

## Supplemental Security Income (SSI) for Children: Determining Childhood Disability

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Children and individuals under age 18 with disabling conditions who experience or are at risk of homelessness (e.g., those aging out of foster care or families who are unable to pay housing expenses) may struggle to access the resources they need. Many have developmental disabilities, serious mental illness, trauma, and medical issues that impact their ability to function. The path to recovery can be extraordinarily challenging when a family is constantly struggling to meet basic needs. Having income and healthcare benefits for children with disabilities is often a crucial first step on the road to recovery. Supplemental Security Income (SSI) from the Social Security Administration can help.

### Introduction

Supplemental Security Income (SSI) disability benefits are available for both low-income adults who are blind, disabled, or elderly and children with disabilities of low-income parents. For each, there are two sets of eligibility criteria: financial criteria and medical criteria. For children, the financial criteria are based on the income and resources of the child and the parents who are living in the same household with the child.

The medical criteria evaluate the severity of the child's impairment or combination of impairments. For both children and adults, the medical determination of disability is made by a State agency, the Disability Determination Services (DDS) using SSA rules. A DDS team, consisting of a disability examiner and a medical or psychological consultant, makes the disability determination. But the evaluation criteria used by SSA to determine disability for children differ markedly from those used by SSA for adults. For adults under age 65, the overarching question is, can they work? For children, SSA evaluates the child's functional abilities as compared with the functional abilities of children of the same age who are not disabled.

Because the medical eligibility determination is the least understood and where most applications for SSI fail, this issue brief focuses on understanding the medical criteria for receipt of SSI for children and documenting these criteria in the application.

Several myths have emerged around how and when a child can receive SSI benefits. The text box (over) examines three of the most common myths.

### Sequential Evaluation for Children

Since 1997, SSA has considered a child (under age 18) to be disabled if he or she has a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to cause death or can be expected to last for a continuous period of at least 12 months.<sup>1</sup> SSA uses a three-step sequential analysis to determine the disability status of children:<sup>2</sup>

**Step 1.** Is the child working (engaging in substantial gainful activity or SGA<sup>3</sup>)? If the child is working at the level of SGA, the claim for child's SSI will be denied. If the child is not working at this level, SSA moves to step 2.

<sup>1</sup> 42 U.S.C. § 1382c(a)(3)(C)(i)

<sup>2</sup> 20 C.F.R. 416.924

<sup>3</sup> Substantial gainful activity (SGA) is an SSA term with specific criteria and calculations. SSA is looking for activities that are productive (mental or physical) and gainful, meaning work activity for pay or profit, even if profit is not realized. In 2018, SSA calculated this as earnings of \$1,180 per month

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## Myths and Facts about Children and SSI Benefits

**Myth #1:** It is easier to get SSI for a child than an adult.

**Fact:** It is simply different. Many child claimants and advocates find it quite difficult to meet the requirement that the child's impairment(s) must result in "marked and severe functional limitations." However, children with disabilities often have extensive school and medical records, in addition to therapeutic reports, that can help support a finding of marked and severe limitations.

**Myth #2:** If a child is in special education, he or she will receive SSI benefits.

**Fact:** The standards for receiving special education differ from those for determining disability for SSI. Many children who receive special education services are not eligible for SSI. However, many, if not, most children who have been found eligible for SSI likely are receiving special education services or some educational accommodations.

**Myth #3:** If a child is found eligible for SSI as a child, he or she will automatically keep receiving benefits as an adult.

**Fact:** When a child turns 18, SSA will review the child's medical condition during the year that begins on his or her 18<sup>th</sup> birthday and will make a determination as to whether he or she is eligible under adult SSI criteria. An individual who is eligible as a child may not be eligible as an adult.

**Step 2.** Does the child have a medically determined impairment, or combination of impairments, that is severe? Severe is defined as more than "a slight abnormality or a combination of slight abnormalities that causes no more than minimal functional limitations." If not, the child will be denied. If the child has a severe impairment, SSA moves to step 3.

**Step 3.** Does the child's impairment meet, medically equal, or functionally equal one of the listed impairments?

Although the first two steps mirror those for adults, Step 3 is unique to the evaluation of childhood disability and where the heart of the analysis lies.

### Meeting a Listing

The first part of Step #3 considers whether a child meets a listing.<sup>4</sup> It is important to remember that, although a child can meet an adult listing, there are special listings just for children, organized by body system, similar to those for adults.<sup>5</sup>

While the childhood listings mirror the adult listings, many sublistings take into account that children are developing and, as a consequence, certain illnesses and/or their recommended treatments impact and affect children differently than adults. It is therefore important to read and study the listings carefully.

### Childhood Listings of Impairments

<b>100.00</b>	Low Birth Weight and Failure to Thrive
<b>101.00</b>	Musculoskeletal System
<b>102.00</b>	Special Senses and Speech
<b>103.00</b>	Respiratory System
<b>104.00</b>	Cardiovascular System
<b>105.00</b>	Digestive System
<b>106.00</b>	Genitourinary Disorders
<b>107.00</b>	Hematological Disorders
<b>108.00</b>	Skin Disorders
<b>109.00</b>	Endocrine Disorders
<b>110.00</b>	Congenital Disorders that Affect Multiple Body Systems
<b>111.00</b>	Neurological Disorders
<b>112.00</b>	Mental Disorders
<b>113.00</b>	Cancer (Malignant Neoplastic Diseases)
<b>114.00</b>	Immune System Disorders

<sup>4</sup> The Listings of Impairments is SSA's categorized lists of illnesses and conditions and the specific severity criteria that must be met for a person to be considered disabled by the illness/condition. The Listings are selective not exhaustive; many serious and potentially disabling medical conditions, diseases, illnesses, and impairments are not found in the Listings.

<sup>5</sup> <http://www.ssa.gov/disability/professionals/bluebook/ChildhoodListings.htm>

All of these listings, with the exception of 112.14, apply to children from age three to age 18. Listing 112.14 is specific to children from birth to age 3.

Listing 112.05 (for Intellectual Disorders) has two Subparts that are unique to that listing. A child must satisfy the requirements of either Subpart A or Subpart B. Each Subpart requires that a child have significantly sub-average general intellectual functioning and significant deficits in current adaptive functioning.<sup>1</sup>

<sup>1</sup> Listing 112.00(A)(3).

## Mental Disorders

Studies show that over one-half of children who receive SSI benefits have a mental disorder.<sup>6</sup>

The listings for mental disorders for children changed significantly in January 2017 and are now more similar to the listings for adults. The listings concerning mental disorders are arranged in the following 12 categories:

- 112.02 - Neurocognitive disorders
- 112.03 - Schizophrenia spectrum and other psychotic disorders
- 112.04 - Depressive, bipolar and related disorders
- 112.05 - Intellectual disorder
- 112.06 - Anxiety and obsessive-compulsive disorders
- 112.07 - Somatic symptom and related disorders
- 112.08 - Personality and impulse-control disorders
- 112.10 - Autism spectrum disorder
- 112.11 - Neurodevelopmental disorders
- 112.13 - Eating disorders
- 112.14 - Developmental disorders in infants and toddlers
- 112.15 - Trauma- and stressor-related disorders<sup>7</sup>

Listings 112.07, 112.08, 112.10, 112.11, 112.13, and 112.14 have two paragraphs, designated Subpart A and Subpart B. A child's mental disorder must satisfy the requirements of both Subpart A and Subpart B<sup>8</sup>

Listings 112.02, 112.03, 112.04, 112.06, and 112.15 have three paragraphs, designated Subparts A, B, and C. A child's mental disorder must satisfy the requirements of both Subpart A and Subpart B, or the requirements of both Subpart A and Subpart C.<sup>9</sup>

The Subpart A criteria are specific to the diagnostic criteria of the specific disorder.<sup>10</sup>

The Subpart B criteria assesses a child's functional limitations. To satisfy Subpart B, a child must have marked limitations in at least two of four areas of mental functioning or extreme limitations in one area of mental functioning. For children ages 3 to 18, the four areas of mental functioning are as follows:

- Understand, remember, or apply information
- Interact with others
- Concentrate, persist, or maintain pace
- Adapt or manage oneself<sup>11</sup>

The Subpart C criteria evaluates whether a child's mental disorder is "serious and persistent."<sup>12</sup> In order for a disorder to be considered "serious and persistent," there must be a medically documented history of the existence of the disorder over a period of at least 2 years, and evidence that satisfies the criteria in both Subpart C1 and Subpart C2.<sup>13</sup> Subpart C1 is met when the evidence shows that a child relies "on an ongoing basis, upon medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s), to diminish the symptoms and signs of his/her mental disorder."<sup>14</sup> Subpart C2 is met when the evidence shows that, despite a child having some lessening of his/her symptoms and signs, the child still has only "achieved marginal adjustment."<sup>15</sup> "Marginal adjustment" means that the child's "adaptation to the requirements of daily life is fragile" and that the child has "minimal capacity to adapt to changes in his/her

<sup>6</sup> "SSI Annual Statistical Report, 2016" Social Security Office of Retirement and Disability Policy

[https://www.ssa.gov/policy/docs/statcomps/ssi\\_asr/2016/sect04.html](https://www.ssa.gov/policy/docs/statcomps/ssi_asr/2016/sect04.html)

<sup>7</sup> Listing 112.00(A)(1)

<sup>8</sup> Listing 112.00(A)(2)

<sup>9</sup> Listing 112.00(A)(2)

<sup>10</sup> Listing 112.00(A)(2)(a)

<sup>11</sup> Listing 112.00(A)(2)(b). For children under the age of 3, a developmental assessment is completed, comparing the child's level of development with that typically expected for the child's chronological age.

<sup>12</sup> Listing 112.00(G)(1)

<sup>13</sup> Listing 112.00(G)(1)

<sup>14</sup> Listing 112.00(G)(2)(b)

<sup>15</sup> Listing 112.00(G)(2)(c).

environment or to demands that are not already part of his/her daily life.”<sup>16</sup>

## Medically Equaling a Listing

An impairment or combination of impairments is medically equivalent to a listing if the medical findings are at least equal in severity and duration to listing-level findings.<sup>17</sup> Specifically, whether a claimant medically equals a listing may be considered in one of three ways. First, a child might medically equal a listing when the child does not meet one or more of the specified medical criteria of a listing or exhibits all of the medical findings, but one or more is not as severe as is required by the listing criteria.<sup>18</sup> A second situation occurs when a child has an impairment that is not described in the listings, but is closely analogous to a listed impairment.<sup>19</sup> For example, a child might suffer from all of the symptoms for one of the respiratory listings, but have a respiratory impairment that is not contained in the listings. Finally, a child claimant might medically equal a listing if the child has a combination of impairments, where no single impairment meets a particular listing, but the combination of symptoms is closely analogous to a listing.<sup>20</sup>

## Functionally Meeting a Listing<sup>21</sup>

The last part of step #3 considers the functional limitations that a child’s impairment or combination of impairments might cause. Generally, this evaluation focuses on a child’s activities, growth, and development inasmuch as children are not expected to engage in work activity.

The functional equivalence analysis seeks to answer the following questions with regard to a particular child claimant in comparison with children of the same age who do not have impairments:<sup>22</sup>

- What activities is the child able to perform?
- What activities is the child not able to perform?
- Which activities are limited or restricted?

- Where does the child have difficulty performing activities?
- Does the child have difficulty initiating, sustaining, or completing activities?
- What kind of help does the child need?

If a child has marked limitation in at least two of six domains or extreme limitations in at least one of six domains, the child claimant will be found to have functionally equaled the listings. The following are the six domains:

1. **Acquiring and Using Information**—how well a child acquires or learns information and uses the information he/she has learned<sup>23</sup>
2. **Attending and Completing Tasks**—how well the child is able to focus and maintain attention, and begin, carry through, and finish activities, including the pace at which activities are performed and the ease with which the child changes them<sup>24</sup>
3. **Interacting and Relating With Others**—how well a child initiates and sustains emotional connections with others, develops and uses language, cooperates with others, complies with rules, responds to criticism, and respects and takes care of the possessions of others<sup>25</sup>
4. **Moving About and Manipulating Objects**—how well the child moves his/her body from one place to another (gross motor skills) and moves and manipulates things (fine motor skills)<sup>26</sup>
5. **Caring for Yourself**—how well the child maintains a healthy emotional state, how the child copes with stress and change, and whether the child takes care of his/her own health, possessions, and living area, including an assessment of whether the child engages in any self-injurious behaviors<sup>27</sup>
6. **Health and Physical Well-Being**—how the cumulative physical effects of impairments and their associated treatments affect the child’s

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16 Listing 112.00(G)(2)(c).

17 20 C.F.R. 416.926(a)

18 20 C.F.R. 416.926(b)(1)(i)(A) and (B)

19 20 C.F.R. 416.926(b)(2)

20 20 C.F.R. 416.926(b)(3)

21 20 C.F.R. 416.926a

22 20 C.F.R. 416.926(b)(2)

23 20 C.F.R. 416.926a(g)

24 20 C.F.R. 416.926a(h)

25 20 C.F.R. 416.926a(i)

26 20 C.F.R. 416.926a(j)

27 20 C.F.R. 416.926a(k)

functioning (not considered in the domain on motor functioning)<sup>28</sup>

Marked limitations are defined as follows:<sup>29</sup>

- interfere seriously with the child’s ability to independently initiate, sustain, or complete activities
- more than moderate, but less than extreme
- when standardized test scores are available, scores that are at least 2, but less than 3 standard deviations below the mean
- for children under 3, if the child’s functioning is at a level that is more than one-half, but less than two-thirds, of the child’s chronological age

Extreme limitations affect the child’s functioning as follows:<sup>30</sup>

- interfere very seriously with the child’s ability to independently initiate, sustain, or complete activities
- when standardized test scores are available, scores that are at least 3 standard deviations below the mean
- for children under 3, if the child’s functioning is at a level that is one-half of the child’s chronological age or less

Marked and extreme have the same definitions for all domains except **Health and Physical Well-Being**. In this domain, marked is defined as a child who is frequently ill because of his/her impairments, with significant and documented symptoms or signs. Frequent means episodes or exacerbations that occur on average of three times per year or once every 4 months, each lasting 2 weeks or more. It also can be more frequent and of shorter durations, or less frequent and of longer durations, if equal in severity. Extreme limitations for the domain of **Health and Physical Well-Being** refer to limitations in excess of the requirements for marked. Generally a child with an extreme limitation in this domain also will have an impairment that meets or medically equals a listing.<sup>31</sup>

The six domains of functioning are described in SSA regulations. Each domain, with the exception of **Health and Physical Well-Being**, also contains age-appropriate criteria in accordance with the following age groups:<sup>32</sup>

- newborns and young infants (up to age 1)
- older infants and toddlers (1–3)
- preschool children (3–6)
- school-age children (6–12)
- adolescents (12–18)

In 2009, additional guidance was also provided through the Social Security Rulings.<sup>33</sup>

### Special Considerations when Determining Disability in Child Claimants

In conducting the sequential evaluation and making a determination of disability for a child claimant, the SSA must consider all relevant information—both medical and nonmedical. For nonmedical evidence to be considered, there must be some evidence of a medically determinable impairment.<sup>34</sup> Federal regulations specify the type of analysis that SSA must conduct and the factors SSA must consider. These factors are described below.

**Effects of Treatment.** SSA considers the effects of treatment, including the side effects of medication, how long the child will need treatment, the frequency of treatment, and whether the treatment interferes with the child’s participation in typical activities.<sup>35</sup>

**Structured or Supportive Settings.** SSA also assesses the child’s need for a structured or supportive setting and the degree of limitation in functioning he/she would have outside the structured setting.<sup>36</sup> Even if the child is able to function adequately in a structured or supportive setting, the SSA must consider how the child would function in other settings and whether the child would continue to function at an adequate level without the structured or supportive setting.<sup>37</sup> SSA also assesses whether the

28 20 C.F.R. 416.926a(l)

29 20 C.F.R. 416.926a(e)(2)

30 20 C.F.R. 416.926a(e)(3)

31 20 C.F.R. 416.926a(e)(2)(iv) and 20 C.F.R. 416.926a(e)(3)(iv)

32 20 C.F.R. 416.926a(f)-(k)

33 Social Security Rulings, which went into effect in March 2009, add greater clarity and guidance to the determination of functional equivalence for children. See [https://www.ssa.gov/OP\\_Home/rulings/ssi/02/SSR2009-01-ssi-02.html](https://www.ssa.gov/OP_Home/rulings/ssi/02/SSR2009-01-ssi-02.html) (Determining Childhood Disability Under the Functional Equivalence Rule—the “Whole Child” Approach) and f (Determining Childhood Disability—Documenting a Child’s Impairment-Related Limitations). For domain-specific guidance, please see SSR 2009-03 through SSR 2009-08.

34 20 C.F.R. 416.924a(a)

35 20 C.F.R. 416.924a(b)(9)

36 20 C.F.R. 416.924a(b)(5)(iv)(A)

37 20 C.F.R. 416.924a(b)(5)(iv)(C)

structured or supportive setting is minimizing some of the signs and symptoms of child's impairments.<sup>38</sup>

A structured or supportive setting is defined as follows:<sup>39</sup>

1. The child's home in which family members or other people (nurses or home health workers) make adjustments to accommodate the child's impairments
2. The child's classroom in school, whether it is a regular education classroom in which the child is accommodated or a special classroom
3. A residential facility or school where the child lives for a period of time

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*Often parents and caregivers make adaptations to help a child cope with his/her disability and do not even recognize that they do so (it becomes second nature for the caregiver).*

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**Unusual Settings.** SSA recognizes that children may behave and perform differently in unusual settings (i.e., testing or one-on-one situations). Thus, SSA regulations instruct that this behavior should not be relied upon in isolation in determining the severity of functional limitations.<sup>40</sup>

**Test Scores.** SSA is not permitted to rely on any single test score alone.<sup>41</sup> Moreover, it is permissible to find that a child has marked or extreme limitations in a given area of functioning even if the child's test scores are slightly higher than the level required if other evidence shows that the child's functioning is seriously or very seriously limited.<sup>42</sup> Regulations instruct disability evaluators to resolve any inconsistency between test scores and other evidence in the case record.<sup>43</sup> And when SSA does not rely on test scores that are in the record, it must explain the reasons for doing so in the case record or decision.<sup>44</sup>

## Assisting with SSI Applications for Children

For those assisting child claimants and their caregivers with a child's application for SSI, it is important to focus on whether and where the child needs extra help (more help than a child of the same age without the impairments would need). In doing so, it is imperative to consider the nature and extent of any accommodations that are made to assist the child and also whether these accommodations might mask the true extent of the child's functional limitations.

Some accommodations may be quite apparent. For example, the child might require assistive devices or assistive technology. However, other accommodations require investigation. Often parents and caregivers make adaptations to help a child cope with his/her disability and do not even recognize that they do so (it becomes second nature for the caregiver). For example, a parent might help a child eat or get dressed and not realize that most parents of children that age no longer do so. Or a parent may curtail activities or provide extensive supervision or redirection and not recognize that the need to do so is not ordinarily required for a child of that age.

**Providing Documentation.** SSA needs evidence from acceptable medical sources to establish whether a child has a medically determinable impairment(s). Acceptable medical sources are:

- licensed physicians (medical or osteopathic);
- licensed or certified psychologists (includes school psychologists, for purposes of establishing intellectual disability, learning disabilities, and borderline intellectual functioning);
- licensed optometrists (for the measurement of visual fields or acuity);
- licensed podiatrists (for purposes of establishing impairments of the foot, or foot and ankle, depending on the state);
- qualified speech-language pathologists (for purposes of establishing speech or language impairments); and
- other individuals authorized to send copies or summaries of the medical records from a hospital, clinic, or other health care facility.

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38 20 C.F.R. 416.924a(b)(5)(iv)(E)

39 20 C.F.R. 416.924a(b)(5)(iv)(B)

40 20 C.F.R. 416.924a(b)(6)

41 20 C.F.R. 416.926a(e)(4) (i)

42 20 C.F.R. 416.926a(e)(4) (ii)(A)

43 20 C.F.R. 416.926a(e)(4) (iii)

44 20 C.F.R. 416.926a(e)(4) (iii)(B)

In claims with a filing date on or after March 27, 2017:

- Licensed physician assistants for impairments within the licensed scope of practice only
- Licensed audiologists for impairments of hearing loss, auditory processing disorders, and balance disorders
- Licensed Advanced Practice Registered Nurses (also known as Certified Nurse Midwife, Nurse Practitioners, etc.)

Evidence from other medical and non-medical sources to show the severity of the impairment(s) and how it affects the child's functioning can also be very helpful. Other medical sources not listed above include, for example, physicians' assistants, nurse practitioners, audiologists, and licensed clinical social workers. Non-medical sources include, for example, schools, public and private social welfare agencies, parents, guardians and other caregivers.

**Importance of School Records.** Educators and other school professionals (counselors, nurses, early intervention team members), in particular, can provide the specific information that SSA needs about how the child has functioned in school over the last 12 months. Children with disabilities often receive extra help and attention at school, typically in the form of special education.<sup>45</sup> When a child has a disability that affects his/her ability to learn, a local school district must provide the child with special education services based upon the child's unique needs. Special education services can continue until a child graduates from high school or the youth's 22<sup>nd</sup> birthday. For children under age 3 who are experiencing significant developmental delays, the school district or some local public agency is similarly obligated to provide early intervention services.

Accordingly, the need to obtain a child claimant's school records and to review these records carefully is critical. Typical school records for a child who is receiving special education services likely include some or all of the following:

- referrals for evaluations
- evaluations and reevaluations
- Individualized Education Program (IEPs for children age 3-22) or Individual Family Service Plans (IFSPs for children age 0-3)
- progress updates

- therapy notes
- incident or disciplinary reports
- report cards
- attendance records

Importantly, the term special education not only refers to a child's designated class or school, but also to specific related services, transition services, testing accommodations, necessary assistive technologies, and extended school year services. Descriptions of these items should be set forth in a child's Individual Education Program (IEP). In addition, a child's eligibility for special education is based on numerous evaluations,<sup>46</sup> teacher reports, and test results, among other factors, all of which also should be summarized on the child's IEP. Much of the information included in a child's IEP is useful in a determination of a child's disability by the SSA:

- how and why a child was found eligible for special education
- type of special education program
- related services (transportation, speech-language therapy, counseling, occupational therapy, physical therapy, etc.)
- evaluation summaries, present levels of performance, strengths and weaknesses
- annual educational goals
- extent to which student is not participating in a regular classroom and why
- behavior intervention plans
- transition plans (for children 16 and older)
- need for summer school (called Extended School Year)
- testing accommodations
- modified graduation requirements

Finally, when reviewing school records and other assessments of a child, it is critical to consider the standard of comparison. For example, when a special education teacher states that a child is doing well, those assisting the child claimant must further question what this means and upon what standard the special education teacher is relying. Is the teacher comparing the child to what one would expect of this child, given his/her limitations, or is the teacher comparing the child to other children in the special education class or to children

45 20 C.F.R. 416.924a(b)(7)

46 Common evaluations that are conducted by local school districts to assess whether a child is eligible for special education, and if so, what services are necessary, include, but are not limited to, the following: (1) psychological evaluations, (2) assessments of a child's academic functioning, and (3) evaluations of specific skills such as speech/language, motor (need for physical therapy or occupational therapy), memory, and/or neurological function.

in the general school environment who do not have impairments. Likewise, when a child in special education receives a report card with As and Bs on it, one must ask what this means. Does it mean the child is doing A and B work on his/her grade level or merely maintaining appropriate effort, but still functioning significantly below his/her grade level.

The key is to remember that the SSA compares the child's functional capabilities to those of children of the same age without the child claimant's impairments. Thus, the child's application will be aided by increased information and detail about the child's functional limitations. However, it is incumbent on the caregiver and those assisting the caregiver to look carefully at the data and records so that proper comparisons and analyses are made and assumptions and misunderstandings are avoided.

### **Approval for SSI Is a New Beginning**

A child who is eligible for federal SSI cash payments is also eligible, depending on the state, for state supplemental payments, Medicaid, Food Stamps, and other social services. This financial, medical, and rehabilitation support may enable a child to improve his or her level of functioning. When coupled with various work incentives provided by SSA, this support can ultimately lead an older child to independence and recovery in adulthood.

### **For More Information**

This issue brief was produced by the SAMHSA SOAR Technical Assistance (TA) Center under contract to the Substance Abuse and Mental Health Services Administration (SAMHSA). The SAMHSA SOAR TA Center develops and provides training and technical assistance to support children and adults who are experiencing or at risk of homelessness to apply for SSA disability benefits. For more information about SOAR or to take the SOAR Online Course: Child Curriculum, please visit <https://soarworks.samhsa.gov>.

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