

Commentary

Poverty and disability: What pediatric rehabilitation specialists should know about Supplemental Security Income for children with disabilities

Childhood disability is on the rise [1,2]. Children with disabilities are among the most vulnerable in our health care system due to their extensive health care needs and high rates of unmet need for health and related services [3]. Additionally, children with disabilities are more likely to live in poverty. Poverty is a risk factor for disability and disability is a risk factor for family poverty [2,4,5]. Pediatric rehabilitation specialists (physicians, nurses, therapists, psychologists, social workers...) have extensive tools in their armamentaria to help improve the health, function and well-being of children with disabilities. One tool that may be underutilized is referring children with disabilities living in poverty to the Social Security Administration (SSA) for evaluation for eligibility for Supplement Security Income (SSI). One potential reason that providers are not referring or educating families about the SSI program is lack of provider knowledge/confusion about how the program works.

In the 1970s, the SSA began paying benefits through the SSI program to low-income families of children with severe physical or severe mental disabilities. SSI provides monthly cash assistance to families of children with serious disabilities who are financially eligible and are United States citizens. Not all children with disabilities qualify; some will not meet financial criteria and some will not meet the disability criteria. The child must have “a medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to

last for a continuous period of not less than 12 months.” (Social Security Act, Section 1614(a)(3)(C)(i)).

Once an application on behalf of the child is submitted and the process of assuring income eligibility is complete, there is a multi-step process of disability determination. This process requires the gathering documentation regarding the child’s medical, psychological and functional status and history. This information is often collected from a multitude of service providers including, but not limited to physicians, physical, occupational and speech therapists, mental health professionals, and schools, as well as family members [6]. Health care professionals do not decide if a child qualifies for SSI, but their records are frequently essential components of the determination process. The first major step in the process is to identify a medically determinable impairment (mental or physical) that results from “anatomical, physiological, or psychological abnormalities which can be shown by medical acceptable clinical and laboratory diagnostic techniques” [7]. This step is followed by a medical screen to determine if the child has a condition that ‘meets or medically equals a listing’ [8]. If the child meets criteria at this stage, they are awarded; if not, there is an additional process of determining if their impairment functionally equals the listings. There are six areas of functioning that the SSA uses in this step: acquiring and using information; attending and completing tasks; interacting and relating with others; moving about and manipulating objects; caring for yourself; and health and physical well-being. To be deemed eligible based on functional limitations, the child must have marked limita-

tions in two of the six domains or have extreme limitations in one domain [9]. Thinking about our patients with brain injury, spina bifida, muscular dystrophy or cerebral palsy, it is clear that many of these children living in poverty would likely qualify for SSI if applications were submitted on their behalf.

Families of children with disabilities who receive cash benefits from SSI are frequently lifted out of poverty. In 2010, nearly half of all families were [10]. Children who receive SSI are automatically enrolled in Medicaid for health insurance and are also referred to their state's Title V programs for children with special health care needs [6]. Title V programs vary state to state, but in general, provide a cadre of medical, social, developmental and educational services. Therefore, the value of SSI is clear. Unfortunately, not all eligible children with disabilities actually receive SSI benefits because they aren't applying. A National Academy of Medicine report titled, *Mental Disorders and Disabilities Among Low-Income Children* [11], released September 2015, found that there is a likely a large reservoir of children living in poverty with mental health disabilities who could qualify for SSI due to rise in childhood poverty and the rise in mental health disorders among children [11]. Many of the children served by pediatric rehabilitation providers have concurrent physical and mental health disabilities, making them potentially even more likely to qualify for SSI.

SSI provides children with disabilities with financial and medical supports that can help improve their overall health, function and well-being. Pediatric rehabilitation service providers are on the front lines of providing care for children with disabilities and can be a crucial resource for families. Improving our knowledge about programs that can help children with disabilities and their families is an important part of providing optimal care. Pediatric rehabilitation providers are encouraged to learn about SSI and develop processes in their clinical settings to help make referrals for potentially eligible children as a part of the family centered care they provide.

For those readers interested in other findings from the National Academy of Medicine (formally the

Institute of Medicine) report, *Mental Disorders and Disabilities Among Low-Income Children*, the entire report is accessible from the Academy at <http://nas.edu/SSIChildrenMentalDisability>.

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