight hours a week
- In grades 7-12 for at least 12 hours a week
- In a training course to prepare for employment for at least 12 hours a week (15 hours a week if the course involves shop practice), or
- For less time than indicated above for reasons beyond the student’s control, (e.g., illness).
If you are home taught because of a disability, you may be considered “regularly attending school” by:

☑ Studying a course or courses given by a school (grades 7-12), college, university or government agency, and

☑ Having a home visitor or tutor who directs the study.

SSA applies the student earned income exclusion before the general income exclusion or the earned income exclusion.
Plan for Achieving Self-Support (PASS)

How could a PASS help me?

A plan for achieving self-support (PASS) allows you to set aside income and/or resources for a specified time for a work goal.

For example, you could set aside money for education, vocational training or starting a business.

SSA does not count the income that you set aside under your PASS when it figures your SSI payment amount. SSA does not count the resources that you set aside under your PASS when it determines your initial and continuing eligibility for SSI.

A PASS can help you establish or maintain SSI eligibility and increase your SSI payment amount.

A PASS does not affect any SGA determination for your initial eligibility decision.

Requirements for a PASS

Your plan must:

☑ Be designed especially for you
☑ Be in writing (SSA prefers that you use their form, the SSA-545-BK)
☑ Have a specific work goal that you are capable of performing
☑ Have a specific timeframe for reaching your goal
☑ Show what money (other than your SSI payments) and other resources you have or receive that you will use to reach your goal
☑ Show how your money and resources will be used to reach your work goal
☑ Show how the money you set aside will be kept identifiable from other funds
☑ Be approved by SSA
☑ Be reviewed by SSA periodically to ensure your plan is actually helping you achieve progress
Who can have a PASS?

If you receive or could qualify for SSI, you can have a PASS. You may not need a PASS now, but you may need one next month or next year to remain eligible or increase your SSI payment amount.

Who can help you set up a PASS?

Anyone may help you with your PASS, including vocational counselors, social workers or employers. SSA evaluates the plan and decides if it is acceptable. SSA also helps people put their plans in writing.

How does a PASS affect SSI?

SSA does not count resources set aside under a PASS toward the resource limit when it figures your SSI payment amount. It applies this exclusion to your countable income after it applies all other applicable exclusions.

How can I get more information about PASS?

You can get a PASS Specialist’s toll-free telephone number from your local SSA office, you can call SSA’s national toll-free at 800-772-1213 or you can visit the Internet web site, www.ssa.gov/work/workincentives.htm. You can get copies of the form, SSA-545-BK from your local SSA office, any PASS Specialist or the web site.
Property Essential to Self Support

How can this provision help me?

SSA does not count some resources that are essential to your means of self-support when it decides your initial and continuing eligibility for SSI.

What is not counted?

SSA does not count property that you use in a trade or business (e.g., inventory) or use for work as an employee (e.g., tools or equipment). Other use of the items does not matter.

SSA does not count up to $6,000 of equity value of non-business property that you use to produce goods or services essential to daily activities (e.g., land used to produce vegetables or livestock solely for consumption by your household).

SSA does not count up to $6,000 of equity value of non-business, income-producing property if the property yields an annual rate of return of at least 6 percent (e.g., rental property). It does not consider liquid resources (e.g., stock, bonds, notes) as property essential to self-support unless you use them as part of a trade or business.
Special SSI Payments for People Who Work — Section 1619(a)

How can Section 1619(a) help me?

You can receive SSI cash payments even when your earned income (gross wages and/or net earnings from self-employment) is at the SGA level. This eliminates the need for the trial work period or extended period of eligibility under SSI.

**NOTE: If you are blind, this does not apply to you, because the SGA requirement never applied to you under SSI.**

Who qualifies?

To qualify, you must:

- Have been eligible for an SSI payment for at least one month before you begin working at the SGA level
- Still be disabled, and
- Meet all other eligibility rules, including the income and resource tests.
How does it work?

Your eligibility for SSI will continue for as long as you meet the basic eligibility requirements and the income and resources tests. SSA will continue to figure your SSI payment amount in the same way as before. If your state provides Medicaid to people on SSI, you will continue to be eligible for Medicaid.

Do I need to apply?

You do not need to file a special application, just keep SSA up to date on your work activity.
Continued Medicaid Eligibility — Section 1619(b)

How can Section 1619(b) help me?

Your Medicaid coverage can continue even if your income becomes too high for a SSI cash payment.

Who qualifies?

To qualify you must:

- Have been eligible for an SSI cash payment for at least one month
- Still be disabled
- Still meet all other eligibility rules, including the resources test
- Need Medicaid in order to work, and
- Have gross earned income that is insufficient to replace SSI, Medicaid and any publicly funded attendant care (see “threshold amount” section following).

What is the “threshold amount”?

The “threshold amount” is what SSA calls the measure that it uses to decide whether your earnings are high enough to replace your SSI and Medicaid benefits. Your threshold amount is based on:

- The amount of earnings that would cause your SSI cash payments to stop in your state, and
- The annual per capita Medicaid expenditure for your state
If your gross earnings are higher than the threshold amount for your state, SSA can figure an individual threshold if you have:

- Impairment-related work expenses
- Blind work expenses
- A plan to achieve self-support
- Publicly funded attendant or personal care
- Medical expenses above the state per capita amount
- Continued Medicaid Eligibility in Certain States

The following states use their own eligibility rules for Medicaid that are different from federal SSI eligibility rules:

- Connecticut
- Indiana
- New Hampshire
- Hawaii
- Minnesota
- North Dakota
- Virginia
- Oklahoma
- Ohio
- Illinois
- Missouri

If you live in one of these states, you will continue to be eligible for Medicaid under the Section 1619(a) and (b) if you were eligible for Medicaid in the month before you became eligible for Section 1619.
Special Benefits for People Eligible Under Section 1619 (a) or (b) Who Enter a Medical Treatment Facility

Are there provisions for people who go into a treatment facility?

If you are eligible under Section 1619, you can receive a SSI cash benefit for up to two months while in a Medicaid facility or a public medical or psychiatric facility.

Usually, if you enter a Medicaid facility (i.e., a facility where Medicaid pays more than 50 percent of the cost of care), your SSI payment is limited to $30 per month minus any countable income. If you are eligible under Section 1619, however, your benefit will be figured using the full Federal Benefit Rate for up to two months.

If you are in a public medical or psychiatric facility, you are not eligible to receive a SSI payment. If you enter a public medical or psychiatric facility while you are eligible under Section 1619, however, your SSI cash benefits can continue for up to two months. For this provision to apply, the facility must enter an agreement with SSA that will allow you to keep all of the SSI payment.
Reinstating Eligibility Without a New Application

Do people always have to fill out a new application to become eligible again?

If you have been ineligible for SSI benefits for 12 months or less, you do not have to file a new application to restart your SSI cash payment and/or Medicaid coverage. When your situation changes, contact SSA and ask about how you can restart your SSI benefits or Medicaid.

**Examples:**

**Example 1 — If:**

You are eligible for continued Medicaid coverage under Section 1619(b), and your countable income drops enough to allow a payment

Then: SSA can start your SSI cash payments again.

**Example 2 — If:**

You become ineligible for SSI because your earnings exceed the threshold amount, and

Your countable income drops enough to allow payment within 12 months

Then: SSA can start your SSI cash payments again and notify your state to start your Medicaid coverage again.
Example 3 — If:

You become ineligible for continued Medicaid coverage under Section 1619 (b) because your earnings exceed the threshold amount, and

Your earnings drop below the threshold amount within 12 months

Then: SSA can notify your state to start your Medicaid coverage again.
Special rules for people who are blind

What are special rules for people who are blind?

Work incentives, in general, are special rules that help you return to work or work for the first time. Some of the rules apply only to people who are blind. Congress designed these rules specifically to make it easier for people who are blind to go to work.

How does SSA define blindness?

Blindness is central visual acuity of 20/200 or less in the better eye with best correction, or a limitation in the field of vision in the better eye so that the widest diameter of the visual field subtends an angle of 20 degrees or less (tunnel vision).

Under SSDI, this condition has to have lasted or is expected to last at least 12 months.

There is no duration requirement for blindness under SSI.

How SGA is applied under SSDI to persons who are blind?

Every year, SSA changes the SGA level for beneficiaries who are blind every year to reflect changes in general wage levels. For 2000, if you are blind, average monthly earnings over $1170 will ordinarily demonstrate that you are performing SGA. This is higher than the current guideline for non-blind, workers with disabilities.

REMINDER: If you are blind, you may use any or all of the deductions from earnings that apply to SGA decisions. SSA can deduct each item only once.
How is SGA applied to self-employed SSDI beneficiaries who are blind?

SSA can decide the SGA of self-employed persons who are blind solely on their earnings. SSA does not look at time spent in the business or services rendered as it does for non-blind self-employed persons.

How is SGA applied to SSDI beneficiaries who are blind and age 55 or older?

After your 55th birthday, if your earnings demonstrate SGA but your work requires a lower level of skill and ability than the work you did before age 55, benefits are only suspended, not terminated. Your eligibility for SSDI benefits continues indefinitely, and SSA pays your benefits for any month earnings fall below SGA.

Is SGA applied under SSI to people who are blind?

If you meet the medical definition of blindness, SGA is not a factor for your SSI eligibility. Your SSI eligibility continues until you medically recover or SSA ends your eligibility because of a non-disability-related reason.
Blind Work Expenses (BWE) under SSI

How does BWE help?

If you are blind, SSA does not count any earned income that you use to meet expenses needed to earn that income in deciding your SSI eligibility and your payment amount.

To qualify you must be:

☑ Under age 65, or
☑ Age 65 or older and have received SSI payments because of blindness.

The BWE items do not have to be related to your blindness. When SSA figures your SSI payment amount, SSA treats items as BWE instead of impairment-related work expenses.

Examples of BWE items:

☑ Guide dog expenses
☑ Transportation to and from work
☑ Federal, state and local income taxes
☑ Social Security taxes
☑ Attendant care services
☑ Visual and sensory aids
☑ Translation of materials into Braille
☑ Professional association fees
☑ Union dues
The Ticket to Work and Work Incentive Improvement Act of 1999

How does the “Ticket to Work and Work Incentive Improvement Act of 1999” affect SSA work-related programs?

The Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) created a program called the Ticket to Work and Self-Sufficiency Program. This program supplements previously-existing programs and makes some fundamental changes to the way the issue of work for individuals with disabilities is handled by the SSA.

The program establishes entitlement to a “ticket to work and self-sufficiency” for every individual who meets eligibility criteria established by the SSA. The Ticket may be used to obtain vocational rehabilitation, employment services and other support services. The beneficiary holding a ticket may take the Ticket to any employment network (i.e., a service provider) of his or her choice that is willing to accept the assignment.

Note: Some beneficiaries will begin to receive Tickets early in 2001. During the first year of operation, beginning January 2001, the program will be available only in certain states. In the following years, SSA will expand the program to other parts of the country. The program will be operating in the entire country by January 1, 2004.

Changes to the SSA programs by TWWIIA:

☑ A beneficiary who fails to accept rehabilitation services can no longer have his or her SSI or SSDI benefits reduced or terminated.

☑ The provision requiring prompt referral of specified individuals with disabilities under the SSDI and SSI programs to state VR agencies is repealed.
What will a Ticket look like?

The ticket will be a paper document that will have some personal information and some general information about the Ticket Program.

How will I get my Ticket?

SSA will be working with an organization the law calls a Program Manager. The Program Manager will help SSA manage the Ticket program and send the Tickets in the mail with letters explaining the program.

Where would I take my Ticket to get services?

You will take your Ticket to what the law calls an Employment Network. The Employment Networks will be private organizations or public agencies that have agreed to work with Social Security to provide services under this program.

How will I find out about the Employment Networks?

You will receive a list of the approved Employment Networks in your area when SSA sends you your Ticket. Some Employment Networks may contact you to offer their services. This information also will be available on SSA’s web site and in other places.

How will I choose an Employment Network?

You can contact any Employment Network in your area to see if it is the right one for you. You and the Employment Network have to agree to work together.
Can I change Employment Networks?

Yes. You can stop working with one Employment Network and begin working with another. Before you make this decision, however, you should make sure you fully understand how the Employment Network plans to help you to work.

How can I get more information about the Ticket program?

Contact Social Security:

☑️ You can call the toll-free number at 1-800-772-1213.

☑️ Pamphlets and other written material available are at local Social Security offices.

☑️ Information about the Ticket program also is available from many other private and government organizations that assist people with disabilities.

☑️ If you have access to the Internet, you can get information from SSA’s special web site, www.ssa.gov/work.

Note: Effective January 2001, you can contact the Program Manager. SSA will announce their toll-free telephone number and the date they are available to answer questions.

If I get a Ticket, do I have to use it?

No. The Ticket Program is voluntary.
If I go back to work, will I automatically lose my disability benefits?

No, the new law has not changed SSA’s work incentive rules. For more information about Social Security’s work incentives you should:

Call SSA’s toll-free number at 1-800-772-1213;
Contact your local Social Security office; or
Visit SSA’s special web site at www.ssa.gov/work

If my disability benefits stop because I go back to work, will I have to file a new application if I can’t work anymore?

Effective January 1, 2001, if your benefits have ended because of work, you can request that SSA start your benefits again without a new application. There are some important conditions:

✔ You have to be unable to work because of your medical condition.

✔ The medical condition must be the same as or related to the condition you had when SSA first decided that you should receive disability benefits.

✔ You have to file your request to start your benefits again within 60 months of the date you were last entitled to benefits.
Will I have to wait for SSA to make a new medical decision before I can receive benefits?

No. SSA will make a new medical decision, but while it is making the decision, you can receive up to six months of temporary benefits.

If SSA decides that it is unable to start my benefits again, will I have to pay back the temporary benefits?

No.

Will SSA still review my medical condition?

Effective January 1, 2001, SSA does not review the medical condition of a person receiving disability benefits if that person is using a Ticket.

Effective January 1, 2002, under certain conditions, SSA does not review the medical condition of beneficiaries who have received Social Security Disability Insurance benefits for at least 24 months.

Does the new law include changes in health care coverage?

Yes. TWWIIA extends premium-free Medicare Part A (Hospital Insurance) coverage for an additional 4½ years beyond the current limit. This new law is for people who want to receive Social Security disability benefits and go to work.
How long is Medicare extended?

Medicare (Part A) coverage is extended for 4½ years.

General Rule:

You will get the extended Medicare coverage for the additional 4½ years if:

- You still have a disabling condition, and sign up for Premium Hospital Insurance (Part A)
- You are starting to work for the first time after your disability benefits began
- You are in a trial work period (TWP)
- You are in your 36-month extended period of eligibility (EWE) which began after June 1997
- Your Medicare coverage under the current law didn’t end before September 30, 2000

Under this law, how long will I get to keep Medicare if I return to work?

As long as your disabling condition still meets SSA rules, you can keep your Medicare coverage for at least 8½ years. (The 8½ years includes your nine month trial work period.)

After my TWP, under this law, how long will I have Medicare coverage?

You will get at least seven years and nine months of continued Medicare coverage, as long as your disabling condition still meets SSA rules.
I completed my TWP. I am now in my 36-month Extended Period of Eligibility. Will this law apply to me?

If you are in an EPE that began after June 1997, the law will apply to you. This means you will get the additional Medicare coverage of 4½ years. If your EPE began before July 1997, SSA must consider the following factors before it can decide if the new law applies to you:

- Are you still disabled?
- When did your trial work period end?
- Are you working at substantial gainful activity (SGA)?
- What was the first month you worked SGA after your TWP?

I have Medicare hospital insurance (Part A) and medical insurance (Part B) coverage. Will I get to keep both parts under this law?

Yes. As long as your disabling condition still meets SSA rules. Your Medicare hospital insurance (Part A) coverage is premium-free. Your Medicare medical insurance (Part B) coverage also will continue. You or a third party (if applicable) will continue to pay for Part B. If your Social Security Disability Insurance cash benefits stop because of your work, you or a third party (if applicable) will be billed every three months for your medical insurance premiums. If you are receiving cash benefits, your medical insurance premiums will be deducted monthly from your check.
I have Medicare (Part A) but I did not take Part B coverage when it was first offered to me. Can I get Part B when the new law changes?

Yes. The law did not change the enrollment periods. However, you do not get a new enrollment period. If you did not sign up for Part B when you first could, you only can sign up for it during a general enrollment period (January through March of each year) or during a special enrollment period.

The special enrollment period is a period of time during which you may enroll if:

☑ You did not enroll during your initial enrollment period because you are covered under a group health plan based on your own current employment or the current employment of any family member, or

☑ You enrolled (or were deemed to be enrolled) in your initial enrollment period (and any subsequent special enrollment periods), and have been covered under a group health plan based on your own current employment or the current employment of any family member.

The special enrollment period may occur during any month you are covered under a group health plan based on current employment, or during the eight-month period that begins the first full month after employment or group health plan coverage ends, whichever comes first.
When I return to work and get medical coverage through my employer, does this change my Medicare? Do I need to notify anyone?

☑ Medicare often is the “secondary payer” when you have health care coverage through your work.

☑ Notify your Medicare contractor right away.

☑ Prompt reporting may prevent an error in payment for your health care services.

Under the new law will I still be able to purchase Medicare after my premium-free Medicare (hospital insurance) ends?

Yes. The new law did not change this. The same rules apply.

As long as you still have a disabling condition, you can purchase Medicare (hospital insurance, Part A).

If you purchase Part A, you may purchase medical insurance (Part B).

You cannot purchase Part B unless you purchase Part A.
Do I need to apply for this premium Medicare (hospital insurance, Part A)? If so, when?

Once your Medicare ends, you will get a notice that will tell you when you can file an application to purchase Medicare coverage.

*Note: There is a program that may help you with your Medicare Part A premiums if you decide to purchase Part A after your extended coverage terminates. To be eligible for this help, you must:

- Be under age 65
- Continue to have a disabling impairment
- Sign up for Premium Hospital Insurance (Part A)
- Have limited income
- Have resources worth less than $4,000 for an individual and $6,000 for a couple, not counting the home where you live, usually one car and certain insurance
- Not be eligible for Medicaid already

To find out more about this program, contact your county, local or state Social Services or medical assistance office. Ask about the Medicare buy-in program for Qualified Disabled and Working Individuals. See Chapter 5 on Medicare for more information on this program.
Endnotes

Job Accommodation Network
www.jan.wvu.edu

Institute for Community Inclusion

U.S. Department of Labor
www.dol.gov

Social Security Administration
www.ssa.gov

President's Committee on Employment of People with Disabilities
www.pcepd.gov
Where to Turn...

Family and Medical Leave Act (FMLA)
Your Guide to Federal Disability Policies and Programs

Authors
Patrice Drew, Esq.
Cathy Ficker Terrill
Anne C. Parrette, Esq.

Project Coordinator
Janna Starr

Graphic Designer
Tina Radenberg

Editors
Larry H. Hoffer
Lisa Ward
Monique Marino
The Family and Medical Leave Act (FMLA)

What is the FMLA?

The FMLA entitles eligible employees to take up to 12 weeks of unpaid, job-protected leave in a 12 month period for specified family and medical reasons.

Am I eligible for FMLA leave?

To be eligible for FMLA benefits, an employee must:

- work for a covered employer;
- have worked for the employer for a total of 12 months;
- have worked at least 1,250 hours over the previous 12 months; and
- work at a location in the United States or in any territory or possession of the United States where at least 50 employees are employed by the employer within 75 miles

Is my employer covered by FMLA?

FMLA applies to all:

- public agencies, including state, local and federal employers, local education agencies (schools), and
- private-sector employers who employed 50 or more employees in 20 or more workweeks in the current or preceding calendar year and who are engaged in commerce or in any industry or activity affecting commerce — including joint employers and successors of covered employers
What are valid reasons for leave?

A covered employer must grant an eligible employee up to a total of 12 workweeks of unpaid leave during any 12 month period for one or more of the following reasons:

☑ for the birth and care of the newborn child of the employee;

☑ for placement with the employee of a son or daughter for adoption or foster care;

☑ to care for an immediate family member (spouse, child, or parent) with a serious health condition; or

☑ to take medical leave when the employee is unable to work because of a serious health condition.

What is a “Serious Health Condition?”

“Serious health condition” means an illness, injury, impairment, or physical or mental condition that involves either:

☑ any period of incapacity or treatment connected with inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical-care facility, and any period of incapacity or subsequent treatment in connection with such inpatient care; or
Continuing treatment by a health care provider which includes any period of incapacity (i.e., inability to work, attend school or perform other regular daily activities) due to:

(1) A health condition (including treatment therefore, or recovery there from) lasting more than three consecutive days, and any subsequent treatment or period of incapacity relating to the same condition, that also includes:

- treatment two or more times by or under the supervision of a health care provider; or
- one treatment by a health care provider with a continuing regimen of treatment; or

(2) Pregnancy or prenatal care. A visit to the health care provider is not necessary for each absence; or

(3) A chronic serious health condition that continues over an extended period of time, requires periodic visits to a health care provider, and may involve occasional episodes of incapacity (e.g., asthma, diabetes). A visit to a health care provider is not necessary for each absence; or

(4) A permanent or long-term condition for which treatment may not be effective (e.g., Alzheimer’s, a severe stroke, terminal cancer). Only supervision by a health care provider is required, rather than active treatment; or

(5) Any absences to receive multiple treatments for restorative surgery or for a condition which would likely result in a period of incapacity of more than three days if not treated (e.g., chemotherapy or radiation treatments for cancer)
“Health care provider” means:

- doctors of medicine or osteopathy authorized to practice medicine or surgery by the state in which the doctors practice; or

- podiatrists, dentists, clinical psychologists, optometrists and chiropractors (limited to manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist) authorized to practice, and performing within the scope of their practice, under state law; or

- nurse practitioners, nurse-midwives and clinical social workers authorized to practice, and performing within the scope of their practice, as defined under state law; or

- Christian Science practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts; or

- Any health care provider recognized by the employer or the employer’s group health plan benefits manager.

What if my spouse and I work for the same employer? Are we entitled to 12 weeks of leave each?

No. Spouses employed by the same employer are jointly entitled to a combined total of 12 work weeks of family leave for the birth and care of the newborn child, for placement of a child for adoption or foster care, and to care for a parent who has a serious health condition.
If I gave birth, adopted or was granted foster care of a child two years ago, am I still eligible for leave under FMLA?

**No.** Leave for birth and care, or placement for adoption or foster care must conclude within 12 months of the birth or placement.

Must I take the entire 12 weeks of leave at one time?

**No.** Under some circumstances, employees may take FMLA leave intermittently — which means taking leave in blocks of time, or by reducing their normal weekly or daily work schedule.

If FMLA leave is for birth and care or placement for adoption or foster care, use of intermittent leave is subject to the employer’s approval.

FMLA leave may be taken intermittently whenever **medically necessary** to care for a seriously ill family member, or because the employee is seriously ill and unable to work.

May accrued paid leave be used to cover some or all of the FMLA leave?

**Yes.** Substitution of paid accrued vacation, personal, or medical/sick leave may be made for any (otherwise) unpaid FMLA leave needed to care for a family member or the employee’s own serious health condition. Substitution of paid sick/medical leave may be elected to the extent the circumstances meet the employer’s usual requirements for the use of sick/medical leave. An employer is not required to allow substitution of paid sick or medical leave for unpaid FMLA leave “in any situation” where the employer’s uniform policy would not normally allow such paid leave.
An employee, therefore, has a right to substitute paid medical/sick leave to care for a seriously ill family member only if the employer’s leave plan allows paid leave to be used for that purpose. Similarly, an employee does not have a right to substitute paid medical/sick leave for a serious health condition that is not covered by the employer’s leave plan.

When on FMLA leave, do I get to keep my health benefits?

A covered employer is required to maintain group health insurance coverage for an employee on FMLA leave whenever such insurance was provided before the leave was taken and on the same terms as if the employee had continued to work. If applicable, arrangements will need to be made for employees to pay their share of health insurance premiums while on leave.

In some instances, the employer may recover premiums it paid to maintain health coverage for an employee who fails to return to work from FMLA leave.

What happens when I return to work?

Upon return from FMLA leave, an employee must be restored to the employee’s original job, or to an equivalent job with equivalent pay, benefits, and other terms and conditions of employment.

In addition, an employee’s use of FMLA leave cannot result in the loss of any employment benefit that the employee earned or was entitled to before using FMLA leave, nor be counted against the employee under a “no fault” attendance policy.

Under specified and limited circumstances where restoration to employment will cause substantial and grievous economic injury to its operations, an employer may refuse to reinstate
certain highly-paid “key” employees after using FMLA leave during which health coverage was maintained. In order to do so, the employer must:

- notify the employee of his/her status as a “key” employee in response to the employee’s notice of intent to take FMLA leave;
- notify the employee as soon as the employer decides it will deny job restoration, and explain the reasons for this decision;
- offer the employee a reasonable opportunity to return to work from FMLA leave after giving this notice; and
- make a final determination as to whether reinstatement will be denied at the end of the leave period if the employee then requests restoration.

A “key” employee is a salaried “eligible” employee who is among the highest paid ten percent of employees within 75 miles of the work site.

How much notice do I need to give my employer if I wish to utilize FMLA leave?

Employees seeking to use FMLA leave are required to provide 30-day advance notice of the need to take FMLA leave when the need is foreseeable and such notice is practicable.

Employers may also require employees to provide:

- medical certification supporting the need for leave due to a serious health condition affecting the employee or an immediate family member;
- second or third medical opinions (at the employer’s expense) and periodic recertification; and
- periodic reports during FMLA leave regarding the employee’s status and intent to return to work.
When intermittent leave is needed to care for an immediate family member or the employee’s own illness, and is for planned medical treatment, the employee must try to schedule treatment so as not to unduly disrupt the employer’s operation.

Covered employers must post a notice approved by the Secretary of Labor explaining rights and responsibilities under FMLA. An employer that willfully violates this posting requirement may be subject to a fine of up to $100 for each separate offense.

Also, covered employers must inform employees of their rights and responsibilities under FMLA, including giving specific written information on what is required of the employee and what might happen in certain circumstances, such as if the employee fails to return to work after FMLA leave.

What should I do if I feel my rights have been violated?

It is unlawful for any employer to interfere with, restrain, or deny the exercise of any right provided by FMLA. It is also unlawful for an employer to discharge or discriminate against any individual for opposing any practice, or because of involvement in any proceeding, related to FMLA.

The Wage and Hour Division investigates complaints. If violations cannot be satisfactorily resolved, the U.S. Department of Labor may bring action in court to compel compliance. Individuals may also bring a private civil action against an employer for violations.
Individuals who wish to file a complaint under FMLA will need to contact their local Wage & Hour Division of the U.S. Department of Labor. If a complainant is uncertain which office to contact, he or she can call (202) 219-8412 or (800) 326-2577 (TTY) for further information on where to file or check the local telephone directory under the United States Government listings.

For Further Information Regarding the Family & Medical Leave Act (FMLA):

**U.S. Department of Labor**
Wage & Hour Division
200 Constitution Ave., N.W.
Washington, DC 20210
(202) 219-8412
(800) 326-2577 (TTY) (Not Wage & Hour but number is to be used for all TTY Department of Labor calls)

**Job Accommodation Network**
A Service of the President’s Committee on Employment of People with Disabilities
918 Chestnut Ridge Road
Suite 1
P.O. Box 6080
Morgantown, WV 26506-6080
(800) 526-7234 (V/TTY) (800) ADA-WORK (V/TTY)
Web: http://janweb.icdi.wvu.edu
E-mail: jan@jan.icdi.wvu.edu
Bulletin Board: (800) DIAL JAN
Endnotes

U.S. Department of Labor
www.dol.gov
Where to Turn...

Special Education

Brain Injury Association

105 North Alfred Street . Alexandria, VA 22314
Family Helpline: 1-800-444-6443 . (703) 236-6000
www.biausa.org
Special Education

I think my child may need special help in school. What can I do?

Under the Individuals with Disabilities Education Act (IDEA), there is much you can do for your child. IDEA gives eligible children with disabilities the right to receive special services and assistance in school. These services are known as “special education” and “related services.”

What is special education?

Special education can be defined as instruction that is designed specially, at no cost to you as parents, to meet your child’s unique needs. Specially designed instruction means adapting the content, methodology or delivery to:

☑ Address the unique needs of your child that result from his or her disability, and

☑ Ensure your child’s access to the general curriculum so that he or she can meet the educational standards that apply to all children within the jurisdiction of the public agency

Related services may include:

☑ Speech-language pathology and audiology
☑ Psychological services
☑ Physical and occupational therapy
☑ Therapeutic recreation
☑ Mobility services

Special education can include instruction conducted in the classroom, the home, hospitals and institutions, and other settings. It can include instruction in physical education as well. Speech-language therapy, or any other
related service, can be considered special education rather than a related service under state standards if the instruction is specially designed, at no cost to the parents, to meet the unique needs of a child with a disability. Travel training and vocation education also can be considered special education if these standards are met.

Is my child eligible?

Under the IDEA, a “child with a disability” is eligible for special education and related services. This law lists 13 different disability categories under which a child may be found eligible for special education and related services.

According to the IDEA, your child must have a recognized disability, and the disability must affect the child’s educational performance in order to qualify for special education and related services.

For children ages 3 through 9, a “child with a disability” may include, at the discretion of the state and the local education agency (lea) and subject to certain conditions (enumerated at §300.313), a child who is experiencing developmental delays, as defined by the state and measured by appropriate diagnostic instruments and procedures, in one or more of the following areas:

- Physical development;
- Cognitive development;
- Communication development;
- and other conditions specified in the law.
Social or emotional development; or

Adaptive development; and

Who needs, for that reason, special education and related services.[§300.7(b)]

What is my first step for obtaining special education services for my child?

The first step is to **find out if your child has a disability**. To do this, ask the school to evaluate your child. Call or write the director of special education or the principal of your child’s school. Say that you think your child has a disability and needs special education help. Ask the school to evaluate your child as soon as possible. If the school agrees to evaluate your child, then the evaluation is at no cost to you.

The ways your child may be selected to receive an evaluation:

- You may request that your child be evaluated.
- Your child's school may ask to evaluate your child.

If your school refuses to evaluate your child, there are two things you can do immediately:

- Ask the school system for information about its special education policies, including information about appeal procedures.
- Get in touch with your state’s Parent Training and Information (PTI) center. Contact National Information Center for Children and Youth with Disabilities (NICHCY) for more information.
I asked the personnel at my child’s school for an evaluation for my child, and they refused. What can I do?

The school has no obligation to provide your child with an evaluation upon demand. The school may not think your child has a disability or needs special education. If this is the case, the school has an obligation to inform you of its decision in writing, setting forth the reasons for the denial of the evaluation.

Once you have received indication that your child’s school has refused your request to evaluate him or her, make sure that you determine what the school system’s policies are regarding its special education program. Specifically, ask for information on appealing an evaluation denial. Once you have determined the school system’s protocol, be sure to follow each step and provide all required documentation. You are your child’s best advocate and without your constant determination and effort, it is not a “given” that your child will receive the special education resources to which he or she is entitled.

<table>
<thead>
<tr>
<th>Four Evaluation &quot;Musts&quot;</th>
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<tbody>
<tr>
<td><strong>Using the native language:</strong> The evaluation must be conducted in your child's native language or other means of communication, including sign language, unless it is clearly not possible to do so.</td>
</tr>
<tr>
<td><strong>No discrimination:</strong> Tests must be given in a way that does not discriminate against your child because he or she has a disability or is from a different racial or cultural background.</td>
</tr>
<tr>
<td><strong>Trained Evaluators:</strong> The people who test your child must know how to give the tests they decide to use. They must give each test according to the instructions that came with the test.</td>
</tr>
<tr>
<td><strong>More than one procedure:</strong> Evaluation results will be used to decide if your child is a &quot;child with a disability&quot; and help determine what kind of educational program your child needs. These decisions cannot be made based on a single procedure, such as just one test.</td>
</tr>
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</table>

What happens during an evaluation?

Once you have been notified in writing by the school that it has agreed to evaluate your child, the school will assemble an evaluation team. This group of people, including you, will evaluate your child. They will begin by looking at your child’s school file and recent test scores. You and your child’s teacher may provide information to be included in this review.
Before the school can conduct any testing on your child, you must give your permission. Additionally, the school must describe the tests it will use with your child and the other ways information about your child will be collected. Only after receiving your informed written consent may the school begin the evaluation process.

Tests are an important part of the evaluation process, but they are only a piece. The evaluation also should include:

- The observations and opinions of professionals who have worked with your child;
- Your child’s medical history, when it is relevant to his or her performance in school; and
- Your ideas about your child’s experience abilities, needs and behavior in school and outside of school, and his or her feelings about school.

Professionals will observe your child. In order to capture a picture of the “whole child,” they will want to know more about:

- How well your child speaks and understands language
- How your child thinks and behaves
- How well your child adapts to change
- What your child has achieved in school
- What your child’s potential or aptitude (intelligence) is
- How well your child functions in areas such as movement, thinking, learning, seeing and hearing
- What job-related and other post-school interests and abilities your child has.
So my child has been found eligible for special education. What next?

Based on your child’s evaluation results, a group of people will decide if your child is eligible for special education and related services. Under the IDEA, you have the right to be part of any group that decides your child’s eligibility for special education and related services.

If your child is found eligible for special education and related services, the next step is to write an individualized education program (IEP) for your child. This is a written document that you and school personnel develop together. The IEP will describe your child’s educational program, including the special services your child will receive.

The IEP has two general purposes:

1. To set reasonable learning goals for your child; and

2. To specify the services that the school district will provide for your child.

It is very important that children with disabilities participate in the general curriculum as much as possible. They should have the same curriculum as children without disabilities, including, for example, reading, math, science, social studies and physical education. In some cases, this curriculum may need to be adapted for your child to learn, but it should not be omitted altogether. Participation in extracurricular activities and other nonacademic activities also is important. Your child’s IEP needs to be written with this in mind.
Who develops my child’s IEP?

Many people come together to develop your child’s IEP. This group is called the IEP team and includes most of the same categories of people that were involved in your child’s evaluation. Team members will include:

- You, the parents
- At least one regular education teacher, if your child is participating in the regular education environment
- At least one of your child’s special education teachers or special education providers
- A representative of the public agency (school system) who (a) is qualified to provide or supervise the provision of special education, (b) knows about the general curriculum; and (c) knows about the resources the school system has available
- An individual who can interpret the evaluation results and talk about what instruction may be necessary for your child
- Your child, when appropriate
- Representatives from any other agencies that may be responsible for paying for or providing transition services (if your child is 16 years or, if appropriate, younger)
- Other individuals (invited by you or the school) who have knowledge or special expertise about your child. For example, you may wish to invite a relative who is close to the child or a childcare provider.
What information is in your child’s IEP?

Your child’s IEP will contain the following statements:

- **Present levels of educational performance.** This statement describes how your child currently is doing in school. This includes how your child’s disability affects his or her involvement and progress in the general curriculum.

- **Annual goals.** The IEP must state annual goals for your child, meaning what you and the school team think he or she can accomplish reasonably in a year. This statement of annual goals includes individual steps that make up the goals (often called short-term objectives) or major milestones (often called benchmarks). The goals must relate to meeting the needs that result from your child’s disability. They also must help your son or daughter be involved in, and progress in, the general curriculum.

- **Special education and related services to be provided.** The IEP must list the special education and related services to be provided to your child. This includes supplementary aids and services (such as a communication device). It also includes changes to the program or supports for school personnel that will be provided for your child.

- **Participation with children without disabilities.** How much of the school day will your child be educated separately from children without disabilities or not participate in extracurricular or other nonacademic activities, such as lunch or clubs? The IEP must include an explanation that answers this question.
Participation in state and district-wide assessments. Your state and district probably give Tests of student achievement to children in certain grades or age groups. In order to participate in these tests, your child may need individual modifications or changes in how the tests are administered. The IEP team must decide what modifications your child needs and list them in the IEP. If your child will not be taking these tests, the IEP must include a statement as to why the tests are not appropriate for your child and how your child will be tested instead.

Dates and location. The IEP must state (a) when services and modifications will begin; (b) how often they will be provided; (c) where they will be provided; and (d) how long they will last.

Transition service needs. If your child is age 14 (or younger, if the IEP team determines it appropriate), the IEP must include a statement of his or her transition service needs. Transition planning will help your child move through school from grade to grade.

Transition services. If your child is age 16 (or younger, if determined appropriate by the IEP team), the IEP must include a statement of needed transition services and, if appropriate, a statement of the interagency responsibilities or any needed linkages.

Measuring progress. The IEP must state how school personnel will measure your child’s progress toward the annual goals. It also must state how you, as parents, will be informed regularly of your child’s progress and whether that progress is enough to enable your child to achieve his or her goals by the end of the year.
Can my child’s IEP be changed?

**Yes.** At least once a year a meeting must be scheduled with you to review your child’s progress and develop your child’s next IEP. This annual IEP meeting allows you and the school to review your child’s educational program and change it as necessary. But you don’t have to wait for this annual review. You may ask to have your child’s IEP reviewed or revised at any time.

Will my child be re-evaluated?

**Yes.** Under the IDEA, your child must be re-evaluated at least every three years. The purpose of this re-evaluation is to find out: (1) if your child continues to be a “child with a disability,” as defined within the law and (2) your child’s educational needs.

Although the law requires that children with disabilities be re-evaluated at least every three years, your child may be re-evaluated more often if you or your child’s teacher(s) request it.

What if I disagree with the school about what is right for my child?

If you disagree with the school’s decisions concerning your child, the idea affords you several protections. The law and regulations include ways for the parents and school to resolve disagreements. These include:

- **Mediation** — you and school personnel sit down with an impartial third person (called a mediator), talk openly about the areas where you disagree and try to reach agreement.
Due process — you and the school present evidence before an impartial third person (called a hearing officer), and he or she decides how to resolve the problem.

Filing a complaint with the state education agency (SEA) — you write directly to the SEA and describe what requirement of IDEA the school has violated. The SEA either must resolve your complaint itself or it may have a system in which complaints are filed with the school district and parents can have the district’s decision reviewed by the SEA. In most cases, the SEA must resolve your complaint within 60 calendar days.

What do I do if I want to put my child in a private school?

Parents always may remove their child from the public school and enroll him or her in a private school at their own expense. The law does not require an IEA to pay for the cost of education, including special education and related services, of a child at a private school or facility if that agency made a free and appropriate public education available to the child and the parents chose to place the child in the private school or facility. Disagreements between parents and a public agency regarding the availability of a program appropriate for the child may arise.

If, as parents, you decide to place your child in a private school and you want the public agency to pay for the cost, certain provisions of the law apply. If you enroll your child in a private preschool, elementary or secondary school on referral by the state agency, a court or hearing officer may require the agency to reimburse you for the cost of that enrollment if the court or
hearing officer finds: (a) that the public agency had not made a free and appropriate education available to your child in a timely manner prior to the private school enrollment, and (b) that the private placement is appropriate.

Another important provision is that the cost of this reimbursement may be reduced or denied for a number of reasons, including if:

- At the most recent IEP meeting that you attended prior to removing your child from the public school, you did not inform the IEP team that you were rejecting the placement proposed by the public agency, including stating your concerns and your intent to enroll your child in a private school at public expense

- At least 10 business days (including any holidays that occur on a business day) prior to removing your child from the public school, you did not give written notice to the public agency of the information described above

- If, prior to your removal of your child from the public school, the agency informed you of its intent to evaluate your child, but you did not make your child available for the evaluation

- Upon a judicial finding of unreasonableness with respect to actions taken by you, as parents

There are exceptions to these provisions. The cost of reimbursement may not be reduced or denied for failure to provide notice above if any of the following apply:

- You are illiterate and cannot write in English

- Providing the notice as required by law would result in likely physical or serious emotional harm to your child
The school prevented you from providing the notice

You had not received notice that you were required to provide the public agency with notification of your intentions, as described above
Resources

National Information Center for Children and Youth with Disabilities (NICHCY)
P.O. Box 1492
Washington, DC 20013-1492
1-800-695-0285 (Voice/TTY)
(202) 884-8200 (Voice/TTY)
www.nichcy.org

Families & Advocates Partnership for Education Pacer Center, Inc.
4826 Chicago Avenue South
Minneapolis, MN 55417-1098
888-248-0822 or 612-827-2966 Phone
612-827-7770 TTY
612-827-3065 Fax
fape@pacer.org E-mail
www.fape.org

Office of Special Education Programs (OSEP)
600 Independence Avenue, SW
MES-2722
Washington, DC 20202
(202) 205-5507 Phone
(202) 205-9179 Fax
www.ed.gov/offices/OSERS/OSEP/index.html

CADRE, The Consortium for Appropriate Dispute Resolution in Special Education
Dispute Resolution in Special Education 3875 Kincaid Street #18
Eugene, OR 97405-4599
(541) 686-5060 Phone
(541) 686-5063 TTY
(541) 686-5063 Fax
www.directionservice.org/cadre
Academy for Educational Development (AED)
1875 Connecticut Ave., NW, Suite 900
Washington, DC 20009
(202) 884-8215 Phone
(800) 695-0285 TTY
(202) 884-8443 Fax
frc@aed.org E-mail
www.dssc.org/frc

ERIC - Clearinghouse on Disabilities and Gifted Education (ERIC/EC)  Council for Exceptional Children (CEC)
1920 Association Drive
Reston, VA 20191-1589
(800) 328-0272 Phone
(703) 264-9449 TTY
ericec@cec.sped.org E-mail
ericec.org

National Association of State Directors of Special Education (NASDSE)  1800 Diagonal Road
Suite 320
Alexandria, VA 22314
(703) 519-3800 Phone
(703) 519-7008 TTY
(703) 519-3808 Fax
nasdse@nasdse.org E-mail
www.nasdse.org

Office of Special Education and Rehabilitative Services (OSERS)
Switzer Building
Room 3006
Washington, DC 20202-2500
(202) 205-5465 Phone
(202) 205-5465 TTY
(202) 205-9252 Fax
www.ed.gov/offices/OSERS/
Endnotes:

National Information Center for Children and Youth with Disabilities
www.nichcy.org

U.S. Department of Education
www.ed.gov
Where to Turn...

Assistive Technology

Brain Injury Association

U.S. Department of Health and Human Services
Health Resources and Services Administration
Maternal and Child Health Bureau

105 North Alfred Street . Alexandria, VA 22314
Family Helpline: 1-800-444-6443 . (703) 236-6000
www.biausa.org
What is Assistive Technology?

The term “assistive technology” refers to a range of mechanical aids that substitute for or enhance the function of a physical or mental ability that is impaired. Assistive technology can be anything homemade, purchased off the shelf, modified or commercially available that is used to help an individual perform some task of daily living. The term assistive technology encompasses a broad range of devices from “low tech” (e.g., pencil grips, splints, paper stabilizers) to “high tech” (e.g., computers, voice synthesizers, braille readers). These devices include the entire range of supportive tools and equipment, from adapted spoons to wheelchairs and computer systems for environmental control.

Perhaps the most comprehensive approach to assistive technology can be found in the Individuals with Disabilities Education Act (IDEA), the federal special education law. IDEA provides the following legal definition of an assistive technology device: “any item, piece of equipment, or product system... that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.” Under IDEA, assistive technology devices can be used in the educational setting to provide a variety of accommodations or adaptations for people with disabilities.

IDEA also lists the services a school district may need to provide in order to ensure that assistive technology is useful to a student in the school setting. The law defines assistive technology service as: “any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device.” This service includes all of the following possibilities:

- **Evaluation** of the technology needs of the individual, including a functional evaluation in the individual’s customary environment
- **Purchasing**, leasing or otherwise providing for the acquisition of assistive technology devices for individuals with disabilities
Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing of assistive technology devices.

Coordinating and using other therapies, interventions or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs.

Assistive technology training or technical assistance with assistive technology for an individual with a disability, or, where appropriate, the family of an individual with disabilities.

Training or technical assistance for professionals, employers or other individuals who provide services to, employ, or otherwise are involved substantially in the major life functions of individuals with disabilities.

The intention of the special education law is that if a student with disabilities needs technology in order to be able to learn, the school district will (a) evaluate the student’s technology needs; (b) acquire the necessary technology; (c) coordinate technology use with other therapies and interventions; and (d) provide training for the individual, the individual’s family and the school staff in the effective use of the technology.

During the time that people with disabilities are in school, they can have the opportunity to learn to use technology at the same time that they are learning academic subjects and social skills. The efficient and effective use of assistive technology can be as basic a skill as reading, writing and arithmetic, since the use of technology can go a long way toward circumventing the limitations of disability and providing people with disabilities with a “level playing field” in every area of life accomplishment.
What is an accommodation?

Accommodations are reasonable modifications that are made to compensate for skills or abilities that an individual lacks. For example, if a person does not digest spicy foods well, we might accommodate this individual by adjusting his or her diet so that the person eats only bland foods.

When the word accommodation is used in connection with disability issues, it refers to a way of modifying a task or assignment so that a person with a disability can participate despite the challenges the disability may pose. For example, when a student who is unable to remember math facts is allowed to do math problems with a calculator, the use of the calculator is an accommodation that allows the student to work around his or her disability. With an accommodation, the student still can perform math problems, but he or she does so using a different method.

In the school setting, sometimes it is necessary to make accommodations for individuals with disabilities in order to compensate for skills or abilities they do not have. For example, for some people with learning disabilities, spelling words correctly may be a skill they never acquire, or never acquire with a degree of fluency that will do them any good in written expression. To compensate for this inability to spell, such people may be encouraged to use alternative methods for spelling, like a spell-check software program for the computer or a hand-held spelling device.
What is an adaptation? How does adaptation differ from accommodation?

Adaptation means developing unique devices or methods designed specifically to assist persons with disabilities with performing daily tasks. An adaptation is something specially designed that is not used normally by other people. An accommodation, on the other hand, is simply a change in routine, method or approach that may be used by people with or without disabilities. Examples of adaptations include special grips to turn stove knobs or specially designed keyboards to operate computers.

What are common types of assistive technology?

Assistive technology refers to a number of types of accommodations and adaptations that enable individuals with disabilities to function more independently. Computers are an important type of assistive technology, because they open up so many exciting possibilities for writing, speaking, finding information or controlling an individual’s environment. But computers are not the only avenues to solving problems through technology. There are many low tech (and low cost) solutions for problems that disabilities pose. Examples of inexpensive, low tech solutions include wrist splints, clipboards for holding papers steady or velcro tabs to keep positioning pads in place.
The following is a list of common assistive technology applications:

**Positioning:** In the classroom or at work, individuals with physical disabilities may need assistance with their seating positions so that they can participate effectively in the work or school environment. Generally, therapists try to achieve an upright, forward facing position by using padding, structured chairs, straps or supports to hold the body in a stable and comfortable manner. The person’s position in relation to others also is considered. It is necessary to design positioning systems for a variety of settings so that the person can participate in multiple activities. Examples of equipment used for positioning are side lying frames, walkers, crawling assists, floor sitters, chair inserts, wheelchairs, straps, trays, standing aids, bean bag chairs and sand bags.

**Access:** In order to accomplish tasks, some people require special devices that provide access to computers or environmental controls. The first step in providing access is to determine which body parts can be used to indicate the person’s intentions. Controllable, anatomical sites like eye blinks, as well as head, neck or mouth movements may be used to operate equipment that provides access to a computer. Once a controllable, anatomical site has been determined, decisions can be made about input devices, selection techniques (direct, scanning), and acceleration strategies (coding, prediction). Input devices include such things as switches, alternative keyboards, alternative mice, trackballs, touch windows, speech...
recognition software and head pointers. Once computer access has been established, it should be coordinated with other systems that the person is using, including powered mobility, communication or listening devices and environmental control systems.

Access also can refer to the physical entrances and exits of buildings or facilities. This kind of assistive technology includes modifications to buildings, rooms and other facilities that let people with physical impairments use ramps and door openers to enter; allow people with visual disabilities to follow braille directions and move more freely within a facility and assist people of short stature or people who use wheelchairs to reach pay phones or operate elevators. Access to shopping centers, places of business, schools, recreation and transportation is possible because of assistive technology modifications.

**Environmental Control:**

Independent use of equipment can be achieved for people with physical disabilities through various types of environmental controls, including remote control switches and special adaptations of on/off switches to make them accessible (e.g., velcro attachments, pointer sticks). Robotic arms and other environmental control systems turn lights on and off, open doors and operate appliances. Location and orientation systems give people with vision impairments information about where they are, what the ground nearby is like and whether or not there is a curb close by.
### Augmentative Communication:

Everyone needs a method of communication in order to interact with others and learn from social contact. People who are nonverbal, or whose speech is not fluent or understandable enough to communicate effectively, may benefit from using communication devices. Communication devices include symbol systems, communication boards and wallets, programmable switches, electronic communication devices, speech synthesizers, recorded speech devices, communication enhancement software and voiced word processing.

<table>
<thead>
<tr>
<th>Input</th>
<th>Processing</th>
<th>Output</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternate keyboards</td>
<td>Abbreviation/expansion and macro programs</td>
<td>Braille displays and embossers</td>
</tr>
<tr>
<td>Interface devices</td>
<td>Access utilities</td>
<td>Monitor additions</td>
</tr>
<tr>
<td>Joysticks</td>
<td>Menu management programs</td>
<td>Screen enlargement programs</td>
</tr>
<tr>
<td>Keyboard modifications</td>
<td>Reading comprehension programs</td>
<td>Screen readers</td>
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<tr>
<td>Keyboard additions</td>
<td>Writing composition programs</td>
<td>Speech synthesizers</td>
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<tr>
<td>Optical pointing devices</td>
<td>Writing enhancement tools (i.e., grammar checkers)</td>
<td>Talking and large print word processors</td>
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<td>Pointing and typing aids</td>
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<td>Switches with scanning</td>
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<td>Scanners &amp; optical character recognition</td>
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<td>Voice recognition</td>
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Assistive Listening: Much of the time in school and at work, people are expected to learn and process information through listening. People who have hearing impairments or auditory processing problems can be at a disadvantage unless they learn to use the hearing they have, or develop alternative means for getting information. Hearing problems may be progressive, permanent or intermittent. Any of these impairments may interfere significantly with learning to speak, read and follow directions. Assistive devices to help with hearing and auditory processing problems include hearing aids, personal FM units, sound field FM systems, Phonic Ear, TDDs or closed caption TV.

Visual Aids: Vision also is a major learning and processing mode. General methods for assisting with vision problems include increasing contrast, enlarging stimuli and making use of tactile and auditory models. Devices that assist with vision include screen readers, screen enlargers, magnifiers, large-type books, taped books, Braillers, light boxes, high contrast materials, thermoform graphics, synthesizers and scanners.

Mobility: Individuals whose physical impairments limit their mobility may need any of a number of devices to help them get around and participate in activities. Mobility devices include such things as self-propelled walkers, manual or powered wheelchairs and powered recreational vehicles like bikes and scooters.
Computer-Based Instruction: Computer-based instruction can facilitate independent participation in activities related to school or training curricula. Software can be selected which mirrors the conceptual framework of the regular curriculum but offers an alternative way of responding to exercises and learning activities. Software can provide the tools for written expression, spelling, calculation, reading, basic reasoning and higher level thinking skills. The computer also can be used to access a wide variety of databases.

Social Interaction: People with disabilities want to have fun and interact socially. Assistive technology can help them participate in recreational activities. Adapted recreational activities include drawing software, computer games, computer simulations, painting with a head or mouth wand, interactive laser disks and adapted puzzles.

Self Care: Some people require assistance with self care activities like feeding, dressing and toileting. Assistive devices that help with self care include robotics, electric feeders, adapted utensils, specially designed toilet seats and aids for tooth brushing, washing, dressing and grooming.
Who are the people who might use assistive technology?

People who require assistive technology are those with mental or physical limitations that interfere with learning or other life functions. The technology helps the person overcome or compensate for the limitation and be more independent in participating at school, at work or in the community. People who benefit from assistive technology may have mild learning problems like learning disabilities, or they may have physical or cognitive disabilities that range from mild to severe. Assistive technology is not necessary or helpful for every person who experiences disability, but it is an important part of a support system for many people with identified disabilities.

Isn’t assistive technology appropriate only for people with more severe disabilities?

Assistive technology is simply a set of tools that can be used to compensate for some deficit that a person may have. For individuals with severe mental or physical disabilities, the technological solutions can help to solve multiple and complex problems. But individuals with less involved problems also can benefit from assistive technology. For example, individuals with learning disabilities who have difficulty with reading or writing can benefit from using the word processing and voiced reading capabilities of computers.

Isn’t assistive technology just a crutch? Won’t people become too dependent on technology and not learn to use the skills they have?

Assistive technology should be used as support for access, as well as learning and performing daily tasks. In general, assistive technology is appropriate when it compensates for disabilities so that the individual can function as normally as possible. If assistive technology is necessary for a person to have access to work opportunities or benefit from education or training, it is not a “crutch,” but a legitimate support.
Some skills are too laborious or taxing to accomplish at a rate or degree of proficiency to allow for participation in the least restrictive environment. With assistive technology, the person can participate more fully in all aspects of life.

The use of assistive technology enhances function and increases skills and opportunities. Though a person may depend on a particular device in order to perform skillfully, denying the device denies him or her an opportunity ever to achieve success at the level of his or her potential.

When is using assistive technology appropriate?

Assistive technology may be considered appropriate when it does any or all of the following things:

- Enables an individual to perform functions that can be achieved by no other means
- Enables an individual to approximate normal fluency, rate or standards—a level of accomplishment that could not be achieved by any other means
- Provides access for participation in programs or activities which otherwise would be closed to the individual
- Increases endurance or ability to persevere and complete tasks that otherwise would be too laborious to be attempted on a routine basis
- Enables an individual to concentrate on learning or employment tasks, rather than mechanical tasks
- Provides greater access to information
- Supports normal social interactions with peers and adults
- Supports participation in the least restrictive environment
Are schools required to pay for assistive technology devices and services for students who need them?

The party who is responsible for paying for assistive technology depends on the circumstances under which the technology is purchased. Under special education law, students with disabilities who are eligible for special education are entitled to a free appropriate public education. Parents do not have to pay for school services, including assistive technology, if that service is part of the student’s Individualized Education Program (IEP). If the student is eligible for Medicaid, the school district can request that Medicaid pay for the device. If parents choose to do so, they may agree to use private insurance to pay for a device that is used at school. Parents cannot, however, be forced to use their insurance in this way. If the private insurance requires a co-payment, the school district is required to pay this amount since parents should not have to pay any special education related costs.

Does Section 504 pay for assistive technology?

Section 504, part of the Rehabilitation Act of 1973, is a piece of civil rights legislation that is intended to prevent discrimination against individuals with disabilities in any program which receives federal funding. People who have disabilities may be eligible for accommodations under Section 504 of the Rehabilitation Act of 1973. Section 504, however, does not provide any funds for accommodations.
Like the special education law, Section 504 requires public schools to provide people with disabilities a free appropriate public education and ensures that people with disabilities are afforded an equal opportunity to participate in school programs. For people with disabilities, this means that schools may need to make special arrangements so that the students have access to the full range of programs and activities offered. For example, a student who needs a wheelchair lift on a school bus to get to school must be provided with this technology. Other modifications which might be required under Section 504 include installing ramps into buildings and modifying bathrooms to provide access for individuals with physical disabilities. Even though required by the law, none of these types of modifications are funded by Section 504.

Under what circumstances does private health insurance pay for assistive technology?

Some private health insurance policies will pay all or part of the cost for some assistive technology devices. The devices are unlikely to be listed specifically in the policy, but may be included under some generic term like “therapeutic aids.” The devices have to be prescribed by a physician in order to be covered by the policy.

When does Medicaid cover assistive technology?

Medicaid (Title XIX) will pay for “prosthetic devices”; that is, replacement, corrective or supportive devices prescribed by a physician or other licensed person. Each state has some flexibility in determining which prosthetic devices it will include in its list of Medicaid covered expenses. Devices that are frequently covered by Medicaid are canes, crutches, walkers, manual wheelchairs and hospital beds. Hearing aids or eyeglasses often are covered for children and youth only.
Where can I find funding for assistive technology?

Funding for assistive technology is available from a variety of public and private sources. To receive public or private funding, a person must meet eligibility criteria for the specific program and provide sufficient documentation of the need for assistive technology.

The following list includes some of the programs that may pay for equipment if the individual needing the device meets their requirements. Many of these programs are run by different agencies in different states, making them hard to find. In general, the state’s Tech Act office can assist consumers and family members in finding and using these programs. (See the Technology-Related Assistance for Individuals with Disabilities Act of 1988.)
Public Programs

Early Intervention Programs (Individuals with Disabilities Education Act, Part H)

Young children (ages 0-3) and their families may receive help through early intervention programs in evaluating what the child needs, in getting assistive technology and learning how to use it. Equipment and services must be included in a written plan, called an Individualized Family Service Plan (IFSP). To find the program for a particular state, call the National Early Childhood Technical Assistance System (NEC*TAS) at 919-962-2001 or 919-966-4041 (TDD).

Head Start

This child development program provides comprehensive educational and health services for eligible children ages 3-5. Since 1982, federal law has required that at least 10 percent of the total number of placements must be available to children who have disabilities and require special services. Head Start is a mainstream placement option for children whose IEP calls for placement with children who do not have disabilities. The January 1993 Head Start regulations specifically require the consideration of assistive technology services and devices. For more information, contact National Head Start Association, 201 N. Union St., Suite 320, Alexandria, VA 22314; 703-739-0875.
Schools (IDEA, Part B)

This program mandates a free, appropriate public education for preschoolers, children and youth with disabilities. An Individualized Education Program (IEP) is required for all children with a disability. These children are entitled to special education, related services or supplementary aids. If the IEP team determines that assistive technology is required for a free, appropriate public education, then it must be provided at no cost to the child. The technology must be included in the child’s Individualized Education Program (IEP). Parents have a right to be involved and should help to develop the IEP goals which may include technology. For help in including assistive technology in the IEP, call the TAPP Focus Center on Assistive Technology at 1-800-222-7585.

State Operated and Supported Schools (Chapter I)

This program provides federal assistance to help educate children with disabilities who are enrolled in state-operated and state-supported programs. Federal funds must be used to pay for services that supplement a child’s basic special education program, such as construction and the purchase of equipment. For more information, contact your State Department of Education.

Section 504 of the Rehabilitation Act of 1973

Section 504 provides a civil-rights mandate that requires accommodations for people who have disabilities such as orthopedic impairments, but who do not qualify for special education services. It denies federal funds to any institution, including a school, whose practices or policies discriminate against individuals with disabilities. This legislation has resulted in a number of outcomes, including various actions that may incorporate assistive technology to remove physical barriers to education. For more information, contact the nearest regional Office of Civil Rights or your State Vocational Rehabilitation Agency.
State Programs for Children with Special Health Care Needs

These programs provide and pay for services for eligible children. Programs for children with special health care needs (CSHCN) vary widely from state to state in the services offered, the number of children served and the requirements for eligibility. Some CSHCN programs pay for assistive technology devices when no other funding source is available and the equipment is necessary for health-related reasons. Most CSHCN programs are run by the state health agency. To contact CSHCN, get in touch with your state health agency.

School-to-Work Transition Programs

Transition Programs are charged with assisting people with disabilities to receive job-related training and placement services to help them move from school to work. Assistive technology may be necessary in order for a student to make a successful transition and become employable. If technology is needed for transition purposes, it can be written into the student’s Individualized Transition Plan (ITP). To receive more information about transition and technology, call the Parent Training and Information Center (PTI) in your state (See Appendix D).

Vocational Rehabilitation Services

State vocational rehabilitation agencies provide information, evaluation services, training and funding for technology and education to help adults go to work or live more independently. If technology is necessary for an individual to work, Vocational Rehabilitation may pay for the equipment as part of an Individualized Work-Related Plan (IWRP). Call your state’s Vocational Rehabilitation Agency for information.
Plan to Achieve Self-Support (PASS)

One of many Social Security Administration work incentive programs, this program provides an income and resource exclusion that allows a person who is blind or has a disability to set aside income and resources for a work goal such as education, equipment purchase, vocational training or starting a business.

This program provides a mechanism for people to set aside funds to purchase work-related equipment, such as assistive technology devices and services. In many cases, if an individual is a recipient of SSI and writes a PASS to purchase education or equipment, an additional SSI check will be provided to cover other living expenses. Sometimes if a person receives Social Security Disability Insurance (SSDI) and designs a PASS, it may make the individual eligible for SSI because the SSDI has been allocated for equipment and services.

Impairment-Related Work Expense (IRWE)

Impairment-Related Work Expense (IRWE)—one of the Social Security Administration’s work incentive programs—allows an employed individual with a disability who receives or is eligible for SSI or SSDI to deduct work-related expenses from gross reported income.

This deduction allows the person to continue drawing SSDI or SSI and associated benefits (Medicaid or Medicare) if the IRWE deduction reduces earning below the Substantial Gainful Activity (SGA) Test.
Although this method does not provide funding to pay for a device or service, it is a way of allowing the use of the individual’s own money to pay for assistive devices and services necessary to return to work. Possible work-related expenses include special transportation to and from work, personal assistance on the job, structural modifications, durable medical equipment, prostheses, medical supplies and services, work-related equipment, non-medical appliances and equipment, routine drug and medical costs and diagnostic procedure costs.

For more information on Social Security Work Incentives, see Chapter 4

**Medicaid**

Medicaid is a joint federal and state program that covers some equipment if it is considered medically necessary. For more information about Medicaid and who and what is covered, contact your State Medicaid Agency.

For more information on Medicaid, see Chapter 6.

**Medicare**

Although not a usual source of funds for assistive technology, Part B of Medicare provides coverage for some durable medical equipment if it is considered medically necessary and is for use in the person’s home. For more information about Medicare benefits, contact the Social Security Administration Regional Office.

For more information on Medicare, see Chapter 5
Technology-Related Assistance for Individuals with Disabilities Act of 1988 (Tech Act)

This federal competitive grants program provides monies for states to establish a statewide, consumer-responsive service delivery system designed to effect systems change regarding assistive technology. In most Tech Act states, a funding specialist or policy analyst is available to assist with accessing assistive technology. Several states operate loan programs to help with the purchase of devices and services. For more information, contact RESNA Technology Assistance Project, 1700 N. Moore Street, Suite 1540, Arlington, VA 22209-1903; 703-524-6686.
Private Programs

Private Insurance

Some health insurance plans will buy equipment, depending on the specific wording of the policy. Unless the policy says the equipment is not covered, it makes sense to ask the insurance company to pay for it. The equipment must be considered medically necessary and requires a doctor’s prescription.

Loans

There are several low or no interest loans available to help buy technology. Call your state Tech Act program or the manufacturer of the equipment for information on this type of loan.

Non-Profit Disability Associations

There are many disability organizations, some of which may be able to loan equipment or provide information about other funding sources or support groups. These organizations include the Brain Injury Association, National Easter Seal Society, March of Dimes, Muscular Dystrophy Association, United Way, United Cerebral Palsy Associations, The Arc, your state’s Protection and Advocacy System and the Braille Institute.

Foundations

Some private foundations have been set up specifically to provide help to people with disabilities. A listing of such foundations can be found at your local library or may be available from the state Tech Act program.
Programs Providing Assistive Technology

The state Tech Act programs offer referrals for evaluation and equipment recommendations as well as assistance with identifying funding or equipment lending sources. A therapy department in a local hospital or Disabled Students Center at a local college or university also may offer to help locate technology programs in the area. Alliance for Technology Access Centers (ATA) sometimes have loan programs or information about purchasing used equipment or renting equipment.

Civic Organizations

There are many local civic and service organizations that may provide money to help someone in their community. Lists of these organizations are available from the Chamber of Commerce. Examples of these organizations are: Lions Club, Masons, Grotto, Veterans of Foreign Wars (VFW), Elks Club, Rotary Club, Kiwanis, Knights of Columbus and Soroptomists. Some of these organizations have a national focus on disability or on a particular disability. Others will fund devices for a particular child who is known to the local club.

Charities and Fund-Raisers

Local churches, high school groups, neighborhood organizations, labor unions or special interest groups (e.g., computer clubs, ham radio operators) may plan a fund-raiser to help purchase assistive technology. College student organizations (fraternities and sororities) may give money or students’ time to help a special cause. Even if money is not available, they may be willing to help organize a fundraiser. Local media (radio, television, newspapers) sometimes will sponsor fund-raising activities to fund devices. They may not contribute money but will help with organizing the fund-raising activity and publicizing it to the community.
Other Options

In addition to federal and private funding sources, there are a number of education-related grants, corporate technology donation programs and funding options that consumers should consider. Information on these alternative options is available through a number of sources, including the following:

Newsletters

Education Grants Alert, Capital Publications Inc., P.O. Box 1453, Alexandria, VA 22313-2052; 800-655-5597.

Education Technology News, Business Publishers Inc, 951 Pershing Dr., Silver Spring, MD 20910-4464; 301-5878-6300.

Financing Assistive Technology, Smiling Interface, P.O. Box 2792, Church St. Station, New York, NY 10008-2792; 415-864-2220.

Special Education Report, Capital Publications Inc., P.O. Box 1453, Alexandria, VA 22313-2053; 800-655-5597.


Technology Manufacturers

If it is not possible financially to purchase equipment, consumers sometimes can rent or borrow equipment directly from the manufacturer.
Used Equipment

Used equipment often is advertised for sale in disability-related publications, or the consumer can place a newspaper ad to see if used equipment can be purchased locally. Several companies refurbish old computers and sell them at low prices. Listings of outlets for used computers can be obtained from ATA Centers or state Tech Act programs.

Leasing

Many manufacturers of assistive technology devices have equipment available for rent or lease. Sometimes the rent or lease payments can be applied toward purchase. Check with the manufacturer to see if this is an option.

Equipment Loan Programs

Many states have equipment loan programs, as do some rehabilitation facilities and disability organizations. Information about loan programs is available from Tech Act programs.
How To Apply For Funding

There is an art to applying for funding for assistive technology. It is necessary to use just the right words to suit the particular agency that might be the funding source. It also is crucial to document the need for and projected outcome of assistive technology. This documentation should include at minimum:

- A written statement of medical need from doctors or other health professionals. If the person had an evaluation by a rehabilitation professional, also include this report.

- A description of the person’s problems resulting from the disability. This description can come from the doctor or other professional.

- Description of how the technology helps the person. For example, the equipment may make the person safer or allow him or her to do things more independently. Be sure to point out how money will be saved if use of the equipment allows attendant care to be reduced.

- A clear statement, based on assessment, that the person is a good candidate who has the cognitive and physical capacities necessary for using the technology.

In summary, the documentation to support an assistive technology funding request should include a physician’s prescription, the person’s assessment, an explanation of projected benefit from use of the technology or service, and any correspondence obtained from professionals that would support the person’s need for technology.
The initial funding request should include not only the cost of the device, but also the cost of ongoing support and instruction in the use of the technology. Assistive devices often have “hidden” expenses that are incurred with their purchase, and these expenses frequently are costly over time. Battery-powered devices may require frequent charging or cleaning. Upgrades for computer software may be necessary. Special modifications of the home or school environment may be necessary for the technology to be used. In each of these examples, costs associated with the technology may have to be assumed by the individual or the family if they are not considered in the initial application for funding.

It also is helpful to include with the funding request a picture or a descriptive brochure about the device being requested. This is important, because people who are reviewing the application often do not know about the wide range of technologies that might be appropriate.

Appropriate wording on the application is absolutely necessary. Key concepts for Medicaid include “medical necessity” and “restore the patient to his or her best functional level.” The term “medical necessity” means that the device is included in the course of treatment being provided to the person and that a professional, such as a physician or speech therapist, is supervising its use. Medicaid and private insurers generally pay for technologies that help restore people to “functioning levels” and/or take the place of a body part that is not working. Typically, these programs do not pay for technologies or services whose function is educational or life-enhancing rather than health-related.
The key for private insurance is “terms of the policy.” It must be remembered that coverage by any insurance company does not set a precedent. Just because one beneficiary receives needed technology under a particular policy issued by a company does not mean that all other covered beneficiaries will have technology paid for by that company. Each application stands on its own based on the expressed terms of the policy.

It usually is under the major medical provisions of a health policy that assistive technology can be provided as “other medical services and supplies.” It may, however, be necessary to purchase additional insurance coverage or a “rider” in order for technology costs to be included in the terms of the policy. It is important to remember that health insurance policies are oriented toward health care, not toward changes in the environment or rehabilitation.

Both private health insurance policies and Medicaid sometimes impose limits on the number of assistive technology devices over a certain cost that can be purchased within a certain time frame. Sometimes the rule is that the funding source will purchase only one device in the individual’s lifetime. With these kinds of restrictions, it is all the more critical to be sure that the technology choice is the right one.
**Tips That Lead To Success**

- Apply to several funding sources at the same time. Be sure to meet the requirements of each agency.
- Find out if agencies will share costs.
- Fill in the agency’s forms correctly. Many applications are denied because forms are not filled out properly.
- In addition to the standard form, include any other information that describes or shows what the equipment does and how it benefits the person. Assume no knowledge on the part of the reviewers.
- Turn in all documentation at the same time.
  - Avoid using jargon; define all unfamiliar terms.
  - Take the funding request package to the agency in person. While there, have it checked to make sure everything required has been included. Get the name of the person who reviewed the application.
- Call regularly to check on the funding request. Try to talk to the same person each time.
- Be extremely polite—and persistent!
What If Funding Is Denied?

It is not at all unusual for an initial funding request to be denied. Even when family members and professionals have been meticulous in preparing applications requesting funding for needed technology, denials should be anticipated. Making an appeal is worth the effort since many denials are reversed at the appeal level.

To start the appeal process, obtain any documentation or information provided by the funding agency (e.g., Medicaid or the private insurance company) relating to appeal procedures, such as forms to use, timelines and filing procedures. This information will help in the prompt preparation for appeal. The kind of appeal to be made depends on the reason for denial.

When developing an appeal, find out the following:

- Why the request was denied. Ask for the reason in writing. Sometimes requests are denied because a reviewer lacks understanding of the technology, or there may be an error in the paperwork.
- If needed, correct any mistakes or include more information, then resubmit the request.
- Going to appeal makes sense because generally the appeal sends the application to more experienced persons in the decision-making hierarchy. The technology requested often is new, and the initial examiners in the process may be unaware of its usefulness. Also, insufficient documentation may have been provided in the original application, and the problem can be remedied on appeal.
- Don’t be daunted by the length of the appeal process. Follow it through to its completion. In some states, families may be able to appeal a denial beyond the first level. For example, some states have “unfair claims settlement practices” regulations, administered by the insurance commissioner’s office.
Always make your appeal in person, and take an example of the equipment if possible. If only part of the money is offered by one agency, ask another agency to share costs. If the appeal is denied, try again. Submit the funding request to another agency. Being persistent often results in success.

When going through the appeal process, you can turn to the state Protection and Advocacy Program (P & A) for guidance and support. P & A advocates can help ensure that a person’s rights to technology and, for students, related services, are not denied. To locate your state’s P & A Program, call the National Association of Protection and Advocacy Systems at 202-408-9514.
For More Information:

Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)—www.resna.org
RESNA is an interdisciplinary association of people with a common interest in technology and disability.
700 North Moore Street, Suite 1540
Arlington, VA 22209-1903
Phone: 703-524-6686 Fax: 703-524-6630 TTY: 703-524-6639

ABLEDATA—www.abledata.com
A national database of information on more than 17,000 products currently available for people with disabilities.

Access Board
www.access-board.gov
An independent federal agency. Contains information on Section 508 of the Rehabilitation Act, as amended, requiring that electronic and information technology developed, procured, maintained or used by the federal government be accessible to people with disabilities. In 1998, the Board established an Electronic and Information Technology Access Advisory Committee (EITAAC) to help the Board develop standards under Section 508.

Accessible Website Design Resources
www.itpolicy.gsa.gov/cita/wpa.html
Connects to a Government Services Administration (GSA) site with links to several organizations with “how-to’s” on designing websites for accessibility for people with disabilities, including a link to “Top Ten Mistakes in Web Design.”

Alliance for Technology Access
www.ataccess.org
Provides location information for the Alliance for Technology Access regional centers. The Alliance assists individuals with disabilities in accessing technology, mainly through computer resources.
Apple’s Disability Solutions
www.apple.com/disabled
Information on computer access solutions for individuals with disabilities.

Assistive Technology Funding And Systems Change Project (ATFSCP)
www.ucpa.org
Assistive technology funding and systems change information.

Aztech, Inc
http://cosmos.ot.buffalo.edu
Information on transforming inventions into products for individuals with disabilities.

Breaking New Ground Resource Center
http://abe.www.ecn.perdue.edu/ABE/Extension/BNG/
Provides information and resources on assistive technology for agricultural workers and agricultural worksites. In 1990, the Outreach Center of Breaking New Ground became a part of the USDA AgrAbility program.

Center for Information Technology Accommodation (CITA)
www.itpolicy.gsa.gov/coca/index.htm
Legislation and policies on information systems accessibility including the Assistive Technology Act of 1998.

Closing the Gap
www.closingthegap.com
Closing the Gap’s role is to provide information on microcomputer materials and practices that can enrich the lives of persons with special needs.
Consortium for Citizens with Disabilities (CCD)
www.c-c-d.org
CCD is a working coalition of more than 100 national consumer, advocacy, provider and professional organizations working together with and on behalf of the 54 million children and adults with disabilities and their families living in the United States. CCD has several task forces on various disability issues, such as Employment and Training, Developmental Disabilities, Health, Social Security, Long-Term Services and Supports, Telecommunications and Technology, and Rights.

Cornucopia of Disability Information (CODI)
http://codi.buffalo.edu/
A wealth of information relating to disabilities including topics such as: aging; statistics; computing; Centers for Independent Living; and universal design. This site is based at the State University of New York/Buffalo.

Do-It Internet Resources
www.washington.edu/doit
Resources are listed in many categories including general resources, education, technology, legal, social and political issues.

Equal Access to Software and Information (EASI)
www.rit.edu/%7Eeasi
EASI is part of the Teaching, Learning and Technology Group, an affiliate of the American Association of Higher Education. EASI’s mission is to promote the same access to information and resources for people with disabilities as everyone else.

Federal Communications Commission (FCC)
www.fcc.gov
Contains the Telecommunications Act of 1996 and links to FCC’s Disabilities Issues Task Force, which contains press releases and reports that affect telecommunications and technology issues for people with disabilities.

IBM Special Needs Solutions
www.software.ibm.com
Information on IBM computer access solutions for persons with disabilities.
**Job Accommodation Network (JAN)**
http://janweb.icdi.wvu.edu
A service of the U.S. Department of Labor’s President’s Committee on Employment of People with Disabilities, JAN provides information about job accommodation and the employability of people with functional limitations. Publishes quarterly reports on number of cases handled by state, types of businesses and organizations requesting information, and ADA-related concerns, among many other outcome data statistics.

**Learning Disabilities OnLine**
www.ldonline.org
Interactive guide to learning disabilities for parents, teachers and children.

**National Center to Improve Practice (NCIP)**
www.edc.org/FSC/NCIP/
NCIPnet focuses on special education and technology, assistive technology, augmentative and alternate communication.

**National Rehabilitation Information Center (NARIC)**
www.naric.com
NARIC is a library and information center on disability and rehabilitation. More than 50,000 National Institute on Disability and Rehabilitation Research (NIDRR)-funded, other federal agencies, and private disability-related publications are held and abstracted by NARIC in their REHABDATA database, searchable online.

**National Institute on Disability and Rehabilitation Research (NIDRR)**
www.ed.gov/offices/OSERS/NIDRR
NIDRR, part of the U.S. Department of Education, manages and funds more than 300 projects on disability and rehabilitation research, including 56 state and U.S. territory Assistive Technology projects and several Rehabilitation Engineering Research Centers.
Trace Research & Development Center
www.trace.wisc.edu/
The Trace Center conducts research aimed at improving technology that can benefit individuals with disabilities by making it more accessible in four main areas: communication; control; computer access; and next generation communication information and transaction systems.

West Virginia Rehabilitation Research and Training Center (WVRRTC)
www.icdi.wvu.edu
Information resources on vocational rehabilitation, including links to the Job Accommodation Network and Project Enable.

WheelchairNet
www.wheelchairnet.org
WheelchairNet is a continuously developing resource for a broad community of people who are interested in wheelchairs: consumers, clinicians, manufacturers, researchers and funders. It contains resources for lifestyle, wheelchair technology and research developments, discussions, products, industry product standards, funding, services, etc.

World Wide Web Consortium (W3C)
www.w3c.org
The W3C, an international industry consortium, was founded in October 1994 to lead the World Wide Web to its full potential by developing common protocols that promote its evolution and ensure its operability. The W3C also includes the World Accessibility Initiative, which provides guidelines on website accessibility.

Office of Special Education and Rehabilitative Services
Department of Education
Mary E. Switzer Building
330 C Street, S.W.
Washington, D.C. 20202
Phone: Voice/TDD: (202) 205-5465
Endnotes:


Family Guild to Assistive Technology, Parents, Let’s Unite for Kids, www.pluk.org

Parents, Let's Unite for Kids (PLUK) www.pluk.org


Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) www.resna.org
Where to Turn...

Telecommunications

105 North Alfred Street, Alexandria, VA 22314
Family Helpline: 1-800-444-6443  (703) 236-6000
www.biausa.org
Where to Turn…

Your Guide to Federal Disability Policies and Programs

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Patrice Drew, Esq.
Cathy Ficker Terrill
Anne C. Parrette, Esq.

Project Coordinator
Janna Starr

Graphic Designer
Tina Radenberg

Editors
Larry H. Hoffer
Lisa Ward
Monique Marino

Brain Injury Association

U.S. Department of Health and Human Services
Health Resources and Services Administration
Maternal and Child Health Bureau
What are the major provisions in the Telecommunications Act of 1996 regarding disability access?

Two provisions of the Telecommunications Act focus entirely on access by persons with disabilities: Sections 255 and 713.

Section 255 of the Act requires all manufacturers of telecommunications equipment and providers of telecommunications services to ensure that such equipment and services are designed and developed to be accessible to and usable by individuals with disabilities, if readily achievable. The FCC will undertake a rulemaking proceeding to implement this provision.

Section 713 aims to ensure that video services are accessible to individuals who are hearing impaired and/or visually impaired. It requires the FCC to study the level at which video programming is closed-captioned, and then to establish a timetable for closed captioning requirements. (The FCC is authorized to exempt programming for which the provision of closed captioning would be economically burdensome.) Section 713 also directs the FCC to study the use of video description in order to assure the accessibility of this service to persons with visual impairments.

Other provisions of the Act aim to promote access to telecommunications by all Americans, including those with disabilities.

Are there any other provisions of the Telecommunications Act relevant to people with disabilities?

Yes. Section 706 requires the FCC to encourage deployment of advanced telecommunications to all Americans, and to elementary and secondary schools and classrooms in particular. It requires the FCC to assess the level at which advanced telecommunications are available, and then to take steps, if necessary, to accelerate deployment of such services by removing barriers to infrastructure investment. This provision could significantly benefit children with disabilities as well as children without disabilities and adults.
Section 254 concerns universal service. Section 254 directs the FCC and a Federal-State Joint Board to define what services should be made universally available and to take other actions as needed to further the Act’s universal service principles. Section 254 also revises the definition of universal service to include schools, libraries, and health care facilities. It says that telecommunications companies must provide services to these public institutions at affordable rates, upon request. The FCC and the States must decide what constitutes “affordable rates,” what telecommunications services should be covered, and how discounts should be made available to public institutions.

Section 256 directs the FCC to establish procedures for oversight of telecommunications network planning. It also states that the FCC may participate with the industry in developing standards for “interconnectivity” (the ability of telecommunications carriers to connect to each other’s networks). These standards would promote access to telecommunications networks by people with disabilities.

Section 251 states that telecommunications carriers may not install network features, functions, or capabilities that do not comply with the guidelines and standards established under Sections 255 and 256.
What services are available to individuals with disabilities?

Telecommunications Relay Services (TRS)

Telecommunications Relay Services (TRS) enables telephone conversations between people with and without hearing or speech disabilities. TRS relies on communications assistants (CAs) to relay the content of calls between users of text telephones (TTYs) and users of traditional handsets (voice users). For example, a TTY user may telephone a voice user by calling a TRS provider (or “relay center”), where a CA will place the call to the voice user and relay the conversation by transcribing spoken content for the TTY user and reading text aloud for the voice user.

TRS is required by Title IV of the Americans with Disabilities Act (ADA) and, to the extent possible, must be “functionally equivalent” to standard telephone services. Interstate and intrastate relay services are available in all 50 states and the District of Columbia 24 hours a day, 7 days a week.

How do I access TRS?

Simply dial your local TRS provider, either through TTY or voice telephone, and your call will be answered by a communications assistant (CA). Provide the CA with the number of the party you wish to contact, and the CA will complete the call and “relay” the conversation, verbatim and in real time.
The TRS provider number is listed in the local telephone directory, usually in the information section, or may be obtained from directory assistance. (Some states have separate TRS provider numbers for TTY and voice callers.) The FCC also publishes a TRS Directory.

**How are TRS services funded?**

The cost of interstate TRS is recovered from all providers of interstate telecommunications services, as a percentage of their gross revenues and a “contribution factor” determined annually by the FCC. Contributions are administered in a TRS Fund by the National Exchange Carrier Association (NECA). The NECA is an association of local telephone companies. TRS providers are compensated for interstate TRS minutes of use based on a “payment rate” also determined annually by the FCC.

The FCC has also established an interstate TRS Fund Advisory Council that is comprised of consumer representatives, TRS users, state regulatory officials, TRS providers, and state relay administrators who advise the TRS Fund Administrator on funding issues. The Advisory Council’s meetings are open to the public.

**What is meant by “Universal Design?”**

“Universal design” is the concept of achieving accessibility of structures, products, and services by planning for the fullest range of human function at the blueprint stage. The dual goals of universal design are:

- Accessibility to the widest range of individuals
- Elimination of the need for retrofitting and reconstruction

Some examples of universally-designed telecommunications...
products include televisions with closed-captioning decoder circuitry, telephones with volume control and built-in hearing aid compatibility, and public telephones that are lowered to heights accessible to people who use wheelchairs and that feature built-in TTY keyboards.

**What is “Closed-Captioning?”**

Closed-captioning is the display of audio portions of television and video programming as printed words on the television screen. In addition to displaying spoken dialogue and music lyrics, captions may identify speakers, sound effects, background music, and laughter. “Open” captions always appear directly on the television screen, while “closed” captions are hidden as encoded data within the television signal and are displayed only when activated by the viewer. Since 1992, all televisions with screens 13” or larger are required to be equipped with the technology to display captioning. Consumers may purchase set-top decoders for older TV models.

**What is “Video Description?”**

Video description is an auditory depiction of a television or video program’s visual elements for persons who are blind or visually impaired. Video description is inserted in the natural pauses of a program’s dialogue, and may be used to describe visual elements such as body language, settings, and actions. In order to receive video description, an audience member must have a stereo television or VCR that is capable of receiving the Second Audio Program (SAP) “channel.” The SAP feature is available on most new TVs and VCRs. Consumers may also purchase receivers for converting TV sets to stereo with SAP.
What are “Volume Control Telephones?”

Volume control telephones allow the user to amplify the sound output level of the telephone receiver. In addition to benefiting persons with hearing loss and persons losing their residual hearing later in life, volume control can also benefit persons who must use telephones in noisy environments.

What are “Assistive Listening Devices?”

Assistive listening devices (ALDs), also known as “auditory assistance devices” (AADs), are forms of telecommunications equipment designed to enhance the ability of people with hearing disabilities to hear in various settings, including theaters, classrooms, lecture halls and meeting rooms.

What is the Disabilities Rights Office?

The Disabilities Rights Office (DRO) is an internal FCC Office within the Consumers Information Bureau, dedicated to ensuring that FCC actions and policies promote access to telecommunications equipment and services by individuals with disabilities.

For more information, contact:

Federal Communications Commission
445 12th Street, S.W.
Washington, D.C.  20554
(888) 225-5322
Endnotes

Federal Communications Commission
www.fcc.gov
Where to Turn...

Voting Rights

Brain Injury Association

U.S. Department of Health and Human Services
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105 North Alfred Street . Alexandria, VA 22314
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Brain Injury Association

U.S. Department of Health and Human Services
Health Resources and Services Administration
Maternal and Child Health Bureau
**Voting Rights**

I am a person with a disability and a registered voter. What rights do I have to ensure my access to and participation in the voting process?

You are protected by the National Voter Registration Act (NVRA) of 1993.

**What is the NVRA?**

Congress enacted the NVRA of 1993 (often called the “Motor Voter Act”) to enhance voting opportunities for every American and to remove the appearances of discrimination that historically have resulted in lower voter registration rates of minorities and persons with disabilities. The NVRA has brought new voices to the political process by making it easier for all Americans to exercise their fundamental right to vote.

**What does the NVRA say?**

The NVRA requires states to provide the following:

- **“Motor Voter” Registration:** Automatic voter registration simultaneous with motor vehicle driver’s license application or renewal.

- **Agency-based Voter Registration:** Voter registration opportunities must be offered to each applicant for services, service renewal or address change through all offices that provide public assistance and all offices that provide state-funded programs primarily engaged in providing services to persons with disabilities. Applicants must be provided with a voter registration form, a declination form, assistance in completing the forms and assistance with forwarding the completed applications to the appropriate state official.

- **Mail-in Voter Registration:** Voter registration must be available through mail-in forms developed by each state and the Federal Election Commission.
The NVRA places limitations on removal of voters from registration lists, specifically prohibiting purges for not voting. It allows voters to be removed from the registration rolls only at their request, because of criminal convictions, death or mental incapacity, or due to a change of address (provided that particular safeguards are followed). The NVRA also provides additional safeguards under which registered voters would be able to vote despite minor technical problems (voters who move within a district or a precinct will retain the right to vote even if they have not re-registered at their new address.).

When did my rights under the NVRA begin?

The NVRA generally became effective on January 1, 1995. Beginning August 1, 1994, states that had no voter registration or that permitted same-day registration at the polling place are exempt from the Act. These states are Minnesota, North Dakota, Wisconsin, Wyoming, New Hampshire and Idaho. A later effective date was allowed for states that would need to change their constitutions in order to comply with the NVRA and maintain a unitary registration system for both federal and state elections. These states include: Vermont, Virginia and Arkansas.
Are there any other voting protections available to me?

Yes. You are also protected under the Voting Accessibility for the Elderly and Handicapped Act (VAEHA). The VAEHA of 1984 generally requires polling places across the United States to be physically accessible to people with disabilities for federal elections. Where no accessible location is available to serve as a polling place, a political subdivision must provide an alternate means for a person to cast a ballot on the day of the election. This law also requires states to make available registration and voting aids for voters who are disabled and elderly, including information by telecommunications devices for people who are hearing impaired (TDDs) which are also known as teletypewriters (TTYs).

See Chapter 15 - Telecommunications

For more information on these two laws, contact:

Voting Section
Civil Rights Division
U.S. Department of Justice
P.O. Box 66128
Washington, D.C. 20035
(800) 253-3931
www.usdoj.gov/crt/voting
Endnotes:

U.S. Department of Justice, Civil Rights Division
www.usdoj.gov
Where to Turn...

Transportation and Travel

105 North Alfred Street . Alexandria, VA 22314
Family Helpline: 1-800-444-6443 . (703) 236-6000
www.biausa.org
Where to Turn...

Your Guide to Federal Disability Policies and Programs

Authors
Patrice Drew, Esq.
Cathy Ficker Terrill
Anne C. Parrette, Esq.

Project Coordinator
Janna Starr

Graphic Designer
Tina Radenberg

Editors
Larry H. Hoffer
Lisa Ward
Monique Marino

Brain Injury Association

U.S. Department of Health and Human Services
Health Resources and Services Administration
Maternal and Child Health Bureau
Transportation and Travel

Background

Since the passage of the Americans with Disabilities Act in 1990, people with disabilities are able to participate more fully in employment, recreation and travel activities. The Census Bureau estimates that in 1995, 26.1% of people with severe disabilities between the ages of 21 and 64, approximately 2.7 million people, were employed in the United States. The Census Bureau also estimates that 25.9% of the 2.3 million long-term users of mobility equipment (e.g., wheelchair, cane, walker, crutches) in this age group, (approximately 600,000 people) are employed.
Motor Vehicles

Which government agency handles motor vehicle transportation issues for people with disabilities?

The National Highway Traffic Safety Administration (NHTSA), under the Department of Transportation (DOT), handles transportation issues for people with disabilities.

What is NHTSA?

NHTSA is a Federal agency with the authority to regulate the manufacture of automotive adaptive equipment and modified vehicles used by people with disabilities. NHTSA was established under the Highway Safety Act of 1970. NHTSA’s charge is to carry out safety programs under the National Traffic Safety and Motor Vehicle Safety Act of 1966, the Highway Safety Act of 1966, and the Motor Vehicle Information and Cost Savings Act of 1972.

What is the current legislation covering motor vehicle safety?

The Vehicle Safety Act has been recodified under Title 49 of the U.S. Code in Chapter 301, Motor Vehicle Safety.

What are NHTSA’s responsibilities?

NHTSA is responsible for reducing deaths, injuries and economic losses caused by motor vehicle crashes. NHTSA also is responsible for setting and enforcing safety performance standards for motor vehicles and motor vehicle equipment. NHTSA provides grants to state and local governments to enable them to conduct effective local highway safety programs.
Can you give me some examples of the work NHTSA does?

Yes. NHTSA:

- Investigates safety defects in motor vehicles
- Sets and enforces fuel economy standards
- Helps state and local communities reduce the threat of drunk drivers
- Promotes the use of safety belts, child safety seats and airbags
- Provides consumer information on motor vehicle safety topics
- Conducts research on driver behavior and traffic safety to develop the most efficient and effective means of bringing about safety improvements

Is there a number I can call if I have a question, complaint or safety problem with my modified vehicle or adaptive equipment?

Yes. You may call DOT’s Auto Safety Hotline: 1-888-DASH-2-DOT or 1-888-327-4236. The TTY number for people who have hearing impairments is: 800-424-9153. The hotline operates from 8:00 a.m. to 10:00 p.m., Eastern Time, Monday through Friday. A Spanish-speaking telephone operator is available from 8:00 a.m. to 4:00 p.m., Eastern Time. You also may file a complaint electronically via email on the NHTSA website: www.nhtsa.dot.gov/hotline.
What questions should I ask NHTSA?

You may want to ask:

☑ How can I learn how to deactivate my car’s airbag?

☑ How can I learn how to remove my car’s airbag?

☑ How do I make my car’s child restraints safe for my child with a disability?

☑ What are the car seatbelt requirements for people with disabilities, especially if I am in a wheelchair?

How can my phone call to the DOT Auto Safety Hotline make a difference?

Your phone call to the DOT Auto Safety Hotline is your method of identifying safety problems in your motor vehicle and adaptive equipment. Your call may help lead to a change in safety standards for people with disabilities or a product recall. The equipment manufacturer may fix certain safety defects in equipment at no cost to you.

Where can I find information on purchasing an adaptive vehicle?

In February 2000, NHTSA released a free consumer brochure to help people with disabilities in the market for an adaptive vehicle. The brochure is called “Adapting Motor Vehicles for People with Disabilities.” It is available through NHTSA, local automakers and the NHTSA website: www.nhtsa.dot.gov.
How can NHTSA help me in my state?

NHTSA has 10 regional offices that provide numerous services to the states and other public and private sector customers. The regional offices provide technical assistance, promote legislation that favors people with disabilities and assist with coalition building.

How can I contact my NHTSA Regional Office?

Following is a list of the NHTSA Regional Offices and how to contact them.

**NHTSA Region I**

Transportation Systems Center
Kendall Square Code 903
Cambridge, MA 02142
617-494-3427
617-494-3646 Fax
States – CT, ME, MA, NH, RI, VT

**NHTSA Region II**

222 Mamaroneck Avenue, Suite 204
White Plains, NY 10605
914-682-6162
914-682-6239 Fax
States - NY, NJ, Puerto Rico, Virgin Islands

**NHTSA Region III**

10 South Howard Street
Suite 4000
Baltimore, MD 21201
410-962-0090
410-962-2770 Fax
States - DE, DC, MD, PA, VA, WV
**NHTSA Region IX**

201 Mission Street, Suite 2230  
San Francisco, CA 94105  
415-744-3089  
415-744-2532 Fax  
States - AZ, CA, HI, NV, Amer. Samoa, Guam, Mariana Island

**NHTSA Region X**

3140 Jackson Federal Building  
915 Second Avenue  
Seattle, WA 98174  
206-220-7640  
206-220-7651 Fax  
States - AK, ID, OR, WA
Airplanes and Airports

What law covers people with disabilities traveling on airplanes?

The Air Carrier Access Act protects people with disabilities from discrimination in air travel by air carriers. The law applies to air carriers that provide regularly scheduled services for hire to the public.

Tell me more about the Air Carrier Access Act.

Congress passed the Air Carrier Access Act (ACAA) in 1986 to guarantee that people with disabilities would receive consistent and nondiscriminatory treatment when traveling by air.

What does the ACAA say?

The ACAA says, simply:

No air carrier shall discriminate against any otherwise qualified [disabled] individual, by reason of such [disability], in the provision of air transportation.

What does the ACAA cover?

The ACAA covers a wide range of issues surrounding your right to travel by air, including boarding assistance, accessibility features in newly built aircraft and new or altered airport facilities.
Does the ACAA apply to ALL airplanes?

No. The ACAA applies only to new airplanes ordered after April 5, 1990, or delivered after April 5, 1992. These airplanes must achieve a higher degree of accessibility than older airplanes. Airplanes that were in service as of April 5, 1990 are not required to be upgraded for accessibility. Any airplane, however, that undergoes replacement of its cabin interior, lavatory or seats must meet the new requirements.

So what are my rights when I travel by air?

Cannot refuse you transportation: Air carrier personnel may not refuse transportation to any passenger with a disability, except on the basis of safety, nor may they limit the number of passengers with disabilities on a flight.

Cannot require you to travel with an attendant: Air carriers may not require a passenger with a disability to travel with an attendant except in very limited situations. If the air carrier does override a passenger’s decision to travel without an attendant, it may designate an attendant for the passenger, but it cannot charge the attendant for his or her transportation.

Cannot exclude you from sitting in a certain seat: Air carriers may not exclude any qualified individual with a disability from sitting in any seat except in order to comply with the Federal Aviation Administration (FAA) safety regulations. For example, the FAA exit row seating rules require that people sitting in these seats meet certain criteria. These criteria may deny some people with disabilities from sitting in an exit row.
Cannot exclude a service animal: Air carriers may not exclude a service animal from sitting next to the assigned seat of a passenger with a disability. The air carrier must offer to move the passenger to an alternative seat that will accommodate the service animal. Air carriers must allow service animals to accompany a passenger with a disability on the flight. Air carriers may require medical certificates only in limited circumstances.

Must provide appropriate services and equipment: Air carriers must provide assistance to passengers with disabilities when the passengers are: boarding, deplaning, making flight connections and transporting between gates. Boarding must be by level entry where possible. Air carriers must not leave a passenger in a wheelchair unattended on the ground, or while boarding, for more than 30 minutes.

Must allow use of personal medical devices: Air carriers must allow passengers with disabilities to use personal ventilators, respirators or other devices while on board the airplane.

Must allow storage of assistive devices and wheelchairs in overhead compartment: Passengers with disabilities must be allowed to store assistive devices in overhead compartments consistent with carry-on baggage rules. If a passenger with a disability chooses to pre-board and the on-board storage area will accommodate a collapsible wheelchair, the passenger’s wheelchair may be stored with priority over other passengers’ carry-on baggage. Assistive devices and wheelchairs will be checked and returned as close as possible to the door of the aircraft and must have priority over other luggage in the baggage compartment.

Cannot allow waiver of damage for assistive devices: Air carriers must return assistive devices to passengers in the same condition in which they are received. Air carriers cannot require a passenger to sign a waiver for damage or loss of a wheelchair or assistive device, nor can they limit liability to less than twice the liability established for lost or damaged luggage.
**Must provide passenger information:** Air carriers must provide passengers with disabilities general information in the terminal (e.g., departure delays), including accommodating people with vision or hearing impairments. Air carriers, upon request, must provide passengers with information on the ACAA regulations and the accessible features or limitations of the airplane.

Is there anything the air carrier can require ME to do? Does the air carrier have any rights?

**Yes.** The air carrier may require the following from passengers with disabilities:

**Advance Notice:** An air carrier may require up to 48-hours advance notice and one-hour advance check-in, but only for the following reasons:

- ✓ **Transportation by an electric wheelchair** on an air craft with less than 60 seats
- ✓ **Special handling** by the air carrier of hazardous materials packaging for a wheelchair battery
- ✓ **Special equipment** such as oxygen, incubator, hook-up for a respirator or a stretcher
- ✓ **Accommodation** for 10 or more people with disabilities traveling as a group (e.g., a sports team)
- ✓ **Accommodation** for an on-board wheelchair on an airplane without an accessible lavatory
If a passenger with a disability does not provide advance notice, air carriers must provide the service if they are able to do so with reasonable efforts and without delaying the flight.

**Personal Assistance:** Personnel on aircraft that cannot accommodate lifts or boarding chairs (aircraft with less than 30 seats) are not required to hand-carry a passenger on to the airplane. Air carrier personnel are not required to assist passengers with disabilities with eating, medical services, personal hygiene or with assistance in the airplane bathroom.

**How can I assert my rights under the Air Carrier Access Act?**

You can file a complaint with the U.S. Department of Transportation, or you can file a lawsuit in Federal court.

**How do I file a complaint?**

If you believe an airline or airline official has violated the ACA, you have several options:

- **Complaints Resolution Official (CRO):** Every airline must make a CRO available to passengers at every airport. This person is able to act on behalf of the airline. The CRO’s decision can be overruled only by the pilot-in-command for safety reasons. If you do not reach a satisfactory result when dealing with the CRO, the CRO must provide a written statement about the facts of the situation and the reasons for the decision. The CRO must inform the passenger of the right to pursue an enforcement action with the DOT.
**Written Complaint to Airline:** You may submit a written complaint to the airline. Be sure to include all pertinent information about the discrimination you experienced. Also, include the name of the CRO (if you contacted one), the date of the incident and any written report from the CRO. The airline must respond to any written complaint within 30 days of receipt of the complaint.

**IMPORTANT:** The airline is **not required to respond** to any complaint made more than **45 days after the date of the alleged violation.**

File a Complaint with DOT’s Office of Civil Rights:

Departmental Office of Civil Rights  
Office of the Secretary  
U.S. Department of Transportation  
400 Seventh Street, S.W.  
Washington, D.C. 20590  
Phone: (202) 366-4648 or (202) 366-8538 (TTY)

You also may file a complaint with the Aviation Consumer Protection Division:

Aviation Consumer Protection Division  
U.S. Department of Transportation  
400 Seventh Street, S.W., Room 10405  
Washington, D.C. 20590  
Phone: (202) 366-2220 or (202) 755-7687 (TTY)
Does the FAA oversee hiring practices of the airlines so that people with disabilities get a fair chance at jobs?

The People with Disabilities Program was established to ensure that the Federal Aviation Administration (FAA) takes a positive role in complying fully with Section 504 of the Rehabilitation Act of 1973 (see chapter 3). The Program assists the FAA with providing equal opportunity employment to people with disabilities and eliminate employment barriers.
Public Transportation

What law protects people with disabilities using public transportation services?

Title II of the Americans with Disabilities Act (ADA) contains transportation provisions that cover public transportation services (e.g., city buses) and public rail transit (e.g., subways, commuter rails, Amtrak).

What does the ADA’s Transportation Provision say?

The ADA’s transportation provision states that public transportation authorities may not discriminate against people with disabilities in the provision of their services.

What does the ADA say about public transportation personnel?

Public transportation personnel must:

- Comply with accessibility requirements in newly-purchased vehicles
- Make good faith efforts to purchase or lease accessible used buses
- Remanufacture buses in an accessible manner
- Provide paratransit options where they operate fixed-route bus or rail systems
What is “Paratransit?”

Paratransit is a service provided to people who are unable to use the regular transit system independently because they have a disability. Paratransit provides pick-up and drop-off services to these people.

What about Section 504 of the Rehabilitation Act?

Section 504 of the Rehabilitation Act of 1973 is a non-discrimination act that prohibits organizations that receive federal funds from discriminating against otherwise qualified people, solely on the basis of their disability. Any transit system that receives federal money, whether it is a private or public system, is subject to Section 504. The U.S. Department of Education’s Office of Civil Rights (OCR) enforces Section 504.

What should I do if I have a question or complaint about public transportation?

You should contact the Federal Transit Administration:

Federal Transit Administration
U.S. Department of Transportation
400 Seventh Street, S.W.
Washington, D.C. 20590
Phone: (202) 366-1656 or (202) 366-4567 (TTY)

What should I do if I have a legal question about public transportation?

You should call the Office of Chief Counsel at DOT’s Federal Transit Administration:

Phone: (202) 366-1936 (TTY) or (202) 366-9306 (voice)
What should I do if I want to enforce the ADA transportation provisions in my state?

You should contact the Office of Civil Rights at DOT’s Federal Transit Administration:

Phone: (202) 366-2285 (voice) or (202) 366-0153 (TTY)
Endnotes

1 See Estimating the Number of Vehicles Adapted for Use by Persons with Disabilities, NHTSA Research Note, December 1997.

U.S. Department of Transportation
www.dot.gov
Where to Turn...

Older Americans Act of 1965 and Older Americans Act Amendments of 1999
Where to Turn…

Your Guide to Federal Disability Policies and Programs

Authors
Patrice Drew, Esq.
Cathy Ficker Terrill
Anne C. Parrette, Esq.

Project Coordinator
Janna Starr

Graphic Designer
Tina Radenberg

Editors
Larry H. Hoffer
Lisa Ward
Monique Marino

Brain Injury Association

U.S. Department of Health and Human Services
Health Resources and Services Administration
Maternal and Child Health Bureau
Older Americans Act of 1965 and Older Americans Act Amendments of 1999

What is the Older Americans Act?

The Older Americans Act of 1965 (OAA) is federal legislation that provides funding for a wide variety of home and community-based services, as well as health services for Americans who are over the age of 60. The OAA helps Americans who are older maintain their independence and autonomy, allowing them to stay in their own homes as long as possible. The law focuses on improving the lives of people who are older in the areas of income, housing, health, employment, retirement, and community services.

What is the History of the OAA? How has it Changed?

Initially, the OAA established small grants to state agencies to fund social services programs. OAA funding also supported state planning and coordinating activities. Amendments to the law in 1972 added the “national nutrition program.” Beginning in the late 1970s, the focus of OAA activities shifted to certain populations identified as “vulnerable.” These populations included older people who are frail, women who are older, minorities who are older, and people living in rural communities who are older. Although OAA services are provided without regard to a person’s income or health, they are targeted to these “vulnerable” groups. As the number of people who are older has increased in this country, OAA’s emphasis has shifted from community-based services, to health services and long-term services and supports.
What services are covered by the OAA?

The OAA covers the following services:

- Home-delivered meals (Meals-on-Wheels program)
- Meals served at community centers and other social settings
- In-home assistance with chores and personal care
- Transportation to shopping, doctor appointments, and other essential activities
- Protection against elder-abuse
- Employment of seniors
- Adult day care services
- Senior centers
- Legal Assistance

Why is the OAA important currently?

Today, the OAA is more important than ever for Americans who are aging. People over the age of 85 are the fastest-growing segment of the U.S. population. According to the U.S. Census Bureau, this figure will increase by 50% by the year 2010. As Americans are able to live longer through the advances of science and medicine, it is inevitable that more Americans will need help to remain at home and to access the services provided by the OAA.
Who administers the OAA?

At the federal level, the U.S. Administration on Aging, in the Department of Health and Human Services administers the OAA. The U.S. Administration on Aging distributes OAA funds to state offices on aging. The state offices (State Units on Aging) then fund Area Agencies on Aging (AAA). The AAAs use their OAA funds as “seed money” and raise additional non-federal monies from the private sector.
Tell me more about the Administration on Aging.

The OAA established the Administration on Aging (AOA). The AOA is an agency of the U.S. Department of Health and Human Services, and is headed by the Assistant Secretary on Aging. AOA is the federal focal point and advocacy agency for people who are older. AOA works to heighten awareness among other federal agencies, organizations, groups and the public about the valuable contributions that older Americans make in the United States and about the special needs of people who are older. AOA works closely with its nationwide network of regional offices and state and area agencies on aging to plan, coordinate, and develop community-level systems of services. AOA administers programs at the federal level, as mandated under various titles of the OAA.

What are the State Units on Aging?

Each state is required by the OAA to have a State Unit on Aging. Although the activities vary from state to state, most State Units on Aging are responsible for:

☑ Coordination of state activities related to the OAA

☑ Development of a state plan on aging

☑ Reviewing and commenting upon all state plans, budgets and policies affecting Americans who are older

☑ Providing technical assistance to any agency, organization, association or individual representing the needs of Americans who are older
What are OAA Service Providers?

Under Title III of the OAA, service providers are contracted by the State Unit on Aging to provide needed services to Americans who are older. OAA service providers include nutrition providers, adult day service providers, transportation providers, and legal service agencies.

What are the Older Americans Act Amendments of 1999?

The Older Americans Act Amendments of 1999 revise the OAA of 1965. The amendments extend authorizations of appropriations for programs under the Act through fiscal year 2003. The amendments establish a National Family Caregiver Support Program, modernize aging programs and services, and address the need of Americans who are older to engage in life course planning. President Clinton signed the OAA Amendments of 1999 into law on November 13, 2000.
How can I find more information about the OAA?

You can write to the U.S. Administration on Aging at the following address:

U.S. Administration on Aging  
330 Independence Avenue, SW  
Washington, DC 20201

You can telephone the U.S. Administration on Aging at the following telephone numbers:

(800) 677-1116 (Eldercare Locator - to find services for an older person in his or her locality)

(202) 619-7501 (AOA’s National Aging Information Center — for technical information and public inquiries)

(202) 401-4541 (Office of the Assistant Secretary for Aging, Congressional and Media Inquiries)

You can send a fax inquiry to the U.S. Administration on Aging to the following number:

FAX: (202) 260-1012

And you can go to the U.S. Administration on Aging’s website:

aoainfo@aoa.gov
Where to Turn...

Appendices
# Appendix A

## Ten Standardized Medigap Plans A through J

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
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1 This chart does not apply if you live in Massachusetts, Minnesota or Wisconsin.

2 Basic Benefits: Cover Part A coinsurance and the cost of 365 extra days of hospital care during your lifetime after Medicare coverage ends
Covers of the Part B coinsurance (generally 20% of the Medicare-approved payment amount)
Covers the first 3 pints of blood each year
LIST OF ADDRESSES AND TELEPHONE NUMBERS FOR OFFICES OF PUBLIC HOUSING

ALABAMA
Alabama State Office
Beacon Ridge Tower
600 Beacon Parkway West
Suite 300
Birmingham, AL 35209-3144
(205) 290-7601

ALASKA
(See the Washington State Office)

ARIZONA
Arizona State Office
Two Arizona Center
400 North 5th Street, Suite 1600
Phoenix, AZ 85004-2361
(602) 379-3045

ARKANSAS
Arkansas State Office
TCBY Tower
425 West Capitol Avenue, Suite 900
Little Rock, AR 72201-3488
(501) 324-5933

CALIFORNIA (NORTHERN AREA)
California State Office
450 Golden Gate Avenue
P.O. Box 36003
San Francisco, CA 94102-3448
(415) 556-1726

CALIFORNIA (SOUTHERN AREA)
Los Angeles Area Office
1615 West Olympic Boulevard
Los Angeles, CA 90015-3801
(213) 251-7187

CALIFORNIA (EASTERN AREA)
Sacramento Area Office
777 - 12th Street, Suite 200
Sacramento, CA 95814-1997
(916) 498-5270
COLORADO
Colorado State Office
First Interstate Tower North
633 - 17th Street
Denver, CO 80202-3607
(303) 672-5376

CONNECTICUT
Connecticut State Office
330 Main Street, First Floor
Hartford, CT 06106-1860
(203) 240-4556

DELAWARE
(See the Pennsylvania State Office)

DISTRICT OF COLUMBIA
(Includes the Washington, DC Metro Areas in Maryland and Virginia)
820 First Street, NE
Washington, DC 20002-4205
(202) 275-7965

FLORIDA
Florida State Office
Southern Bell Tower
301 West Bay Street, Suite 2200
Jacksonville, FL 32202-5121
(904) 232-2357

GEORGIA
Georgia State Office
Richard B. Russell Federal Building
75 Spring Street, SW
Atlanta, GA 30303-3388
(404) 331-4815

HAWAII
Hawaii State Office
Seven Waterfront Plaza
500 Ala Moana Boulevard, Suite 500
Honolulu, HI 96813-4918
(808) 522-8185

IDAHO
(See Colorado State Office)
ILLINOIS
Illinois State Office
Ralph H. Metcalfe Federal Building
77 West Jackson Boulevard
Chicago, IL 60604-3507
(312) 353-1915

INDIANA
Indiana State Office
151 North Delaware Street
Indianapolis, IN 46204-2526
(317) 226-7018

IOWA
Iowa State Office
Federal Building
210 Walnut Street, Room 239
Des Moines, IA 50309-2155
(515) 284-4840

KANSAS (INCLUDES WESTERN MISSOURI)
Kansas/Missouri State Office
Gateway Tower II
400 State Avenue
Kansas City, KS 66101-2406
(913) 551-6916

KENTUCKY
Kentucky State Office
601 West Broadway
P.O. Box 1044
Louisville, KY 40201-1044
(502) 582-6161

LOUISIANA
Louisiana State Office
Ninth Floor
Hale Boggs Federal Building
New Orleans, LA 70130-3099
(504) 589-7251

MAINE
(See New Hampshire State Office)

MARYLAND
Maryland State Office
City Crescent Building
Fifth Floor
10 South Howard Street
Baltimore, MD 21201-2505
(410) 962-2520
MASSACHUSETTS
Massachusetts State Office
Thomas P. O’Neill, Jr.
Federal Building
10 Causeway Street, Room 375
Boston, MA 02222-1092
(617) 565-5196

MICHIGAN (EASTERN AREA)
Michigan State Office
Patrick V. McNamara
Federal Building
477 Michigan Avenue
Detroit, MI 48226-2592
(313) 226-5500

MICHIGAN (WESTERN AREA)
Grand Rapids Area Office
Third Floor
Trade Center Building
50 Louis Street, NW
Grand Rapids, MI 49503-2648
(616) 456-2127

MINNESOTA
Minnesota State Office
220 Second Street, South
Minneapolis, MN 55401-2195
(612) 370-3135

MISSISSIPPI
Mississippi State Office
Doctor A.H. McCoy Federal Building
100 West Capitol Street, Room 910
Jackson, MS 39269-1016
(601) 965-4746

MISSOURI (EASTERN AREA)
St. Louis Area Office
Robert A. Young Federal Building
1222 Spruce Street, Third Floor
St. Louis, MO 63103-2836
(314) 539-6505

MONTANA
(See Colorado State Office)
NEBRASKA
Nebraska State Office
Executive Tower Centre
10909 Mill Valley Road
Omaha, NE 68154-3955
(402) 492-3137

NEVADA
(See Arizona State Office for
Las Vegas & Clark County)

NEVADA
(See California State Office
for remainder of State)

NEW HAMPSHIRE
New Hampshire Area Office
Norris Cotton Federal Building
275 Chestnut Street
Manchester, NH 03101-2487
(603) 666-7493

NEW JERSEY
New Jersey State Office
One Newark Center
13th Floor
Newark, NJ 07102-5260
(201) 622-7900

NEW MEXICO
New Mexico State Office
625 Truman Street, NE
Albuquerque, NM 87110-6443
(505) 262-6303

NEW YORK (DOWNSTATE AREA)
New York State Office
26 Federal Plaza
New York, NY 10278-0068
(212) 264-3312

NEW YORK (UPSTATE AREA)
Buffalo Area Office
Lafayette Court
465 Main Street, Fifth Floor
Buffalo, NY 14203-1780
(716) 551-5719
NORTH CAROLINA
North Carolina State Office
Koger Building
2306 West Meadowview Road
Greensboro, NC 27407-3707
(910) 547-4038

NORTH DAKOTA
(See Colorado State Office)

OHIO (EASTERN AREA)
Cleveland Area Office
Renaissance Building
1350 Euclid Avenue, Suite 500
Cleveland, OH 44115-1815
(216) 522-2700

OHIO (WESTERN AREA)
Ohio State Office
200 North High Street
Columbus, OH 43215-2499
(614) 469-5787

OKLAHOMA
Oklahoma State Office
500 West Main Street
Oklahoma City, OK 73102
(405) 553-7555

OREGON
Oregon State Office
Suite 700
400 Southwest Sixth Avenue
Portland, OR 97204-1632
(503) 326-2661

PENNSYLVANIA (EASTERN AREA)
Pennsylvania State Office
The Wanamaker Building
100 Penn Square East
Philadelphia, PA 19107-3390
(215) 656-0574

PENNSYLVANIA (WESTERN AREA)
Pittsburgh Area Office
412 Old Post Office Courthouse Building
7th and Grant Street
Pittsburgh, PA 15219-1906
(412) 644-6571
PUERTO RICO
Caribbean Office
New San Juan Office Building
159 Carlos E. Chardon Avenue
San Juan, PR 00918-1804
(809) 766-5252

RHODE ISLAND
Rhode Island State Office
10 Weybosset Street
Providence, RI 02903-3234
(401) 528-5370

SOUTH CAROLINA
South Carolina State Office
1835 Assembly Street
Columbia, SC 29201-2480
(803) 765-5831

SOUTH DAKOTA
(See Colorado State Office)

TENNESSEE (WESTERN AREA)
Tennessee State Office
Suite 200
251 Cumberland Bend Drive
Nashville, TN 37228-1803
(615) 736-5063

TENNESSEE (EASTERN AREA)
Knoxville Area Office
John J. Duncan Federal Building
710 Locust Street, Third Floor
Knoxville, TN 37902-2526
(615) 545-4389

TEXAS (NORTHERN AND WESTERN AREAS)
Texas State Office
1600 Throckmorton
P.O. Box 2905
Fort Worth, TX 76113-2905
(817) 885-5934

TEXAS (SOUTHEASTERN AREA)
Houston Area Office
Norfolk Tower
2211 Norfolk, Suite 200
Houston, TX 77098-4096
(714) 834-3235
TEXAS (SOUTHWESTERN AREA)
San Antonio Area Office
Washington Square
800 Dolorosa Street
San Antonio, TX 78207-4563
(210) 229-6783

UTAH
(See Colorado State Office)

VERMONT
(See New Hampshire State Office)

VIRGINIA
Virginia State Office
The 3600 Centre
3600 West Broad Street
P.O. Box 90331
Richmond, VA 23230-0331
(804) 278-4559

WASHINGTON
Washington State Office
Seattle Federal Office Building
909 1st Avenue, Suite 200
Seattle, WA 98104-1000
(206) 220-5290

WEST VIRGINIA
West Virginia State Office
Kanawha Valley Building
405 Capitol Street, Suite 708
Charleston, WV 25301-1795
(304) 347-7057

WISCONSIN
Wisconsin State Office
Henry S. Reuss Federal Plaza
Suite 1380
310 West Wisconsin Avenue
Milwaukee, WI 53203-2289
(414) 297-1029

WYOMING
(See Colorado State Office)
Appendix C

STATE VOCATIONAL REHABILITATION AGENCIES

Alabama (AL)

Alabama Department of Rehabilitation Services
2129 East South Boulevard
P.O. Box 11586
Montgomery, AL 36116
334-281-8780/1-800-441-7607
334-613-2249 (TDD)
334-281-1973 (Fax)
Internet Address: http://www.rehab.state.al.us

Alaska (AK)

Alaska Division of Vocational Rehabilitation
801 West 10th Street
Suite 200
Juneau, AK 99801
907-465-2814/1-800-478-2815
907-465-2856 (Fax)
Internet Address: http://www.educ.state.ak.us/vocrehab/home.html

Arizona (AZ)

Arizona Rehabilitation Services Administration
1789 West Jefferson 2, NW
Phoenix, AZ 85007
602-542-2798/1-800-563-1221
602-542-3778 (Fax)
E-mail Address: azrsa@cir.org
Arkansas (AR)

Arkansas Rehabilitation Services
1616 Brookwood Drive
PO Box 3781
Little Rock, AR 72203
501-296-1600/1-800-330-0632
501-296-1669 (TDD)
501-296-1655 (Fax)
E-mail Address: Bobby.Simpson@state.ar.us (Commissioner)
Don.Wilkerson@state.ar.us (SSA/VR Coordinator)

California (CA)

California Health and Human Service Agency
Department of Rehabilitation
2000 Evergreen Street
Sacramento, CA 95815
916-263-8981 (Voice)
916-263-7477 (TTY)
E-mail Address: suggest@rehabb.cahwnet.gov
Internet Address: http://www.rehab.cahwnet.gov

Colorado (CO)

Colorado Department of Human Services
110 Sixteenth Street, Second Floor
Denver, CO 80202
303-620-4512 (Voice & TDD)
303-620-4189 (Fax)
Internet Address: http://www.cdhs.state.co.us/ods/dvr/index.html

Connecticut (CT)

Bureau of Rehabilitation Services
Department of Social Services
25 Sigourney Street 11th Floor
Hartford, CT 06106
800-842-1508
800-842-4542 (TTY)
E-mail Address: brs.dss@po.state.ct.us
Internet Address: http://www.dss.state.ct.us/divs/brs.htm
Board of Education and Services for the Blind
Vocational Rehabilitation Division
184 Windsor Avenue
Windsor, CT 06095
860-602-4000/1-800-842-4510
860-602-4002 (TTY)
E-mail Address: brian.sigman@po.state.ct.us

Delaware (DE)

Delaware Division of Vocational Rehabilitation
4425 North Market Street
PO Box 9969
Wilmington, DE 19809-0969
302-761-8275 (Voice/TTY)
302-761-6611 (Fax)
E-mail Address: director@dvr.state.de.us

District of Columbia (DC)

D.C. Rehabilitation Services Administration
800 9th Street, SW
Fourth Floor
Washington, DC 20024-2487
202-645-5883
202-645-5847 (TDD)
202-645-3857 (Fax)
202-645-5798 (Chinese Speaking)
202-645-5875 (Spanish Speaking)

Florida (FL)

Division of Vocational Rehabilitation
2002-A Old Saint Augustine Road
Tallahassee, FL 32399-0696
850-488-6210/1-800-451-4327
850-488-8062 (Fax)
Internet: http://www.state.fl.us/vocrehab
Florida Division of Blind Services
2551 Executive Center Circle West
Tallahassee, FL 32399
850-488-1330/1-800-342-1828
850-487-1804 (Fax)

Georgia (GA)

Division of Rehabilitation Services
Georgia Department of Human Resources
2 Peachtree Street, NW
35th Floor
Atlanta, GA 30303-3142
404-657-3000
404-657-3086 (Fax)
E-mail address: gradye@gomail.doas.state.ga.us
Internet Address: http://www.state.ga.us/departments/dhr/

Hawaii (HI)

Hawaii Vocational Rehabilitation & Services for the Blind
The State Kakuhihewa Building
601 Kamokila Boulevard, Room 515
Kapolei, HI 96707
808-692-7722
E-mail Address: pchu@dhs.state.hi.us
Internet Address: http://www.state.hi.us

Idaho (ID)

Idaho Division of Vocational Rehabilitation
Agency of the State Board of Education
650 West State Street
Room 150
PO Box 83720
Boise, ID 83720-0096
208-334-3390/1-800-856-2720
208-334-5305 (Fax)
Internet Address: http://www.state.id.us/idvr/idvrhome.htm
Illinois (IL)

Department of Human Services
Office of Rehabilitation Services
623 East Adams Street
PO Box 19429
Springfield, IL 62794
800-843-6154 (customers)/800-447-6404 (TTY)
800-804-3833 (providers)

Indiana (IN)

Division of Disability, Aging & Rehabilitative Services
402 W. Washington Street C-453
PO Box 7083
Indianapolis, IN 46207-7083
customers(317) 232-1252 fax (317) 232-6478
Internet Address: http://www.state.in.us/fssa

Iowa (IA)

Iowa Division of Vocational Rehabilitation Services
510 East 12th Street
Des Moines, IA 50319
515-281-6731/1-800-532-4703 (Iowa Only)
515-281-4703 (Fax)
Internet Address: http://www.dvrs.state.ia.us

The Iowa Department for the Blind
524 Fourth Street
Des Moines, IA 50309
515-281-1333/1-800-362-2587
515-281-1263 (Fax)
E-mail Address: karenk@blind.state.ia.us
Internet Address: http://www.blind.state.ia.us

Kansas (KS)

Department of Social and Rehabilitation Services
915 Harrison Street Office Building
Topeka, KS 66612
785-296-3959
785-296-2173 (Fax)
Internet Address: http://www.ink.org/public/srs/ISD.htm
Kentucky (KY)

Kentucky Department of Vocational Rehabilitation
209 St. Clair Street
Frankfort, KY 40601
1-800-372-7172 (Voice/TDD)
Internet Address: http://www.ihdi.uky.edu/projects/dvr/dvrhome.htm
E-mail Address: wfd.vocrehab@mail.state.ky.us

Kentucky Department for the Blind
209 St. Clair Street
PO Box 757
Frankfort, KY 40602
502-564-4754/1-800-321-6668
502-564-2929 (TDD)
502-564-2951 (Fax)
E-mail Address: dbohannon@mail.state.ky.us

Louisiana (LA)

Louisiana Rehabilitation Services
8225 Florida Boulevard
Baton Rouge, LA 70806
504-925-4131/1-800-737-2958
504-925-4184 (Fax)
Internet Address: http://www.dss.state.la.us

Maine (ME)

Maine Bureau of Rehabilitation Services
State House Station 150
Augusta, ME 04333-0150
207-287-5100
207-287-5146/800-332-1003 (TTY)
207-287-5166 (Fax)
E-mail Address: Arthur.P.Jacobson@state.me.us

Division for the Blind and Visually Impaired
150 State House Station
Augusta, ME 04333-0150
207-287—5256/1-800-332-1003
207-624-5302 (Fax)
E-mail Address: Paul.E.Cote@state.me.us
Maryland (MD)

Maryland State Department of Education
Division of Rehabilitation Services
2301 Argonne Drive
Baltimore, MD 21218-1696
410-554-9388/1-888-554-0334
1-800-735-2258 (TDD)
410-554-9412 (Fax)
E-mail Address: dors@msde.state.md.us
Internet Address: www.dors.state.md.us

Massachusetts (MA)

Massachusetts Rehabilitation Commission
Fort Point Place
27-43 Wormwood Street
Boston, MA 02210-1616
617-204-3600/800-245-6543
617-204-3868 (TTY or Voice)
617-727-1354 (Fax)
Internet Address: www.state.ma.us/mrc

Massachusetts Commission for the Blind
88 Kingston Street
Boston, MA 02111-2227
617-727-5550/800-392-6450
800-392-6556 (TDD)
617-727-5960 (Fax)
Internet Address: www.state.ma.us/mcb

Michigan (MI)

Michigan Department of Career Development
Rehabilitation Services
608 Allegan
PO Box 30010
Lansing, MI 48909
1-800-605-6722
1-888-605-6722 (TTY)
517-373-0565 (Fax)
E-mail Address: michab@edu.gte.net
Internet Address: http://www.mrs.state.mi.us
FIA, Michigan Commission for the Blind
PO Box 30652
Lansing, MI 48909
517-373-2062/1-800-292-4200
517-373-4025 (TDD)
517-335-5140 (Fax)

Minnesota (MN)

Department of Economic Security
Rehabilitation Services Branch
390 North Robert Street
Saint Paul, MN 55101
612-296-5616/1-800-328-9095
612-296-3900 (TTY)/1-800-657-3973
612-296-5159 (Fax)
Internet Address: www.des.state.mn.us/burgendy/rehab.htm

Mississippi (MS)

Mississippi Department of Rehabilitation Services
PO Box 1698
Jackson, MS 39215-1698
601-853-5321/601-853-5325 (TTY)
601-853-5310 (Fax)

Missouri (MO)

Missouri Division of Vocational Rehabilitation
3024 West Truman Boulevard
Jefferson City, MO 65109
573-751-3251/800-735-2466
573-751-0881 (TTY)/800-735-2966 (TTY)
Internet Address: http://services.dese.state.mo.us/divvocarehab

Missouri Rehabilitation Services for the Blind
PO Box 88
Jefferson City, MO 65103-0088
573-751-4249/800-592-6004
573-751-4984 (Fax)
E-mail Address: mmerrick@mail.state.mo.us
Montana (MT)

Montana Vocational Rehabilitation
111 Sanders
PO Box 4210
Helena, MT 59604-4210
406-444-2590 (Voice/TDD)
406-444-3632 (Fax)
Internet Address: http://www.dphhs.mt.gov

Nebraska (NE)

Nebraska Department of Education
Vocational Rehabilitation
PO Box 94987
301 Centennial Mall, South
Lincoln, NE 68509-4987
402-471-3644/1-800-742-7594
402-471-0788 (Fax)
Internet Address: http://nde4 nde.state.ne.us/VR/VocRe.html

Nevada (NV)

Bureau of Vocational Rehabilitation
505 East King Street
Room 501
Carson City, NV 89701-3704
775-684-4070 (Voice/TDD)/775-684-4186 (Fax)
Internet Address: http://www.state.nv.us/detr/rehab/reh_vorh

New Hampshire (NH)

Department of Education
Division of Vocational Rehabilitation
78 Regional Drive
Concord, New Hampshire
603-271-3471/800-299-1647
800-735-2964 (TDD) 603-271-7095 (Fax)
Internet Address: http://www.state.nh.us/doe/
Department of Education
Services for the Blind and Visually Impaired
78 Regional Drive
Concord, NH 03301-3537
603-271-3537/800-339-9900
800-735-2964 (TDD) 603-271-7095 (Fax)
Internet Address: http://www.state.nh.us/doe/

New Jersey (NJ)

New Jersey Division of Vocational Rehabilitation Services
135 East State Street
PO Box 398
Trenton, NJ 08625-0398
609-292-5987/609-292-8347
609-292-2919 (TDD)
E-mail Address: mford@dol.state.nj.us

New Jersey Department of Human Services
Commission for the Blind and Visually Impaired
153 Halsey Street
6th Floor
PO Box 47017
Newark, NJ 07101
973-648-3333
973-648-7364 (Fax)
E-mail Address: jchilton@dhs.state.nj.us

New Mexico (NM)

New Mexico Division of Vocational Rehabilitation
435 St. Michael’s Drive
Building D
Santa Fe, NM 87505
505-954-8500/1-800-224-7005
505-954-8562 (Fax)
E-mail Address: dadams@state.nm.us
Internet Address: http://www.state.nm.us/dvr
New Mexico Commission for The Blind
P.E.R.A. Building, Room 553
Santa Fe, NM 87503
505-827-4479/888-513-7968
505-827-4475 (Fax)
E-mail: Eblair@state.nm.us
Internet Address: http://www.state.nm.us/cftb/

New York (NY)

Vocational and Educational Services for Individuals with Disabilities
99 Washington Avenue
Albany, NY 12234
1-800-222-JOBS
518-486-4154 (Fax)
E-mail Address: jwelch@mail.nysed.gov
Internet Address: http://web.nysed.gov/vesid

Commission for the Blind and Visually Handicapped
40 North Pearl Street
Albany, NY 11243—0001
518-474-7079 (Voice)
518-474-7501 (TTY)
518-486-5819 (Fax)
Internet Address: www.dfa.state.ny.us/cbvh/

North Carolina (NC)

North Carolina Division of Vocational Rehabilitation Services
805 Ruggles
Raleigh, North Carolina 27603
919-733-3364
919-733-7968 (Fax)
Internet Address: http://www.dhhs.state.nc.us

North Carolina Division of Services for the Blind
317 Ashe Avenue
Raleigh, NC 27606
919-733-9700
919-733-9700 (TDD)
919-715-8771 (Fax)
E-mail Address: vgralla@dhr.state.nc.us
Internet Address: http://www.dhhs.state.nc.us/docs/divinfo/dsb.htm
North Dakota (ND)

N.D. Disability Services Division
Vocational Rehabilitation
600 South 2nd Street
Suite 1B
Bismark, ND 58504
701-328-8950/1-800-755-2745
701-328-8968 (TDD)
701-328-8969 (Fax)

Ohio (OH)

Ohio Rehabilitation Services Commission
400 East Campus View Boulevard
Columbus, OH 43235-4604
614-438-1200 (Voice/TYY)/1-800-282-4536 (Ohio only)
614-438-1257 (Fax)
Internet Address: http://www.state.oh.us/rsc/

Oklahoma (OK)

Department of Rehabilitation Services
3535 NW 58th
Suite 500
Oklahoma City, OK 73112
405-951-3400
405-951-3529 (Fax)

Oregon (OR)

Disability Determination Services
500 Summer Street, NE
Salem, OR 97310-1020
503-945-5878/1-800-452-2147
503-945-6273 (TTY)
503-378-3439
Vocational Rehabilitation Division
Administration Office
500 Summer Street, NE
Salem, OR 97310-1018
503-945-5880
503-945-5894 (TTY)
503-945-8991 (Fax)

Pennsylvania (PA)

Office of Vocational Rehabilitation
Attn: Social Security Administration/Vocational Rehabilitation State Coordinator
Room 1300
Labor and Industry Building
7th and Forster Street
Harrisburg, PA 17120
1-800-442-6351

Rhode Island (RI)

Department of Human Services
Office of Rehabilitation Services
40 Fountain Street
Providence, RI 02903-1898
401-421-7005
401-421-4016 (TDD)
401-421-9259 (Fax)
E-mail Address: rcarroll@ors.state.ri.us
Internet Address: http://www.ors.state.ri.us

Services for the Blind and Visually Impaired
40 Fountain Street
Providence, RI 02093-1898
401-222-2300/800-752-8088 ext 2300
401-222-3010 (TDD)
401-222-1328 (fax)
Internet Address: http://www.ors.state.ri.us/sb vipage.htm
South Carolina (SC)

South Carolina Vocational Rehabilitation Department
State Office Building, 1410 Boston Ave
P O Box 15
West Columbia, SC 29171-0015
803-896-6500
Internet: http://www.scvrd.net/scvrinfo.htm

South Carolina Commission for the Blind
P O Box 79
1430 Confederate Avenue
Columbia, SC 29202-0079
803-898-8700/800-922-2222
803-898-8800(Fax)
E-mail: clawyer@sccb.state.us
Internet: www.sccb.state.sc.us

South Dakota (SD)

Division of Rehabilitation Services
East Highway 34, Hillsview Plaza
c/o 500 East Capitol
Pierre, SD 57501-5070
605-773-3195
605-773-5483 (Fax)
Internet Address: www.state.sd.us/state/executive/dhs/drs/drs.htm

Tennessee (TN)

Department of Human Services
Division of Rehabilitation Services
Citizens Plaza Building, Room 1100
400 Deaderick Street
Nashville, Tennessee 37248-6100
615-313-4902, 615-741-6508 (Fax)

Texas (TX)

Texas Rehabilitation Commission
4900 North Lamar
Austin, TX 78751
512-424-4063/1-800-628-5115
512-424-4730 (Fax)
E-mail Address: trc@rehab.state.tx.us
Texas Commission for the Blind  
4800 North Lamar  
Austin, TX 78756  
512-459-2608/1-800-252-5204  
512-467-6462 (TTY)  
512-459-2685 (Fax)  
E-Mail Address: edb@tcb.state.tx.us  
Internet Address: http://www.tcb.state.tx.us

Utah (UT)  

Utah State Office of Rehabilitation  
250 East 500, South  
Salt Lake City, UT 84111  
801-538-7530/1-800-473-7530  
801-538-7522 (Fax)  
E-mail Address: bpeterse@usoe.k12.ut.us  
Internet Address: http://www.usoe.k12.ut.us/usor/usor.htm

Vermont (VT)  

Division of Vocational Rehabilitation  
Department of Aging and Disabilities  
Agency of Human Services  
Osgood Building, 103 Main Street  
Waterbury, VT 05671-2303  
1-800-361-1239  
1-802-241-2186 (TTY)  
1-802-241-3359 (Fax)  
E-mail Address: peterb@dad.state.vt.us  
Internet Address: http://www.dad.state.vt.us/dvr/

Division for the Blind and Visually Impaired  
Department of Aging and Disabilities  
Agency of Human Services  
Osgood Building, 103 Main Street  
Waterbury, VT 05671-2303  
1-802-241-2210  
1-802-241-3359 (Fax)  
E-mail Address: steve@dad.state.vt.us  
Internet Address: http://www.dad.state.vt.us/dbvi/main.htm
Virginia (VA)

Virginia Department of Rehabilitation Services
8004 Franklin Farms Drive
Richmond, VA 23288
800-552-5019
800-464-9950 (TTY)
804-662-9533 (Fax)
Internet Address: www.state.va.us/hhr/drs

Virginia Department for the Visually Handicapped
397 Azalea Avenue
Richmond, VA 23227-3697
804-371-3140/1-800-622-2155
804-371-3351 (Fax)
Internet Address: http://dit1.state.va.us/hhr/dvh

Washington (WA)

Department of Services for the Blind
1400 South Evergreen Park Drive, SW
Suite 100
PO Box 40933
Olympia, WA 98504-0933
206-721-4056/360-586-1224/1-800-552-7103
206-721-4056 (TDD)
360-586-7627 (Fax)
E-mail Address: shismith@dsb1.wa.gov

State of Washington, Division of Vocational Rehabilitation
Mailing Address: P.O. Box 45340
Olympia, WA 98504
Street Address: 612 Woodland Square Loop SE,
Lacey, WA 98503-1044
1-800-637-5627/360-438-8000 (Voice/TTY)
360-438-8007 (Fax)
Internet Address: http://www.wa.gov/dshs/dvr
West Virginia (WV)

The West Virginia Division of Rehabilitation Services
PO Box 50890, State Capitol
Charleston, WV 25305-0890
304-766-4600/1-800-642-8207
304-766-4690 (Fax)
E-mail Address: charley@mail.wvdrs.wvnet.edu

Wisconsin (WI)

Wisconsin Division of Vocational Rehabilitation
2917 International Lane
Suite 300
PO Box 7852
Madison, WI 53707-7852
608-243-5600
608-243-5601 (TTY)
608-243-5680 (Fax)
E-mail Address: kosmori@mail.state.wi.us
Internet Address: http://www.dwd.state.wi.us/dvr

Wyoming (WY)

Wyoming Division of Vocational Rehabilitation
1100 Herschler Building
1st Floor East Wing
Cheyenne, WY 82002
307-777-7389
307-777-5939 (Fax)
E-mail Address: gchild@missc.state.wy.us
Appendix D

Parent Training and Information Centers (PTI)

Alliance Coordinating Office
PACER Center
4826 Chicago Avenue South
Minneapolis, MN 55417-1098
(612) 827-2966 voice
(612) 827-7770 TTY
(612) 827-3065 fax
1-888-248-0822 (toll-free nationally)
E-mail: alliance@taalliance.org
Web site: www.taalliance.org
Paula F. Goldberg, Project Co-Director
Sharman Davis Barrett, Project Co-Director
Sue Folger, Project Co-Director
Dao Xiong, Multicultural Advisor
Jesus Villaseñor, Multicultural Advisor

Northeast Regional Center
Parent Information Center
P.O. Box 2405
Concord, NH 03302-2405
603-224-7005 voice
603-224-4379 fax
E-mail: picnh@aol.com
Judith Raskin, Regional Director
Mary Trinkley, Technical Assistance Coordinator
Lillye Ramos Spooner, Multicultural TA Coordinator
CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, Puerto Rico, RI, US VI, VT

Midwest Regional Center
Ohio Coalition for the Education of Children with Disabilities (OCECD)
Bank One Building
165 West Center Street, Suite 302
Marion, OH 43302-3741
(740) 382-5452 voice
(740) 383-6421 fax
E-mail: ocecd@gte.net
Margaret Burley, Regional Director
Dena Hook, Technical Assistance Coordinator
Gloria Mitchell, Multicultural TA Coordinator
CO, IL, IA, IN, KS, KY, MI, MN, MO, NE, ND, OH, SD, WI
South Regional Center
Partners Resource Network, Inc.
1090 Longfellow Drive, Suite B
Beaumont, TX 77706-4819
(409) 898-4684 voice
(409) 898-4869 fax
E-mail: txprn@pnx.com
Janice S. Meyer, Regional Director
Beverly Elrod-Wilson, Technical Assistance Coordinator
J. Linda Juarez, Multicultural TA Coordinator
AL, AR, FL, GA, LA, MS, NC, OK, SC, TN, TX, VA, WV

West Regional Center
Matrix Parent Network and Resource Center
94 Galli Drive, Suite C
Novato, CA 94949
(415) 884-3535
(415) 884-3555 fax
E-mail: matrix@matrixparents.org
Deidre Hayden, Regional Director
Nora Thompson, Technical Assistance Coordinator
Patricia Valdez, Multicultural TA Coordinator
AK, AZ, Department of Defense Dependent Schools (DODDS), CA, HI, ID, MT, NV, NM, OR, Pacific Jurisdiction, UT, WA, WY

This list of federally funded Parent Centers was generated by the Alliance Coordinating Office at the PACER Center.

If there are any corrections please notify the Alliance Office.

The Alliance Grant Project Officer is Donna Fluke, Office of Special Education Programs.
Federally Funded Parent Projects

AL, AK, AS, AZ, AR, CA, CO, CT, DC, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, PR, RI, SC, SD, TN, TX, UT, VT, USVI, VA, WA, WV, WI, WY

Alabama
Special Education Action Committee Inc.
Carol Blades, Director
P.O. Box 161274
Mobile, AL 36616-2274
334-478-1208 Voice & TDD
334-473-7877 FAX
1-800-222-7322 AL only
seacoaxmobile@zebra.net
home.hiwaay.net/~seachsv/

Alaska
PARENTS, Inc.
Faye Nieto
4743 E. Northern Lights Blvd.
Anchorage, AK 99508
907-337-7678 Voice
907-337-7629 TDD
907-337-7671 FAX
1-800-478-7678 in AK
parents@parentsinc.org
www.parentsinc.org

American Samoa
American Samoa PAVE
Fa’ Anati Penitusi
P.O. Box 3432
Pago Pago, AS 96799
011-684-699-6946
011-684-699-6952 FAX
SAMPAVE@samoatelco.com
www.taalliance.org/ptis/amsamoa/

Arizona
Pilot Parents of Southern Arizona
Lynn Kallis
2600 North Wyatt Drive
Tucson, AZ 85712
520-324-3150
520-324-3152
ppsa@pilotparents.org
www.pilotparents.org
Southern AZ
Arizona
RAISING Special Kids
Marta Urbina
4750 N. Black Canyon Hwy, Suite 101
Phoenix, AZ 85017-3621
602-242-4366 Voice & TDD
602-242-4306 FAX
1-800-237-3007 in AZ
Central and Northern AZ

Arkansas
Arkansas Disability Coalition
Wanda Stovall
1123 University Ave., Suite 225
Little Rock, AR 72204-1605
501-614-7020 Voice & TDD
501-614-9082 FAX
1-800-223-1330 AR only
adc@alltel.net
www.adcptl.org
Statewide
With FOCUS AR

Arkansas
FOCUS, Inc.
Ramona Hodges
305 West Jefferson Ave.
Jonesboro, AR 72401
870-935-2750 Voice
870-931-3755 FAX
888-247-3755
focusinc@ipa.net
www.grnco.net/~norre/
With Arkansas Disability Coalition AR

California
DREDF
Diane Lipton
2212 Sixth Street
Berkeley, CA 94710
510-644-2555 (TDD available)
510-841-8645 FAX
1-800-466-4232
dredf@dredf.org
www.dredf.org
Northern California
With Parents Helping Parents, Santa Clara

D:4
California
Exceptional Family Support, Education and Advocacy Center
Debbie Rowell
6402 Skyway
Paradise, CA 95969
530-876-8321
530-876-0346
1-888-263-1311
sea@sunlet.net
www.sea-center.org

California
Exceptional Parents Unlimited
Leslie Lee
4120 N. First St.
Fresno, CA 93726
559-229-2000
559-229-2956 FAX
epu1@cybergate.com
www.exceptionalparents.org
Central California

California (CPRC)
Loving Your Disabled Child
Theresa Cooper
4528 Crenshaw Boulevard
Los Angeles, CA 90043
323-299-2925
323-299-4373 FAX
lydc@pacbell.net
www.lydc.org
Most of LA County

California
Matrix
Deidre Hayden
94 Galli Drive, Suite C
Novato, CA 94949
415-884-3535
415-884-3555 FAX
1-800-578-2592
matrix@matrixparents.org
www.matrixparents.org
Northern California
With Parents Helping parents, Santa Clara
California
Parents Helping Parents of San Francisco
Lois Jones
594 Monterey Blvd.
San Francisco, CA 94127-2416
415-841-8820
415-841-8824 FAX
sfphp@earthlink.com
Nine counties in the San Francisco Bay area

California
Parents Helping Parents of Santa Clara
Mary Ellen Peterson
3041 Olcott St.
Santa Clara, CA 95054-3222
408-727-5775 Voice / 408-727-7655 TDD
408-727-0182 FAX
info@php.com
www.php.com
Northern California
With Matrix and DREDF

California (CPRC)
Parents of Watts
Alice Harris
10828 Lou Dillon Ave
Los Angeles, CA 90059
323-566-7556
323-569-3982 FAX
egertonf@hotmail.com
With Loving Your Disabled Child

California
Support for Families of Children with Disabilities
Juno Duenas
2601 Mission #710
San Francisco, CA 94110-3111
415-282-7494
415-282-1226 FAX
sfcdmiss@aol.com
San Francisco

California
TASK
Joan Tellefsen
100 West Cerritos Ave.
Anaheim, CA 92805
714-533-8275
714-533-2533 FAX
taskca@aol.com
Southern California
California
TASK, San Diego
Jesse Coronel, Director
3750 Convoy St., Suite 303
San Diego, CA 92111-3741
858-874-2386
858-874-2375 FAX
tasksd1@aol.com
City of San Diego and Imperial counties

California (CPRC)
Vietnamese Parents of Disabled Children Assoc., Inc. (VPDCA)
My-Lihn Duvan, President
7526 Syracuse Ave
Stanton, CA 90680
310-370-6704
310-542-0522 FAX
luyenchu@aol.com
With Loving Your Disabled Child

Colorado
PEAK Parent Center, Inc.
Barbara Buswell
6055 Lehman Drive, Suite 101
Colorado Springs, CO 80918
719-531-9400 voice / 719-531-9403 TDD
719-531-9452 FAX
1-800-284-0251
info@peakparent.org
www.peakparent.org

Connecticut
Connecticut Parent Advocacy Center
Nancy Prescott
338 Main Street
Niantic, CT. 06357
860-739-3089 Voice & TDD
860-739-7460 FAX (Call first to dedicate line)
1-800-445-2722 in CT
cpacinc@aol.com
members.aol.com/cpacinc/cpac.htm
Delaware
Parent Information Center of Delaware (PIC/DE)
Marie-Anne Aghazadian
700 Barksdale Road, Suite 16
Newark, DE 19711
302-366-0152 voice / 302-366-0178 (TDD)
302-366-0276 FAX
1-888-547-4412
picofdel@picofdel.org
www.picofdel.org

District of Columbia
Advocates for Justice and Education
Bethann West
2041 Martin Luther King Ave., SE, Suite 301
Washington, DC 20020
202-678-8060
202-678-8062 FAX
1-888-327-8060
justice1@bellatlantic.net
www.aje.qpg.com/
District of Columbia

Florida
Family Network on Disabilities
Jan LaBelle
2735 Whitney Road
Clearwater, FL 33760-1610
727-523-1130
727-523-8687 FAX
1-800-825-5736 FL only
fnd@fndfl.org
fndfl.org

Florida (CPRC)
Parent to Parent of Miami, Inc.
Janet Bell Taylor
c/o Sunrise Community
9040 Sunset Drive, Suite G
Miami, FL 33173
305-271-9797
305-271-6628 FAX
PtoP1086@aol.com
Miami Dade and Monroe Counties
Georgia
Parents Educating Parents and Professionals for All Children (PEPPAC)
Linda Shepard
6613 East Church Street, Suite 100
Douglasville, GA 30134
770-577-7771
770-577-7774 FAX
peppac@bellsouth.net
www.peppac.org

Hawaii
AWARE
Jennifer Schember-Lang, Project Director
200 N. Vineyard Blvd., Suite 310
Honolulu, HI 96817
808-536-9684 Voice / 808-536-2280 Voice & TTY
808-537-6780 FAX
1-800-533-9684
ldah@gte.net

Hawaii
Palau Parent Network
Erma Ngwal
c/o Dottie Kelly
Center on Disability Studies, University of Hawaii
1833 Kala Kaua Avenue, #609
Honolulu, HI 96815
808-945-1432
808-945-1440 FAX
dotty@hawaii.edu; patric@palaunet.com

Idaho
Idaho Parents Unlimited, Inc.
Cheryl Fisher
4696 Overland Road, Suite 568
Boise, ID 83705
208-342-5884 Voice & TDD
208-342-1408 FAX
1-800-242-4785
ipul@rmci.net
home.rmci.net/ipul
Idaho
Native American Parent Training and Information Center
Chris Curry & Susan Banks
129 East Third
Moscow, ID 83843
208-885-3500
208-885-3628 FAX
famtog@moscow.com
Nation-wide resource for Native American families, tribes, and communities as well as parent centers and others needing information on this subject.

Illinois
Designs for Change
Donald Moore/Miguel Jimenez
6 North Michigan Ave., Suite 1600
Chicago, IL 60602
312-857-9292 voice / 312-857-1013 TDD
312-857-9299 FAX
dfc1@aol.com
www.dfc1.org

Illinois
Family Resource Center on Disabilities
Charlotte Des Jardins
20 E. Jackson Blvd., Room 300
Chicago, IL 60604
312-939-3513 voice / 312-939-3519 TTY & TTY
312-939-7297 FAX
1-800-952-4199 IL only
frcdptiil@ameritech.net
www.ameritech.net/users/frcdptiil/index.html

Illinois
Family T.I.E.S. Network
Deb Kunz
830 South Spring
Springfield, IL 62704
217-544-5809
217-544-6018 FAX
1-800-865-7842
ftiesn@aol.com
www.taalliance.org/ptis/fties/
Illinois
National Center for Latinos with Disabilities
Everado Franco
1915-17 South Blue Island Ave.
Chicago, IL 60608
312-666-3393 voice / 312-666-1788 TTY
312-666-1787 FAX
1-800-532-3393
ncld@ncld.com
homepage.interaccess.com/~ncld/

Indiana
IN*SOURCE
Richard Burden
809 N. Michigan St.
South Bend, IN 46601-1036
219-234-7101
219-239-7275 TDD
219-234-7279 FAX
1-800-332-4433 in IN
insourc1@aol.com
www.insource.org

Iowa
Access for Special Kids (ASK)
Jule Reynolds
321 E. 6th St
Des Moines, IA 50309
515-243-1713
515-243-1902 FAX
1-800-450-8667
ptliowa@aol.com
www.taalliance.org/ptis/ia/

Kansas (CPRC)
Families ACT
Nina Lomely-Baker
555 N. Woodlawn
Wichita, KS 67203
316-685-1821
316-685-0768 FAX
nina@mhasck.org
www.mhasck.org
Sedgwick County and Outlying area
Kansas
Families Together, Inc.
Connie Zienkewicz
3340 W Douglas, Ste 102
Wichita, KS 67203
316-945-7747
316-945-7795 FAX
1-888-815-6364
fmin@feist.com
www.kansas.net/~family/

Kentucky
Kentucky Special Parent Involvement Network (KY-SPIN)
Paulette Logsdon
2210 Goldsmith Lane, Suite 118
Louisville, KY 40218-1038
502-456-0923
502-456-0893 FAX
1-800-525-7746
spininc@aol.com

Kentucky
Robin Porter
1146 South Third Street
Louisville, KY 40203
502-584-1239
502-584-1261 FAX
info@council-crc.org

Louisiana (CPRC)
Pyramid Parent Training Program
Ursula Markey
4101 Fontainbleau Dr
New Orleans, LA 70125
504-827-0610
504-827-2999 FAX
dmarkey404@aol.com

Louisiana
Project PROMPT
Leah Knight
4323 Division Street, Suite 110
Metairie, LA 70002-3179
504-888-9111
504-888-0246 FAX
1-800-766-7736
fhfgno@ix.netcom.com
www.projectprompt.com
Maine
Special Needs Parent Info Network
Janice LaChance
P.O. Box 2067
Augusta, ME 04338-2067
207-582-2504
207-582-3638 FAX
1-800-870-SPIN in ME
jlachance@mpf.org
www.mpf.org

Maryland
Parents Place of Maryland, Inc.
Josie Thomas
7484 Candlewood Rd Suite S
Hanover, MD 21076-1306
410-859-5300 Voice & TDD
410-859-5301 FAX
info@ppmd.org
www.ppmd.org

Massachusetts
Federation for Children with Special Needs
Richard Robison
1135 Tremont Street, Suite 420
Boston, MA 02120-2140
617-236-7210 (Voice and TTY)
617-572-2094 FAX
1-800-331-0688 in MA
fcsninfo@fcsn.org
www.fcsn.org/

Massachusetts
Urban / PRIDE / IPEST
Charlotte R. Spinkston
1472 Tremont
Roxbury Crossing, MA 02120
617-445-3191
617-445-6309 FAX
1-800-331-0688 in MA
cspinkston@compassinc.com
Michigan
CAUSE
Patrick Strong
3303 W. Saginaw, Suite F-1
Lansing, MI 48917-2303
517-886-9167 Voice & TDD & TDY
517-886-9775 FAX
1-800-221-9105 in MI
info-cause@voyager.net
www.pathwaynet.com/cause/

Michigan
Parents are Experts
Pat Dwelle
23077 Greenfield Road, Suite 205
Southfield, MI 48075-3745
248-557-5070 Voice & TDD
248-557-4456 FAX
1-800-827-4843
ucp@ameritech.net
www.taalliance.org/ptis/mi-parents/
Wayne County

Minnesota
PACER Center, Inc.
Paula Goldberg/Virginia Richardson
4826 Chicago Avenue South
Minneapolis, MN 55417-1098
612-827-2966 (Voice); 612-827-7770 (TTY)
612-827-3065 FAX
1-800-537-2237 in MN
pacer@pacer.org
www.pacer.org

Mississippi
Parent Partners
Aretha Lee, Director
1900 North West St, Ste. C-100
Jackson, MS 39202
601-714-5707
601-714-4025 FAX
1-800-366-5707 in MS
ptiofms@misnet.com
www.taalliance.org/ptis/ms/
Mississippi (CPRC)
Project Empower
Agnes Johnson
136 South Poplar Ave
Greenville, MS 38701
601-332-4852
601-332-1622 FAX
1-800-337-4852
empower@tecinfo.com

Missouri
Missouri Parents Act (MPACT)
Janet Jacoby
1 West Armour Blvd.
Kansas City, MO 64111
816-531-7070
816-931-2992 TDD
816-531-4777 FAX
1-800-743-7634 (in MO only)
ptijcj@aol.com
www.crn.org/mpact/

Montana
Parents Let's Unite for Kids
Katharin Kelker
516 N. 32nd Street
Billings, MT 59101
406-255-0540
406-255-0523 FAX
1-800-222-7585 in MT
plukinfo@pluk.org
www.pluk.org

Nebraska
Nebraska Parents Center
Glenda Davis
1941 South 42nd St., #122
Omaha, NE 68105-2942
402-346-0525 Voice & TDD
402-346-5253 FAX
1-800-284-8520
gdavis@neparentcenter.org
www.neparentcenter.org
Nevada
Nevada Parents Encouraging Parents (PEP)
Karen Taycher
2810 W. Charleston Blvd., Suite G-68
Quall Park IV
Las Vegas, NV 89102
702-388-8899
702-388-2966 FAX
1-800-216-5188
nvpep@vegas.infi.net
www.nvpep.org

New Hampshire
Parent Information Center
Judith Raskin
P.O. Box 2405
Concord, NH 03302-2405
603-224-7005 (Voice & TDD)
603-224-4379 FAX
1-800-232-0986 in NH
picnh@aol.com
www.taalliance.org/ptis/nhipic/

New Jersey
Statewide Parent Advocacy Network (SPAN)
Diana MTK Autin
35 Halsey Street, 4th Floor
Newark, NJ 07102
973-642-8100
973-642-8080 FAX
1-800-654-SPAN
span@spannj.org
www.spannj.org

New Mexico
Parents Reaching Out, Project ADOBE
Larry Fuller
1000-A Main St. NW
Los Lunas, NM 87031
505-865-3700 Voice & TDD
505-865-3737 FAX
1-800-524-5176 in NM
nmproth@aol.com
www.parentsreachingout.org
New Mexico
Southwest Communications Resources
Martha Gorospe
412 Camino Don Thomas, P.O. Box 788
Bernalillo, NM 87004-0788
505-867-3396
505-867-3398 FAX
1-800-524-5176 in NM
epics@swcr.org

New York
The Advocacy Center
Cassandra Archie
277 Alexander St., Suite 500
Rochester, NY 14607
716-546-1700
716-546-7069 FAX
1-800-650-4967 (NY only)
advocacy@frontiernet.net
www.advocacycenter.com
Statewide except for NY city.

New York
Advocates for Children of NY
Ana Espada
151 West 50th Street, 5th Floor
New York, NY 10001
212-947-9779
212-947-9790 FAX
info@advocatesforchildren.org
www.advocatesforchildren.org
Five boroughs of New York City

New York
Resources for Children with Special Needs, Inc.
Karen Schlesinger, Director
200 Park Ave. South, Suite 816
New York, NY 10003
212-677-4650
212-254-4070 FAX
resourcesnyc@prodigy.net
www.resourcesnyc.org
New York City (Bronx, Brooklyn, Manhattan, Queens, Staten Island)
New York
Sinergia/Metropolitan Parent Center
Donald Lash, Executive Director
15 West 65th St., 6th Floor
New York, NY 10023
212-496-1300
212-496-5608 FAX
Sinergia@panix.com
www.panix.com/~sinergia/
New York City

New York (CPRC)
United We Stand
Lourdes Rivera-Putz
C/o Casa del Barrio
728 Driggs Ave
Brooklyn, NY 11211
718-302-4313, ext. 562
718-302-4315 FAX
uwsofny@aol.com
www.taalliance.org/ptis/uws/

North Carolina
ECAC, Inc.
Connie Hawkins
P.O. Box 16
Davidson, NC 28036
704-892-1321
704-892-5028 FAX
1-800-962-6817 NC only
ECAC1@aol.com
www.ecac-parentcenter.org/

North Dakota
ND Pathfinder Parent Training And Information Center
Kathryn Erickson
Arrowhead Shopping Center
1600 2nd Ave. SW, Suite 19
Minot, ND 58701-3459
701-837-7500 voice / 701-837-7501 TDD
701-837-7548 FAX
1-800-245-5840 ND only
ndpath01@minot.ndak.net
www.pathfinder.minot.com
Ohio
Child Advocacy Center
Cathy Heizman
1821 Summit Road, Suite 303
Cincinnati, OH 45237
513-821-2400
513-821-2442 FAX
CADCenter@aol.com
Southwestern Ohio, Northern Kentucky, Dearborn County, Indiana

Ohio
OCECD
Margaret Burley
Bank One Building
165 West Center St., Suite 302
Marion, OH 43302-3741
740-382-5452 Voice & TDD
740-383-6421 FAX
1-800-374-2806
ocecd@gte.net
www.taalliance.org/PTIs/regohio/

Oklahoma
Parents Reaching Out in OK
Sharon Bishop
1917 S. Harvard Avenue
Oklahoma City, OK 73128
405-681-9710
405-685-4006 FAX
1-800-759-4142
prook1@aol.com
www.taalliance.org/ptis/ok/

Oregon
Oregon COPE Project
Anne Brown
999 Locust St. NE
Salem, OR 97303
503-581-8156 Voice & TDD
503-391-0429 FAX
1-888-505-COPE
orcope@open.org
www.open.org/~orcope
Pennsylvania (CPRC)
Hispanos Unidos para Niños Excepcionales
(Hispanics United for Exceptional Children)
Liz Hernandez
Buena Vista Plaza
166 W. Lehigh Ave., Suite 101
Philadelphia, PA 19133-3838
215-425-6203
215-425-6204 FAX
hupni@aol.com
City of Philadelphia, occasional service to surrounding counties

Pennsylvania
Parent Education Network
Louise Thieme
2107 Industrial Hwy
York, PA 17402-2223
717-600-0100 Voice & TTY
717-600-8101 FAX
1-800-522-5827 in PA
1-800-441-5028 (Spanish in PA)
pen@parentednet.org
www.parentednet.org

Pennsylvania
The Mentor Parent Program
Gail Walker
P.O. Box 47
Philadelphia, PA 16340
814-563-3470
814-563-3445 FAX
gal97@penn.com

Puerto Rico
APNI
Carmen Sellés deVilá
P.O. Box 21301
Ponce de Leon 724
San Juan, PR 00928-1301
787-250-4552
787-765-0345 FAX
1-800-981-8492
1-800-949-4232
apnirp@prtc.net
Island of Puerto Rico
Rhode Island
RI Parent Information Network
Cheryl Collins
175 Main Street
Pawtucket, RI 02860
401-727-4144 voice / 401-727-4151 TDD
401-727-4040 FAX
1-800-464-3399 in RI
collins@ripin.org
http://www.ripin.org/

South Carolina (CPRC)
Parent Training & Resource Center
Beverly McCarty
c/o Family Resource Center
135 Rutledge Ave., PO Box 250567
Charleston, SC 29425
843-876-1519
843-876-1518 FAX
mccarthyb@musc.edu
Tri-county: Charleston, Berkeley, and Dorchester

South Carolina
PRO-PARENTS
Mary Eaddy
2712 Middleburg Drive, Suite 203
Columbia, SC 29204
803-779-3859 Voice
803-252-4513 FAX
1-800-759-4776 in SC
pro-parents@aol.com
community.columbiatoday.com/realcities/proparents

South Dakota
South Dakota Parent Connection
Bev Petersen
3701 West 49th St., Suite 200B
Sioux Falls, SD 57106
605-361-3171 Voice & TDD
605-361-2928 FAX
1-800-640-4553 in SD
bpete@dakota.net
www.sdparent.org
Tennessee
Support and Training for Exceptional Parents, Inc. (STEP)
Nancy Diehl
424 E. Bernard Ave., Suite 3
Greeneville, TN 37745
423-639-0125 voice / 636-8217 TDD
423-636-8217 FAX
1-800-280-STEP in TN
tnstep@aol.com
www.tnstep.org

Texas (CPRC)
El Valle Community Parent Resource Center
Laura Reagan
530 South Texas Blvd, Suite J
Weslaco, TX 78596
956-969-3611
956-969-8761 FAX
1-800-680-0255 TX only
texasfiestaedu@acnet.net
www.tfepoder.org
Cameron, Willacy, & Starr Counties.

Texas (CPRC)
The Arc of Texas in the Rio Grande Valley
Parents Supporting Parents Network
David Meraz, Jr.
601 N Texas Blvd
Weslaco, TX 78596
956-447-8408
956-973-9503 FAX
1-888-857-8688
dmeraz@gtemail.net
www.thearcoftexas.org

Texas
Partners Resource Network Inc.
Janice Meyer
1090 Longfellow Drive, Suite B
Beaumont, TX 77706-4819
409-898-4684 Voice & TDD
409-898-4869 FAX
1-800-866-4726 in TX
txprn@pnx.com
www.PartnersTX.org
Texas
Project PODER
Yvette Hinojosa
1017 N. Main Ave., Suite 207
San Antonio, TX 78212
210-222-2637
210-475-9283 FAX
1-800-682-9747 TX only
poder@tfepoder.org
www.tfepoder.org

Utah
Utah Parent Center
Helen Post
2290 East 4500 S., Suite 110
Salt Lake City, UT 84117-4428
801-272-1051
801-272-8907 FAX
1-800-468-1160 in UT
upc@inconnect.com
www.utahparentcenter.org

Vermont
Vermont Parent Information Center
Connie Curtin
1 Mill Street, Suite A7
Burlington, VT 05401
802-658-5315 Voice & TDD
802-658-5395 FAX
1-800-639-7170 in VT
vpic@together.net
homepages.together.net/~vpic

Virgin Islands
V.I. FIND
Catherine Rehema Glenn
#2 Nye Gade
St. Thomas, US VI 00802
340-774-1662
340-774-1662 FAX
vifind@islands.vi
www.taalliance.org/ptis/vifind/
Virgin Islands
Virginia (CPRC)
PADDAC, Inc.
Mark Jacob
813 Forrest Drive, Suite 3
Newport News, VA 23606
757-591-9119
757-591-8990 FAX
1-888-337-2332
webmaster@padda.org
www.padda.org

Virginia
Parent Educational Advocacy Training Center
Cheri Takemoto
6320 Augusta Drive
Springfield, VA 22150
703-923-0010
703-923-0030 FAX
1-800-869-6782 VA only
partners@peatc.org
www.peatc.org

Washington (CPRC)
Parent to Parent Power
1118 S 142nd St.
Tacoma, WA 98444
253-531-2022
253-538-1126 FAX
ylink@aa.net

Washington
PAVE/STOMP
Heather Hebdon
6316 South 12th St.
Tacoma, WA 98465
253-565-2266 Voice & TTY
253-566-8052 FAX
1-800-572-7368
wapave9@washingtonpave.org
washingtonpave.org/stomp.html
U.S. Military installations; and as a resource for parent centers and others needing information on this subject.
Washington
Washington PAVE
Joanne Butts
6316 South 12th
Tacoma, WA 98465-1900
253-565-2266 (Voice & TDD)
253-566-8052 FAX
1-800-572-7368 in WA
wapave9@washingtonpave.org
washingtonpave.org

West Virginia
West Virginia PTI
Pat Haberbosch
371 Broaddus Ave
Clarksburg, WV 26301
304-624-1436 Voice & TTY
304-624-1438
1-800-281-1436 in WV
wvpti@aol.com
www.iolinc.net/wvpti

Wisconsin
Native American Family Empowerment Center
Don Rosin
Great Lakes Inter-Tribal Council, Inc.
2932 Highway 47N, P.O. Box 9
Lac du Flambeau, WI 54538
715-588-3324
715-588-7900
1-800-472-7207 (WI only)
drosin@newnorth.net

Wisconsin
Parent Education Project of Wisconsin
S. Patrice Colletti, SDS
2192 South 60th Street
West Allis, WI 53219-1568
414-328-5520 Voice / 414-328-5525 TDD
414-328-5530
1-800-231-8382 (WI only)
PMColletti@aol.com
members.aol.com/pepofwi/
Wisconsin (CPRC)
Wisconsin Family Assistance Center for Education, Training and Support
Janis M. Serak
2714 North Dr. Martin Luther King Dr., Suite E
Milwaukee, WI 53212
414-374-4645 / 414-374-4635 TTD
414-374-4655 FAX
wifacets@execpc.com

Wyoming
Parent Information Center
Terri Dawson
5 North Lobban
Buffalo, WY 82834
307-684-2277 Voice & TDD
307-684-5314
1-800-660-9742 WY only
tdawsonpic@vcn.com
www.wpic.org
Your Guide to Federal Disability Policies and Programs

Authors
Patrice Drew, Esq.
Cathy Ficker Terrill
Anne C. Parrette, Esq.

Project Coordinator
Janna Starr

Graphic Designer
Tina Radenberg

Editors
Larry H. Hoffer
Lisa Ward
Monique Marino
A
Administration for Aging 1:13, 18:4
State Units on Aging 18:4
Administration for Children and Families (ACF) 1:12
Air Carrier Access Act 17:8
American with Disabilities Act (ADA) 2:1
Employer additional information and assistance 2:6
Frequently Asked Questions 2:7
Information and Resources 2:31
Illegal drug use 2:5
Places of Accommodation 2:15
Protection 2:2
Title I (employment) 2:2
Title II (state and local governments) 2:12
Frequently Asked Questions 2:13
Title III (public accommodations) 2:18
Frequently Asked Questions 2:20
Title IV (telecommunications) 2:30
What do I do if I think I’m being discriminated against? 2:5
Assisted Housing 1:15
Assistive listening devices 15:6
Assistive Technology 14:1
Common types 14:4
How do I apply for funding 14:25
Medicare 14:13
Section 504 14:12
School requirements 14:12
What do I do when my funding is denied 14:29
Where can I find funding? 14:10
Who uses assistive technology? 14:10

B
Bill 1:3
Blind Work Expenses (BWE) 11:29

C
Centers for Disease Control and Prevention (CDC) 1:11
Closed captioning 15:5
Committee System 1:4
What is 1:4
Standing Committees 1:5
Community Development Block Grant Program 1:15
Congress 1:1
Definition 1:1
Overview 1:1
Publications 1:5
Responsibilities 1:4
Congressional Budget Office (CBO) 1:7
Major responsibilities 1:8
Congressional Record 1:4
Consolidated Omnibus Budget Reconciliation Act (COBRA) 6:18
Enforcement of COBRA 6:21
“qualifying events” 6:19

D
Department of Health and Human Services (HHS) 1:9
Programs of 1:9
Grants 1:10
Main Office 1:10
Brain injury 1:10
Department for Housing and Urban Development 1:14
Homeless 1:17
Low income 1:19
Major programs 1:14
Mission 1:14
Disabilities Rights Office 15:6
Disability 2:1, 4:2
Disability Hearing 4:19
Discriminatory Practices 2:3

E
Emergency Shelter Grants 1:18
Employment 11:1
Employment Retirement Income Security Act (ERISA) 6:7
Definition 6:7
Different types of benefit plans 6:8
Not covered 6:7
Regulation 6:8
Extended Period of Eligibility (EPE) 11:11

F
Fair Housing Act 9:1
New building requirements 9:3
Filing complaints 9:5
Violation of rights 9:4
Family & Medical Leave Act (FMLA) 12:1
Adoption 12:5
Eligibility 12:1
Health benefits 12:6
Return to work 12:6
Violation of rights 12:8
Filibuster 1:2
Fiduciary Duty 6:9
Freedom of Choice Waivers 6:1
Federal requirements 6:2
Purpose 6:2
State approval 6:2
Who approves 6:2
General Accounting Office (GAO) 1:6

Head Start 14:15
Health Care Financing Administration (HCFA) 1:12
Health Care Provider 12:4
Health Resources and Services Administration (HRSA) 1:11
HIPPA 6:11, 6:16
Home and Community-based waivers 8:1
HOME Program 1:19
HOPE Program 1:16
Housing Assistance 10:1
  Can I be denied housing based on bad credit or a criminal record? 10:12
  What documentation will I need to apply 10:15
House of Representatives 1:1, 1:2

Impairment:Related Work Expenses (IRWE) 11:5, 14:18
Individualized Education Program (IEP) 13:6

Law 1:3

Major life activity 2:1
Medicaid (section 1619 [a]) 11:21; (section 1619 [b]) 11:23
Medicaid Waivers 6:1
Medicare 5:1
  Continuation of Medicare coverage 11:13
  Health care choice 5:2
  Eligibility 5:1
  People with disabilities who work 11:14
  Premiums 5:2
Medicare Part A 5:4
  Inpatient Hospital Care 5:4
  Home Health Care 5:6
  Hospice Care 5:8
  Programs to help low-income beneficiaries 5:18
  Resources 5:22
  Skilled Nursing Facility Care 5:5
  What if Medicare says no? 5:21
Medicare Part B 5:9
  How do you get part B? 5:12
  Prescription drugs 5:15
  What can doctors charge you? 5:14
  What must you pay? 5:9
Medigap 5:15

Can I be denied housing based on bad credit or a criminal record? 10:12
What documentation will I need to apply 10:15

Older Americans Act (OAA) 18:1
  What is the OAA? 18:1
  What services are covered by OAA 18:2
  Importance 18:2
  Who administers the OAA 18:3
  OAA Service Providers 18:5
  Amendments of 1999 18:5
  Further information 18:6

Paratransit 17:16
PCCM Programs 6:1
Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) 7:1, 7:4
  Teenagers 7:5
Plan for Achieving Self:Support (PASS) 11:18, 14:18
  Requirements 11:18
Public accommodations 2:18
Public Housing Authority 10:1, 10:2
  Application process 10:3
  Applying 10:3
  Determination of rent 10:6
  Eligibility 10:3
Public Housing Offices B:1

Reasonable accommodation 2:3, 3:4, 3:5
  How do I request it? 3:5
Rehabilitation Act of 1973 3:1
  Frequently asked questions 3:10
  How do I file a complaint of discrimination? 3:8
  What employees are covered? 3:2
  What employment practices are covered? 3:6
Research and Demonstration Waivers 6:4
  Section 115 Waiver 6:4
<table>
<thead>
<tr>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Savings and Deemer Clauses 6:10</td>
</tr>
<tr>
<td>School-to-Work Transition Programs 14:17</td>
</tr>
<tr>
<td>Section 8 Certificates/Vouchers 10:2</td>
</tr>
<tr>
<td>How to apply 10:8</td>
</tr>
<tr>
<td>Eligibility 10:9</td>
</tr>
<tr>
<td>Section 8 Moderate Rehabilitation (SRO) 1:18</td>
</tr>
<tr>
<td>Senate 1:1, 1:2</td>
</tr>
<tr>
<td>Serious Health Condition 12:2</td>
</tr>
<tr>
<td>Shelter Plus Care 1:17</td>
</tr>
<tr>
<td>Social Security 4:1</td>
</tr>
<tr>
<td>Appeal 4:19</td>
</tr>
<tr>
<td>Being denied 4:18</td>
</tr>
<tr>
<td>Children 4:13</td>
</tr>
<tr>
<td>Finding a Social Security disability attorney 4:21</td>
</tr>
<tr>
<td>How do I apply 4:15</td>
</tr>
<tr>
<td>How do they decide your disabled? 4:8</td>
</tr>
<tr>
<td>How long will it take to make a decision? 4:16</td>
</tr>
<tr>
<td>Local Social Security Offices 4:22</td>
</tr>
<tr>
<td>Social Security Disability Insurance (SSDI) 4:1</td>
</tr>
<tr>
<td>Definition of “disabled” under SSDI 4:3</td>
</tr>
<tr>
<td>Family members 4:5</td>
</tr>
<tr>
<td>How do I qualify? 4:3</td>
</tr>
<tr>
<td>How long can I receive benefits 4:4</td>
</tr>
<tr>
<td>How many work credits can I earn per yr? 4:3</td>
</tr>
<tr>
<td>How many work credits do I need to earn to be eligible for SSDI benefits 4:4</td>
</tr>
<tr>
<td>Qualify if… 4:3</td>
</tr>
<tr>
<td>Supplemental Security Income Program (SSI) 4:1</td>
</tr>
<tr>
<td>Definition of “disabled” under SSI 4:2, 4:7</td>
</tr>
<tr>
<td>Qualify if… 4:7</td>
</tr>
<tr>
<td>Rules for the blind 4:12</td>
</tr>
<tr>
<td>Where does the money come from? 4:1</td>
</tr>
<tr>
<td>Work disincentives under SSDI and SSI 11:1</td>
</tr>
<tr>
<td>Work incentives 11:4</td>
</tr>
<tr>
<td>Special Education 13:2</td>
</tr>
<tr>
<td>Eligibility 13:3</td>
</tr>
<tr>
<td>Evaluation 13:2</td>
</tr>
<tr>
<td>IEP 13:6</td>
</tr>
<tr>
<td>Private Schools 13:11</td>
</tr>
<tr>
<td>Standardized Medigap Plans A:J A:1</td>
</tr>
<tr>
<td>Student Earned Income Exclusion 11:4</td>
</tr>
<tr>
<td>Subsidies &amp; Special Conditions 11:4</td>
</tr>
<tr>
<td>Substance Abuse and Mental Health Services Administration (SAMHSA) 1:12</td>
</tr>
<tr>
<td>Substantial Medical Proof 4:11</td>
</tr>
<tr>
<td>Supportive housing 1:18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technology:Related Assistance for Individuals with Disabilities Act of 1988 (Tech Act) 14:20</td>
</tr>
<tr>
<td>Telecommunications 15:1</td>
</tr>
<tr>
<td>Telecommunications Act of 1996 15:1</td>
</tr>
<tr>
<td>Ticket to Work 11:2, 11:31</td>
</tr>
<tr>
<td>Transportation and Travel 17:1</td>
</tr>
<tr>
<td>Airplanes and Airports 17:8</td>
</tr>
<tr>
<td>Motor Vehicles 17:2</td>
</tr>
<tr>
<td>Public Transportation 17:15</td>
</tr>
<tr>
<td>Trial Work Period (TWP) 11:9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>V</th>
</tr>
</thead>
<tbody>
<tr>
<td>Video description 15:5</td>
</tr>
<tr>
<td>Vocational Rehabilitation Agencies (state) C:1</td>
</tr>
<tr>
<td>Vocational Rehabilitation Services 14:17</td>
</tr>
<tr>
<td>Volume control telephones 15:6</td>
</tr>
<tr>
<td>Voting Rights 16:1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>W</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welfare &amp; Temporary Assistance for Needy Families (TANF) 7:1</td>
</tr>
<tr>
<td>Welfare-to-Work 7:1</td>
</tr>
<tr>
<td>Welfare-to-Work Tax Credit 7:3</td>
</tr>
<tr>
<td>Work credits 4:3, 4:4</td>
</tr>
<tr>
<td>Workers Compensation Commission 4:2</td>
</tr>
</tbody>
</table>