UNDERSTANDING SSDI: How to Handle the Loss of Benefits; Overpayments; Medicare Eligibility; and Coordination with Other Public and Private Benefits

Patricia E. Kefalas Dudek
Sanford J. Mall
Raymond A. Harris

Many of our elderly clients and those with disabilities will need to (or should) interact with the Social Security Disability Income (SSDI) system. SSDI is an income benefit paid by the Social Security Administration (SSA) to a disabled worker who qualifies for the benefits. SSDI may also be paid on behalf of a disabled worker's dependents who qualify. It is our hope that this outline will help the practitioner become more aware of those clients who may be entitled to this valuable benefit (and the Medicare benefit connected to it) and who may be "falling between the cracks" of the system. Also, the authors hope to help provide a practical and easy-to-follow set of steps related to the appeal of SSDI denials, the resolution of overpayment issues, and the practical coordination with other public and private benefits.

1. **When Benefits Start**
    a. If individual's application is approved, the first Social Security benefit will be paid for the sixth full month after the date SSA finds that the disability began. For example, if individual's disability began on June 15, 2007, the first benefit would be paid for the month of December 2007, the sixth full month of disability.
    b. Social Security benefits are paid in the month following the month for which they are due. This means that the benefit due for December would be paid to individual in January 2008, and so on.
2. **How Much Will be Paid**
    a. The Social Security Statement that SSA sends each year will tell the individual how much the individual would get if he or she became disabled at the time the Statement is prepared.
    b. The disability benefit is equal to 100% of an individual worker's "Primary Insurance Amount" (PIA) as of the first month of his or her waiting period. The PIA is calculated AS IF the worker attained age 62 as of the first month of the waiting period. The only case in which the benefit is not equal to 100% of the PIA is the unusual case where the disability benefit is subject to "actuarial reduction" under SSA § 202(q) because a worker has already received early retirement benefits.[1] On the other hand, an early retirement benefit exactly at age 62 is 75% of one's PIA for individuals having a birth date on the second of the month and 24.58333% for anyone whose birthday is on any other day of the month. This is because for every month prior to the attainment of full retirement age, there is a reduction (called an "actuarial reduction") of 5/9 of 1% for each month prior to full retirement age (age 66 for individuals attaining age 62 in 2007), up to 36 months, plus 5/12 of 1% for each additional month. For someone retiring exactly at age 62 with a birthday on any day other than the second of the month, benefits will not begin in until the following month, since, by law, one must be eligible for

[1] 42 U.S.C. § 423(a)(2).

a benefit throughout a month in order to get it. Thus, for such a person the benefit formula is ((5/9) * (1/100) * 36)) + ((5/12)*(1/100) *11)] x the unreduced benefit (PIA). If the PIA is $1,000, then the reduced benefit would be 754.17, which when rounded down to the nearest $1, as required by law, yields $754.

3. **Denials of SSDI, Appeal Problems, and Options**
    a. The following procedure must be followed as of summer 2008:[2]
        i. Initial determination by SSA
            1. If after this step the only issue is whether the law is unconstitutional, the individual may use an expedited appeals process that permits individual to go directly to Federal or state court to resolve the constitutional issue as a declaratory action.
            2. This step is used for determining the individual's entitlement (or continuing entitlement) to benefits; amount of benefits; deductions from benefits on account of work; termination of benefits; penalty deduction imposed because the individual failed to report certain events; and overpayment/underpayments
            3. This is binding unless the individual requests reconsideration
        ii. Reconsideration
            1. Not used in Michigan except where SSA performs a continuing disability review. But this still happens in other states.
            2. A "Request for Reconsideration" may be filed at an SSA office after 60 days from the dated of the initial determination, but the individual must provide a written statement explaining "good cause" for missing the 60 day deadline. A statement of "good cause" must contain one or more good reasons why the individual did not request reconsideration within 60 days of the date on which he or she received the notice of the initial determination. Federal regulations state that SSA must consider the following in making their determination as to whether "good cause" exists: 1) all the circumstances which prevented an individual from making the request on time; and 2) whether the individual had any physical, mental, educational, or linguistic limitations (including problems speaking or reading in English) which prevented the him or her from filing the "Request for Reconsideration" within the 60 day period described above. If SSA finds that "good cause" exists for failure to file a timely request for reconsideration, the appeal will be accepted and forwarded to the DDS for a second medical determination.[3]
        iii. Hearing before ALJ;
            1. Must be requested within 60 days after the Reconsideration, but further extensions may be granted.
            2. In Michigan, hearing dates usually take 24-30 months or longer after a claim is submitted.

[2] 20 C.F.R. § 404.900(a)(1)-(5)
[3] *See also* POMS SI 04005.015.

a. The individual will be given notice 4 to 8 weeks before the hearing, during which time he or she should gather the most current medical records for the hearing.

3. Dire Need cases: when individual is in danger of losing shelter by foreclosure, forfeiture, or eviction. This will result in a shorter waiting time, usually within 3 to 5 months. Also applicable to utility shut-off notices.
4. Informal proceedings
    a. The Rules of Evidence are applied very loosely; evidence that would otherwise be inadmissible in a formal proceeding may be used here.
    b. Under the new review process (see below), evidence must be submitted at least 5 days ahead of time to the ALJ.[4]
5. The ALJ's decision must be based on evidence presented at hearing or that is in the record.
6. If the evidence in a hearing record supports a finding in favor of the claimant and all parties on every issue, the ALJ may issue a hearing decision without holding oral hearings.[5]
7. The attorney can request a determination on the record.
    a. The ALJ may issue a fully favorable decision.[6]
    b. The ALJ may also issue a "presumed" eligible decision.

iv. Appeals Council review

1. A request for review by the Appeals Council must be made within 60 days of ALJ's decision,[7] but may be extended upon a showing of good cause.[8]
2. The attorney should submit a letter or brief with the appeal form; favorable decisions are rarely granted based on the form alone.
3. The Appeals Council will review if one of the following are alleged:
    a. Abuse of discretion by the ALJ;
    b. Error of law;
    c. Actions, findings, or conclusions of the ALJ are not supported by law; or
    d. There is a broad policy or procedural issue that might affect the general public interest.[9]
    e. The Appeals Council will review all evidence in the record as well as any new and material evidence submitted to it that relates to the period on or before the date of the hearing decision.

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[4] 20 C.F.R. § 405.331(a).
[5] 20 C.F.R. § 404.948(a).
[6] Exhibit 1.
[7] 20 C.F.R. § 404.968(a).
[8] 20 C.F.R. § 404.968(b).
[9] 20 C.F.R. § 404.970(a).

f. The Appeals Council will either make a decision or remand to the ALJ. It may affirm, modify, reverse the ALJ's decision, or it may adopt, modify, reject, or recommend a decision.
    i. The Appeals Council's action is binding unless an action is filed in Federal court.
    ii. Decision can take between take 3 to 24 months.
    iii. The Appeals Council generally denies up to 80% of cases so do not be too discouraged if the individual's claim is denied.[10]

v. Judicial review in Federal court.
1. An action in Federal court must be filed within 60 days of the Appeals Council's decision and generally is brought in the district court for the judicial district in which individual resides or has his or her principle place of business.[11]
2. The court may affirm, reverse, and modify the Appeals Council's action.
3. SSA cases in Federal court are very complex and it is not unusual for an attorney to handle a case all the way through the Appeals Council review but hand it off to an attorney at the Federal level who specializes in Federal SSA cases.

vi. Emergency reviews
1. If you need to have the individual's case heard immediately, one way is to have the case listed as a terminal illness case. Sometimes referred to as a TERI case.[12]

b. Reopening and revising determinations and decisions
i. A closed decision may be reopened at a later date.[13]
1. This must be within 12 months of the date of the notice of the initial determination for any reason.[14] However, the statute of limitations is 4 years from the date of the notice of the initial determination and SSA must find good cause to reopen.[15]
    a. Good cause can be: new and material evidence is furnished; a clerical error in computation was made; or the evidence clearly shows that an error was made.[16] SSA will not reopen solely to challenge a legal interpretation or administrative ruling.[17]
2. Can be reopened at any time in cases involving fraud or other extraordinary cases.[18]

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[10] *See* Exhibit 2 for an overview of the success rates of appeals at the various levels.
[11] 42 U.S.C. § 405(g).
[12] Exhibit 3.
[13] 20 C.F.R. § 404.987(a).
[14] 20 C.F.R. § 404.988(a).
[15] 20 C.F.R. § 404.988(b).
[16] 20 C.F.R. § 404.989(a).
[17] 20 C.F.R. § 404.989(b).
[18] 20 C.F.R. § 404.988(c).

c. The attorney should also help the individual apply for Medicaid coverage during the above appeals process. In Michigan, the wait for SSA hearings is currently two years or longer. However, one can get through the same disability determination process much faster via the State Medicaid process. Then when you get to the SSA hearing the Medicaid coverage can be used as compelling evidence.
d. SSDI enacted sweeping changes to the appeals process in 2006 on a region by region basis, starting with Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont) The new disability improvement process includes the following steps from the initial claim through review and appeals:
    i. Initial determination of the claim-including a "Quick Disability Decision" if appropriate.
    ii. A Federal Reviewing Official (RO) to review state agency determinations upon the request of the claimant. According to SSDI, this will eliminate the reconsideration step of the current appeals process.
    iii. ALJ hearings. Again, note that several changes have been made to these hearings regarding submission of evidence.
    iv. Reviews by the Decision Review Board (DRB). Other than dismissals, these reviews are not claimant-initiated.
    v. Federal Court. Note: no new evidence or testimony will be allowed at this level. Therefore, non-attorney representatives who are not authorized to appear in federal court may not initiate appeals at this level.[19]
e. There have also been important developments under the Equal Access to Justice Act for attorney fees.
    i. As of 2007, the Government has routinely filed motions in district courts opposing the payment of EAJA fees directly to the plaintiff's attorney. In these opposition briefs, the government argues that the statutory language of the Equal Access to Justice Act awards the fee to the "prevailing party," not to the attorney. Thus, it must be payable to the plaintiff, not to the plaintiff's attorney. The government will no longer agree to stipulate that the EAJA check be made payable to the plaintiff's attorney. The government will oppose the payment of the fee directly to the attorney. Now that the government has raised the issue, several courts have recently held that the EAJA fees should be paid to the plaintiff, as the "prevailing party."[20] The Department of Justice and SSA are pursuing a uniform national policy. This issue is expected to arise in every circuit and that the government will be filing similar briefs in every case.
        1. However, this is recent case law that contradicts this.[21]

4. **How Other Payments May Affect SSDI Benefits**

[19] Available at www.ssa.gov/disability/
[20] *See* Manning v. Astrue, 510 F.3d 1246 (10th Cir. 2007); Reeves v. Astrue, 526 F.3d 732 (11th Cir. 2008).
[21] Ratliff v. Astrue, 540 F.3d 800 (8th Cir. 2008) (holding that the government was not authorized to offset attorney fees against claimants' debts as the fees were awarded to the attorney, not the claimant). *See also* Marre v. United States, 117 F.3d 297 (5th Cir. 1997).

a. If an individual receives certain other government benefits such as workers' compensation, public disability benefits or pensions based on work not covered by Social Security (for example, government or foreign employment), the Social Security benefits payable to individual and family may be reduced.
    i. Workers' compensation
        1. Disability payments from private sources, such as private pension or insurance benefits, do not affect individual's Social Security disability benefits.
        2. **However, workers' compensation and other public disability benefits may reduce individual's Social Security benefits.** Workers' compensation benefits are paid to a worker because of a job-related injury or illness. They may be paid by federal or state workers' compensation agencies, employers or by insurance companies on behalf of employers.
        3. Other public disability payments that may affect individual's Social Security benefit are those paid by a federal, state or local government and are for disabling medical conditions that are not job-related. Examples are civil service disability benefits, military disability benefits, state temporary disability benefits and state or local government retirement benefits that are based on disability.
        4. **If the individual receive workers' compensation or other public disability benefits and Social Security disability benefits, the total amount of these benefits cannot exceed 80% of individual's average current earnings before he or she became disabled.**
    ii. Public benefits that will not reduce SSDI
        1. If the individual receives Social Security disability benefits and one of the following types of public benefits, the individual's Social Security benefit will not be reduced:
            a. Veterans Administration benefits;
            b. State and local government benefits, if Social Security taxes were deducted from individual's earnings; or
            c. SSI.

5. **Relationship Between SSDI and Medicare**
    a. The individual who receives disability benefits for 24 months will receive Medicare coverage starting the 25th month.[22]
        i. Months in previous periods of disability may be counted towards the 24-month Medicare qualifying period if the new disability begins:
            1. Within 60 months after the termination month of the workers` receiving disability benefits; or
            2. Within 84 months after the termination of disabled widows` or widowers` benefits or childhood disability benefits; or
            3. At any time if the current disabling impairment is the same as, or directly related to, the impairment which was the basis for the previous period of disability benefits entitlement.

[22] Available at http://www.socialsecurity.gov/disabilityresearch/wi/medicare.htm

b. If an individual entitled to SSDI does not apply for Medicare before his or her 65th birthday, coverage is retroactive to the first month of eligibility provided the application is filed within 6 months of that date. If more than 6 months after the month the individual becomes eligible is retroactive to the 6th month before the month it was filed.[23]
c. An individual can receive at least 93 consecutive months of Medicare hospital and supplemental medical insurance after the trial work period. This provision allows health insurance to continue when individual returns to work and is engaging in SGA.[24]
    i. The trial work period is an incentive for the personal rehabilitation efforts of SSDI beneficiaries who work. The trial work period lets the individuals test their ability to work or run a business for at least 9 months and receive full SSDI benefits, if the individual reports the work activity and the impairment does not improve.

6. **Overpayments**
    a. An overpayment occurs when an individual receives more than the correct payment.
        i. There are two ways to defeat an overpayment allegation: reconsideration and waiver.
            1. If the individual is overpaid and does not agree with the amount, the first step is to ask for a Request for Reconsideration and fill out form SSA-561-U2.
                a. This step can also be used in conjunction with the Waiver request, below, if the individual feels that he or she was overpaid and if so that he or she should not have to refund the overpayment.[25]
                b. Must be requested within 60 days of the initial notice of overpayment.[26]
                c. Reconsideration should be requested unless the existence of the overpayment and the amount are indisputably correct.[27]
            2. Waiver concedes the overpayment but seeks relief from recoupment.[28]
                a. Repayment may be waived if the individual is both without fault and the repayment would either defeat the purpose of Title II or Title XVI or repayment would be against equity and good conscience.[29]
                b. The form "Request for Wavier of Overpayment Recovery or Change in Repayment Rate" must be filled out, and waiver can be requested at any time.[30]

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[23] 42 C.F.R. § 406.6(d)(4).
[24] Available at http://www.socialsecurity.gov/disabilityresearch/wi/medicare.htm
[25] http://www.socialsecurity.gov/online/ssa-561.html
[26] Samuels, Barbara, "*Overpayments: The Curse of Social Security and SSI Recipients,*" (2003) at page 70.
[27] *Id.* at 71
[28] *Id.* at 70.
[29] *Id.* at 73.
[30] *Id.*

c. In determining fault, SSA looks at all pertinent circumstances such as age, intelligence, education, physical and mental condition.[31] What constitutes fault depends on whether the facts show that the incorrect payment to an individual resulted from:
    i. An incorrect statement by the individual that he or she knew or should have known was incorrect;[32]
    ii. A failure to furnish information that the individual known or should have known to be material;[33] or
    iii. With respect to the overpaid individual only, an acceptance of a payment that he or she either know or could have been expected to know was incorrect.[34]
d. Additional regulations for fault determinations for Title II deduction overpayments state that the recipient will be at fault in respect to reporting requirements if either lack of good faith or a failure to exercise a high degree of care is shown.[35]
    i. Additional regulations for fault determinations for Title II entitlement overpayments state that the recipient will be without fault if the recipient relied on SSA misinformation, ambiguous SSA policy, or rate changes due to auxiliary entitlement.[36]
e. In addition to fault, above, the individual most show that repayment would either defeat the purpose of Title II or Title XVI or be against equity and good conscience.[37]
    i. "Defeat the purpose of Title II or Title XVI" means that recovery would deprive a person of income required for ordinary and necessary living expenses (food, clothing, utility payments, rent/mortgage, medical expenses, and expenses for a dependant.)[38]
        1. For Title II overpayments, SSA will presume that recovery would defeat the purpose of Title II if the recipient receives public assistance.[39] This will also be met if the Title II recipient if the individual uses substantially all of his or her income on living expenses and if recovery would

[31] *Id.* at 76.
[32] *Id* at 74.
[33] *Id.*
[34] *Id.*
[35] *Id.*
[36] *Id.* at 74-75.
[37] *Id* at 76.
[38] *Id.*
[39] *Id.*

reduce assets below $3,000 for that individual or $5,000 for an individual with a spouse or one dependent, plus an additional $600 for each additional dependent.[40]

2. Recovery will not "defeat the purpose" for any of the following: retaining the overpayment after notice; spending the overpayment after notice; spending the overpayment before notice if used to purchase assets (i.e. items other than clothing, household furnishings, and family car.)[41]

ii. "Be against equity and good conscience" means that the individual changed his or her position for the worse or relinquished a valuable right because of reliance on a notice that payment would be made or because of the overpayment itself or was living in a separate household from the overpaid person at the time of the overpayment and did not receive the overpayment.[42]

1. Money does not matter here—if this prong is satisfied the overpayment will be waived without evaluating "defeat the purpose."[43]
2. The following example illustrates where recovery would be against equity and good conscience because the individual gave up a valuable right: the beneficiary of retirement benefits resigned from work in reliance on payments that were later determined to be overpayments when he was found ineligible because he was uninsured, and he was too old to get his job. [44]

f. The SSA has the burden of proof to show that an overpayment occurred but the claimant has the burden of proof to show without fault.[45]

ii. Recovery methods

1. Adjustment of ongoing benefit
   a. For SSI recipients, adjustment is limited to 10% of total monthly income.[46]

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[40] *Id.* at 77.
[41] *Id* at 77.
[42] *Id* at 77-78.
[43] *Id* at 78.
[44] *Id.*
[45] *Id* at 81.
[46] *Id.*at 90.

b. There is no limit for Title II recipients but adjustment may be decreased due to hardship, which means the inability to pay for the necessities of life.[47]
c. Where recipient receives both and has a Title II overpayment, only 10% of the Title II benefit can be withheld to recover the Title II debt.[48]
d. For current non-recipients, the outstanding amount may be recouped from any benefits that later become due, to a maximum of ten years from when the debt accrued. [49]
    i. A debt accrues at the later of the following: initial overpayment determination is made; or it is affirmed by an administrative appeal proceeding (reconsideration, ALJ, Appeals Council); or it is affirmed by a court with proper jurisdiction; or adjustment is the method of recovery but it is no longer available; or debtor defaults on repayment agreement.[50]

2. Recovery by civil suit
    a. Limited by a six year statute of limitations after the debt accrues (see above for when debt accrues.)[51]
    b. Prerequisites to filing of a civil suit:[52]
        i. Debt of must be of a sufficient size to warrant collection;
        ii. The action cannot be time-barred;
        iii. The government must be able to prove its case;
        iv. The individual must be located; and
        v. There must be income or assets sufficient to repay a substantial portion of the debt within a reasonable period.
3. Compromises on overpayments
    a. SSA may compromise if the individual (or the estate) does not have the present or prospective ability to pay the full amount within a reasonable time or when cost of collection is likely to exceed cost of recovery. The amount compromised is generally 60% to 80%.[53]
    b. No compromise if indication of fraud or wrongdoing on the individual's part.[54]
    c. If no fraud, then SSA will consider the following in determining whether to accept a compromised amount in

[47] *Id* at 90-91.
[48] *Id.* at 91.
[49] *Id.*
[50] *Id.*
[51] *Id.* at 91-92.
[52] *Id.* at 92.
[53] *Id.*
[54] *Id.*

full settlement: amount of overpayment; percentage of debt offered in compromise; individual's financial circumstances; how long the recoupment process would take if compromise is rejected; and age of claimant.[55]

4. Recovery by seizure of tax refunds
    a. To seize a tax refund, the amount owed must be certain, past due (more than two months), legally enforceable, and eligible for refund offset.[56]
5. Notice to credit reporting agencies and private debt collectors
    a. Amounts more than $25 may be reported to credit agencies and debt collectors.[57]
6. Administrative offset
    a. Used to collect wages or pensions.[58]
7. Recoupment of overpaid SSI benefits from current Title II benefits
    a. Must no longer receive SSI benefits and is limited to 10% of Title II benefit amount.[59]

iii. Options after unfavorable decisions

1. Bankruptcy.[60]
2. New waiver request
    a. Worsened financial condition.[61]
    b. Res judicata-applies if the first waiver decision resulted in a finding of the individual being not "without fault." A second waiver request in this situation will have no effect.[62]
3. Extension of time to appeal the first determination.[63]
4. Statement or stipulation to repay the SSA executed by a pro se individual or incapacitated individual can be successfully "undone."[64]

b. Preserving current eligibility

i. SSA may find that the individual is currently ineligible due to an overpayment.[65]

ii. If current benefits will be terminated due to current ineligibility, this can be appealed within 60 days.[66] Interim benefits while the appeal is pending can be appealed within 10 days.[67]

c. How to avoid common overpayment problems

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[55] *Id.*
[56] *Id.* at 93.
[57] *Id.* at 93.
[58] *Id.* at 94.
[59] *Id.* at 96.
[60] *Id.* at 97.
[61] *Id.*
[62] *Id.*
[63] *Id.*
[64] *Id.*
[65] *Id.*
[66] *Id.* at 98.
[67] *Id.*

i. May problems can simply be avoided by reporting promptly the following events that can impact entitlements to benefits:
    1. Change of address;[68]
    2. Change in living arrangements including change in marital status, death of spouse or member of household, new person living in household, admission to nursing home or hospital, admission to jail or prison;[69]
    3. Change in income, including new or any other income, new benefit payments to household, wages from work, and increase in resources;[70]
    4. Leaving the United States for more than 30 days, including trips to Puerto Rico;[71]
    5. Medical improvement or returning to work.[72]
ii. The above events must be reported to the local SSA office within 10 days after the end of the month in which the event occurred.[73]

7. **Coordinating SSDI with Other Benefits**
    a. SSDI and Medicaid
        i. SSDI payments are counted as unearned income pursuant to PEM 500 for Michigan Medicaid purposes.[74]
        ii. SSDI is a payment to individual, whereas Medicaid is not paid to individual but rather pays for incurred medical expenses.
        iii. In Michigan, SSI automatically makes the individual eligible for Medicaid. However, if the individual receives SSDI, Medicaid eligibility is not automatic.
    b. SSDI-eligible Medicare health insurance coverage versus private health insurance
        i. SSDI as gateway to Medicare health care coverage as described above.
        ii. Medicare does not turn down individuals because of a disability—it covers these individuals because of a disability. Private insurance can turn down or may charge exorbitant rates for people with pre-existing conditions.
        iii. SSDI recipients are encouraged to return to work as soon as feasible but continues to provide a safety net of Medicare health insurance for up to 93 months after return to work.
        iv. High costs of private insurance v Medicare
8. **The Case for Case Management**
    a. What is case management?
        i. A case manager is a health or human services professional with experience in managing healthcare. Most are registered nurses, social workers, psychologists, health administrators, gerontologists, physical or occupational therapists, or vocational rehabilitation counselors.

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[68] *Id.* at 69.
[69] *Id.*
[70] *Id.*
[71] *Id.*
[72] *Id.*
[73] *Id.* at 70.
[74] Available at http://www.mfia.state.mi.us/olmweb/ex/pem/500.pdf.

ii. These professionals can help individuals deal with catastrophic injuries and help them navigate the healthcare system.

b. Areas of expertise
   i. Comprehensive assessment of individual's health and safety.
   ii. Relieving the family or guardian's stress in dealing with the individual's day-to-day demands.
   iii. Connecting individuals to appropriate community services.
   iv. Facilitating communications between healthcare professionals.
   v. Assistance with health, social security disability, and long-tem care insurance plans.

c. What to look for in a case manager
   i. Be aware that there is no state licensing organization, only professional organization certificates—look for the credentials after the professional's name (RN, MD, LMSW, etc.)
   ii. Request professional references.
   iii. Make sure the case manager has experience in dealing with your type of individual.
   iv. Ask how services are billed.

d. Who pays for case management
   i. Usually a state plan services under Medicaid. It is in the state's best interest to secure as much Federal funding as possible.
   ii. Can also be covered under the Medicaid waiver.
   iii. Can also be covered by automobile no-fault carrier or health insurance provider.

e. Trustees of special needs trusts and case managers
   i. The Trustee is often acting as a case manager and may need to work with other options to assure coordination of all public resources.
   ii. Case managers can assist in preparing medical and factual evidence for appeals of benefits.
   iii. Case managers can especially helpful with coordinating drug benefits between Medicare and Medicaid.

9. **Miscellaneous**

a. Often times SSA will not recognize valid Powers of Attorney. However, SSA does have their own forms that can be used to appoint another person.[75]
   i. In one instance, SSA refused even to honor Letters of Conservatorship. A Motion and Order to Show Cause had to be filed in the Oakland County Probate Court to force SSA to acknowledge the Letters of Conservatorship.[76]

b. Whenever anyone talks to a SSA representative, always take down the name of the person, date of conversation, and time. Sometimes they give misleading or wrong information.

c. Section 207 of the Social Security Act protects Social Security benefits.[77] SSA's responsibility for protecting benefits against legal process and assignment usually

[75] See Exhibit 4.
[76] See Exhibit 5.
[77] 42 U.S.C. § 407 *et. seq.*

ends when the beneficiary is paid. However, once paid, benefits continue to be protected under section 207 of the Act as long as they are identifiable as Social Security benefits using normal banking practices. For example, only social security benefits are deposited into a particular bank account. If a creditor tries to garnish an individual's social security check, inform them that unless one of the five exceptions applies, the benefits can not be garnished. The individual should also provide this same information to the financial institution and seek legal assistance if necessary. The five exceptions are:

i. Section 459 of the Act allows Social Security benefits to be garnished to enforce child support and/or alimony obligations;[78]
ii. Section 6334 (c) of the Internal Revenue Code allows benefits to be levied to collect unpaid Federal taxes;[79]
iii. Section 3402 (P) of the Internal Revenue Code allows beneficiaries to elect to have a percentage of their benefits withheld and paid to the Internal Revenue Service to satisfy their Federal income tax liability for the current year;
iv. The Debt Collection Act of 1996 allows benefits to be withheld and paid to another Federal agency to pay a non-tax debt the beneficiary owes to that agency;[80] and
v. The Tax Payer Relief Act of 1997 authorizes the Internal Revenue Service to collect overdue federal tax debts of beneficiaries by levying up to 15 percent of each monthly payment until the debt is paid.[81]

10. **Recent Developments-Medicare Set Asides**
    a. A Medicare Set Aside (MSA) is part of the Medicare Secondary Payer (MSP) statutes. [82]
        i. A MSA is an account which contains the first year of anticipated medical expenses in cash, with the remaining years' anticipated expenses paid into the account through the use of a structured settlement. If the MSA account is exhausted during that year, Medicare becomes the primary payer until the next payment is paid into the account.
            1. A MSA can be used to pay a provider so long as two criteria are met::
                a. the medical treatment or service must be injury related and
                b. it must be a Medicare allowable expense
        ii. Medicare is a secondary payer for any medical services for which payments have been made or which can reasonably expected to be made under a workmen's compensation law
        iii. Beginning July 1, 2009, Medicare will make only provisional payments for services and whenever there is another potential source of payment, CMS will have presumptive rights to claim against it.

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[78] 42 U.S.C. § 659.
[79] 26 U.S.C. § 6334(c).
[80] Public Law 104-134.
[81] Public Law 105-34.
[82] 42 U.S.C.§ 1395y(b).

1. This includes a federal or state plan, automobile or liability insurance policy, a self-insured plan, or under no-fault insurance.[83]
2. While this has long been an issue as it relates to worker's compensation awards, the new amendment significantly broadens the scope of Medicare's right to recovery.
    a. These issues can now arise any situation where there is a settlement paid to or on behalf of any injured party who is either a Medicare recipient or may become one within 30 months.
    b. Medicare regulations states that "[i]f a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work related inquiry or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump sum payment."[84]
    c. MSA outside of the worker's compensation arena
        i. CMS now takes the position that the Medicare Secondary Payer Act requires that a MSA be established in the case of judgments and settlement awards in personal injury cases which do not involve worker's compensation claims.[85]
3. Failure to comply with the new regulations can result in fines of $1,000 per day.[86]
4. This is particularly important to special needs attorneys who advise and counsel not only the client but also personal injury lawyers and others as CMS will be seeking recovery from anyone in the chain that fails to follow proper procedure to perfect and insure CMS' right to offset.
    a. The Northern District of West Virginia recently held that attorneys are included in this "chain" and can be held liable for non-compliance.[87]

b. Steps to analyzing a potential MSA situation
    i. Determine what type of settlement
        1. Structured settlement versus outright payment
            a. If a structured settlement is used, then set-aside should be dealt with through the structure and will probably have occurred prior to special needs lawyer being involved, but the special needs lawyer should verify just in case;

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[83] Section 111 of the MSP

[84] 42 CFR § 411.46

[85] 42 U.S.C. § 1395y(b)(2)(A). That section provides that "Payment under this subchapter may not be made, . . . , with respect to any item or service to the extent that . . . (ii) payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance."

[86] Section 111 of the MSP.

[87] *United States v. Harris*, Case No. 5:08CV102 (N.D.W.V. Nov. 13, 2008).

i. Applicable Federal law relating to structured settlements can be found at 26 U.S.C. § 5891(A)(i)-(ii) & (B)(i)-(ii).[88]

ii. Resolve any existing liens;

iii. Determine if a set-aside for futures is needed;

1. If so, follow the process as set out by statute;
2. Decide whether set-aside will be handled inside or outside of a trust arrangement;
3. Counsel client as to administration of the set-aside including meticulous record keeping;
    a. The onerous nature of compliance is one reason why someone may want to use a set-aside administrator. There are many private companies that specialize in the calculation of the amount of assets to be segregated and administration of these accounts.

11. **Employer Provided Health Care Extended to Adult Child**

a. The Working Families Tax Relief Act of 2004 (WFTRA), effective in 2005, redefined the definition of "dependent" as it applies to health and welfare benefits and also defined-contribution pension plans.

b. WFTRA also unintentionally created technical glitches, the outcomes of which could result in exclusion of individuals that employers thought were covered and possible taxable income for employees when covering certain individuals.[89]

i. Example: Susie is 23 years old and has a disability. She still lives at home with her parents and attends school, and Michigan has special education services from the ages of 0-26. Prior to the WFTRA, if she was a dependent under IRC Section 152, then she could continue to be covered by her father's employer provided health insurance, and the benefit was not included in her father's gross income. However, WFTRA changed the definition and may cause her to lose this coverage, and/or have it included in her father's gross income. Before WFTRA, a child could have been a dependent regardless of age or gross income.[90]

ii. However, the IRS intends to revise the regulations at 26 CFR § 1.1061 to provide that the term "dependent" for purposes of § 106 shall have the same meaning as in § 105(b).[91]

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[88] That section provides defines structured settlement as "An arrangement which is established by suit or agreement for the periodic payment of damages excludable from gross income of the recipient under section 104(a)(2) or an agreement for the periodic payment of compensation under any workers' compensation law excludable from the gross income of the recipient under section 104(a)(1) and under which the periodic payments are of the character described in subparagraphs (A) and (B) of section 130(c)(2) and payable by a person who is a party to the suit or agreement or to the workers' compensation claim or by a person who has assumed liability for such periodic payments under a qualified assignment in accordance with section 130."

[89] Blair, Dennis T. and Malynn, Brian J., *"Solving the Dependent Definition Dilemma in Employee Benefit Plans,"* Benefits Law Journal, Vol. 19, No.1 (Spring 2006). The article includes a description of the individuals that qualify for tax favored treatments as well as model plan document language employers can use to describe the dependents their plans cover.

[90] *Id.*

[91] http://www.irs.gov/irb/2004-49_IRB/ar10.html.

c. In Michigan, state law provides that "[a]ny certificate issued by a health care corporation which provides that coverage of a dependent of the subscriber terminates at a specified age shall not terminate with respect to an unmarried child who is incapable of self-sustaining employment by reason of mental retardation or physical disability, if the following conditions are met: (a) The child became incapable before 19 years of age and is chiefly dependent upon the subscriber for support and maintenance. (b) Before the child turns 19 years of age, or within 31 days thereafter, the subscriber has submitted proof of the dependent's incapacity to the corporation."[92]

12. **Websites of Interest**
    a. National Organization of Social Security Claimant's Representatives (NOSSCR): www.nosscr.org
    b. National Senior Citizens Law Center: www.nsclc.org
    c. Martin on Social Security: www.law.cornell.edu/socsec/martin
    d. Social Security Advisory Service: www.ssas.com

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[92] MCL § 550.1410

EXHIBIT 1

SOCIAL SECURITY ADMINISTRATION

Refer To: [redacted]

Office of Disability Adjudication and Review
Crown Pointe, Ste. 500
25900 Greenfield Road
Oak Park, MI 48237

Date: APR 8 0 2008

[redacted]

NOTICE OF DECISION – FULLY FAVORABLE

I have made the enclosed decision in your case. Please read this notice and the decision carefully.

This Decision is Fully Favorable To You

Another office will process the decision and send you a letter about your benefits. Your local Social Security office or another may first ask you for more information. If you do not hear anything for 60 days, contact your local office.

The Appeals Council May Review The Decision On Its Own

The Appeals Council may decide to review my decision even though you do not ask it to do so. To do that, the Council must mail you a notice about its review within 60 days from the date shown above. Review at the Council's own motion could make the decision less favorable or unfavorable to you.

If You Disagree With The Decision

If you believe my decision is not fully favorable to you, or if you disagree with it for any reason, you may file an appeal with the Appeals Council.

How to File an Appeal

To file an appeal you or your representative must request that the Appeals Council review the decision. You must make the request in writing. You may use our Request for Review form, HA-520, or write a letter.

You may file your request at any local Social Security office or a hearing office. You may also mail your request right to the **Appeals Council, Office of Disability Adjudication and Review, 5107 Leesburg Pike, Falls Church, VA 22041-3255**. Please put the Social Security number shown above on any appeal you file.

See Next Page

Time to File an Appeal

To file an appeal, you must file your request for review within 60 days from the date you get this notice.

The Appeals Council assumes you got the notice 5 days after the date shown above unless you show you did not get it within the 5-day period. The Council will dismiss a late request unless you show you had a good reason for not filing it on time.

Time to Submit New Evidence

You should submit any new evidence you wish to the Appeals Council to consider with your request for review.

How an Appeal Works

Our regulations state the rules the Appeals Council applies to decide when and how to review a case. These rules appear in the Code of Federal Regulations, Title 20, Chapter III, Part 416 (Subpart N).

If you file an appeal, the Council will consider all of my decision, even the parts with which you agree. The Council may review your case for any reason. It will review your case if one of the reasons for review listed in our regulation exists. Section 416.1470 of the regulation lists these reasons.

Requesting review places the entire record of your case before the Council. Review can make any part of my decision more or less favorable or unfavorable to you.

On review, the Council may itself consider the issues and decide your case. The Council may also send it back to an Administrative Law Judge for a new decision.

If No Appeal and No Appeals Council Review

If you do not appeal and the Council does not review my decision on its own motion, you will not have a right to court review. My decision will be a final decision that can be changed only under special rules.

See Next Page

If You Have Any Questions

If you have any questions, you may call, write or visit any Social Security office. If you visit an office, please bring this notice and decision with you. The telephone number of the local office that serves your area is (248)364-4575. Its address is Social Security Admin., 1280 Pontiac Rd., Pontiac, MI 48340.

Gerald A. Freedman
U.S. Administrative Law Judge

cc: Patricia K. Dudek
4190 Telegraph, Suite 3000
Bloomfield Hills, MI 48302

SOCIAL SECURITY ADMINISTRATION
Office of Disability Adjudication and Review

DECISION

IN THE CASE OF

[redacted]
(Claimant)

(Wage Earner)

CLAIM FOR

Supplemental Security Income

[redacted]
(Social Security Number)

JURISDICTION AND PROCEDURAL HISTORY

This case is before the undersigned on a request for hearing dated September 26, 2007. The evidence of record supports a fully favorable decision; therefore, no hearing has been held (20 CFR 416.1448(a)). The claimant is represented by Patricia K. Dudek, an attorney.

The claimant is alleging a disability since May 21, 2007.

ISSUES

The issue is whether the claimant is disabled under section 1614(a)(3)(A) of the Social Security Act. Disability is defined as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment or combination of impairments that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

After careful review of the entire record, the undersigned finds that the claimant was disabled as of May 21, 2007, her alleged onset date, and that the claimant's disability has continued through the date of this decision.

APPLICABLE LAW

Under the authority of the Social Security Act, the Social Security Administration has established a five-step sequential evaluation process for determining whether an individual is disabled (20 CFR 416.920(a)). The steps are followed in order. If it is determined that the claimant is or is not disabled at a step of the evaluation process, the evaluation will not go on to the next step.

At step one, the undersigned must determine whether the claimant is engaging in substantial gainful activity (20 CFR 416.920(b)). Substantial gainful activity (SGA) is defined as work activity that is both substantial and gainful. If an individual engages in SGA, she is not disabled

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regardless of how severe her physical or mental impairments are and regardless of her age, education, and work experience. If the individual is not engaging in SGA, the analysis proceeds to the second step.

At step two, the undersigned must determine whether the claimant has a medically determinable impairment that is "severe" or a combination of impairments that is "severe" (20 CFR 416.920(c)). An impairment or combination of impairments is "severe" within the meaning of the regulations if it significantly limits an individual's ability to perform basic work activities. If the claimant does not have a severe medically determinable impairment or combination of impairments, she is not disabled. If the claimant has a severe impairment or combination of impairments, the analysis proceeds to the third step.

At step three, the undersigned must determine whether the claimant's impairment or combination of impairments meets or medically equals the criteria of an impairment listed in 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 416.920(d), 416.925, and 416.926). If the claimant's impairment or combination of impairments meets or medically equals the criteria of a listing and meets the duration requirement (20 CFR 416.909), the claimant is disabled. If it does not, the analysis proceeds to the next step.

Before considering step four of the sequential evaluation process, the undersigned must first determine the claimant's residual functional capacity (20 CFR 416.920(e)). An individual's residual functional capacity is her ability to do physical and mental work activities on a sustained basis despite limitations from her impairments. In making this finding, the undersigned must consider all of the claimant's impairments, including impairments that are not severe (20 CFR 416.920(e) and 416.945; SSR 96-8p).

Next, the undersigned must determine at step four whether the claimant has the residual functional capacity to perform the requirements of her past relevant work (20 CFR 416.920(f)). If the claimant has the residual functional capacity to do her past relevant work, the claimant is not disabled. If the claimant is unable to do any past relevant work or does not have any past relevant work, the analysis proceeds to the fifth and last step.

At the last step of the sequential evaluation process (20 CFR 416.920(g)), the undersigned must determine whether the claimant is able to do any other work considering her residual functional capacity, age, education, and work experience. If the claimant is able to do other work, she is not disabled. If the claimant is not able to do other work and meets the duration requirement, she is disabled. Although the claimant generally continues to have the burden of proving disability at this step, a limited burden of going forward with the evidence shifts to the Social Security Administration. In order to support a finding that an individual is not disabled at this step, the Social Security Administration is responsible for providing evidence that demonstrates that other work exists in significant numbers in the national economy that the claimant can do, given the residual functional capacity, age, education, and work experience (20 CFR 416.912(g) and 416.960(c)).

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FINDINGS OF FACT AND CONCLUSIONS OF LAW

After careful consideration of the entire record, the undersigned makes the following findings:

1. The claimant has not engaged in substantial gainful activity since May 21, 2007, the alleged onset date (20 CFR 416.920(b) and 416.971 *et seq.*).

2. The claimant has the following severe impairments: borderline intellectual functioning and autism (20 CFR 416.920(c)).

3. The severity of the claimant's autism meets the criteria of section 12.10 of 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 416.920(d)).

In making this finding, the undersigned considered all symptoms and the extent to which these symptoms can reasonably be accepted as consistent with the objective medical evidence and other evidence, based on the requirements of 20 CFR 416.929 and SSR 96-4p and 96-7p. The undersigned has also considered opinion evidence in accordance with the requirements of 20 CFR 416.927 and SSR 96-2p, 96-5p, 96-6p and 06-3p.

The evidence includes an evaluation performed by [redacted], Psy.D., in February 2007 at which time testing showed a verbal I.Q. of 79, performance I.Q. of 80, and a full scale I.Q. of 78. These results placed the claimant within the borderline range of intellectual functioning.

In October 2007, [redacted], Ph.D., evaluated the claimant and found difficulties associated with autism. Her cognitive performance fell within the low average to borderline range based on the WAIS-III which showed a verbal I.Q. of 74, performance I.Q. of 80, and full scale I.Q. of 75. The claimant adapted well through consistent support and care from her family. However, she continued to be easily overwhelmed and had difficulty integrating information and using abstraction to problem solve and anticipate changes.

In addition, [redacted], a limited license psychologist, evaluated the claimant in November 2007 and also reported symptoms of autism, a childhood disintegrative disorder, Asperger's disorder, and nonspecific autistic spectrum disorder. The claimant engaged in repetitive behavior, such as daily walking six miles and cleaning her house which took up most of the day. Any significant disruption in established routine would produce panic reactions and reluctant maladaptive behaviors and resulted in functional limitations in learning, self direction, economic self sufficiency, and independent living. The claimant was considered unemployable.

Thus, the evidence shows qualitative deficits in the development of reciprocal social interaction and verbal and nonverbal communication skills. The claimant has a markedly restricted repertoire of activities and interests which are stereotyped and repetitive. This has resulted in marked restrictions of activities of daily living; marked difficulties in maintaining social functioning; marked difficulties in maintaining concentration, persistence or pace; and no episodes of decompensation.

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Accordingly, the undersigned finds that the claimant's medically determinable impairments could reasonably be expected to produce the alleged symptoms and that her statements concerning the intensity, persistence and limiting effects of these symptoms are generally credible.

The State agency medical opinions are given little weight because the State agency consultants did not adequately consider the claimant's subjective complaints. They found she could perform unskilled work which was not complicated and could be learned in a short time. Since they did not have the benefit of the most recent evidence, their findings are conclusory and not dispositive as to the claimant's ability to work.

4. The claimant has been under a disability, as defined in the Social Security Act, from May 2, 2007, through the date of this decision (20 CFR 416.920(d)).

DECISION

The claimant has been disabled under section 1614(a)(3)(A) of the Social Security Act since May 2, 2007, the date the application for supplemental security income was filed.

The component of the Social Security Administration responsible for authorizing supplemental security income will advise the claimant regarding the nondisability requirements for these payments, and if eligible, the amount and the months for which payment will be made.

Gerald A. Freedman
U.S. Administrative Law Judge

APR 3 0 2008

Date

SOCIAL SECURITY ADMINISTRATION
Office of Disability Adjudication and Review

ORDER OF ADMINISTRATIVE LAW JUDGE

IN THE CASE OF	CLAIM FOR
[redacted]	Supplemental Security Income
(Claimant)	
[redacted]	[redacted]
(Wage Earner)	(Social Security Number)

I approve the fee agreement between the claimant and her representative subject to the condition that the claim results in past-due benefits. My determination is limited to whether the fee agreement meets the statutory conditions for approval and is not otherwise excepted. I neither approve nor disapprove any other aspect of the agreement.

YOU MAY REQUEST A REVIEW OF THIS ORDER AS INDICATED BELOW

Fee Agreement Approval: You may ask us to review the approval of the fee agreement. If so, write us within 15 days from the day you get this order. Tell us that you disagree with the approval of the agreement and give your reasons. Your representative also has 15 days to write us if he or she does not agree with the approval of the fee agreement. Send your request to this address:

Paul C. Lillios
Regional Chief Administrative Law Judge
SSA ODAR Regional Office
Suite 2901
200 W. Adams Street
Chicago, IL 60606

Fee Agreement Amount: You may also ask for a review of the amount of the fee due to the representative under this approved fee agreement. If so, please write directly to me as the deciding Administrative Law Judge within 15 days of the day you are notified of the amount of the fee due to the representative. Your representative also has 15 days to write me if he/she does not agree with the fee amount under the approved agreement.

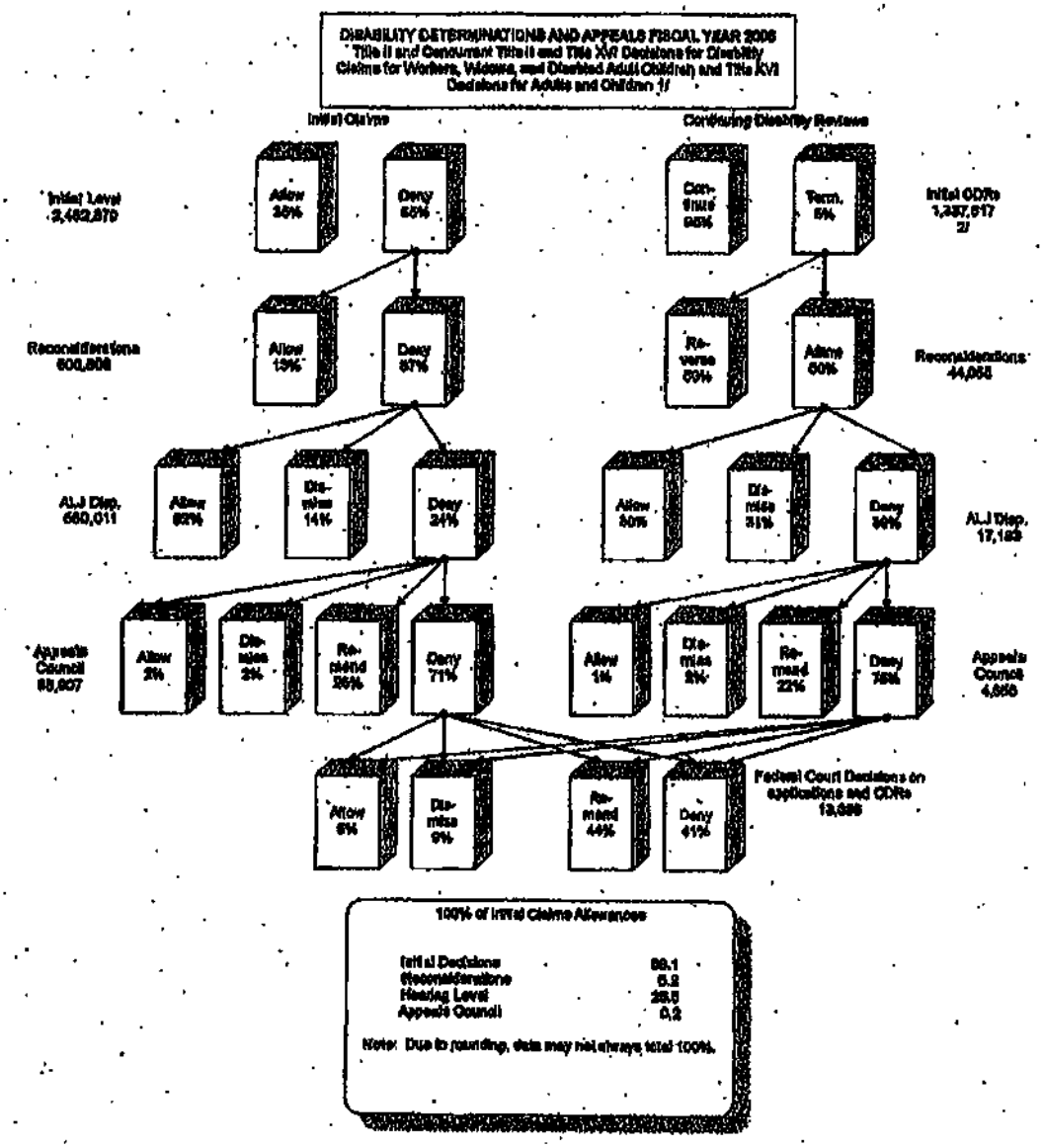
You should include the social security number(s) shown on this order on any papers that you send us.

Gerald A. Freedman
U.S. Administrative Law Judge

APR 30 2008

Date

EXHIBIT 2



1/ Includes all Title II and Title XVI disability determinations. The data relate to workloads processed (but not necessarily received) in fiscal year 2006, i.e., the cases processed at each adjudicative level may include cases received at one or more of the lower adjudicative levels prior to FY 2006. A revised process was introduced 10/1/99 in 10 States, under which initial denials could be appealed directly to OHA without a reconsideration.

2/ Includes non-State CDR initial continuances. Also includes 11,422 CDRs where there was "no decision." The continuance and termination rates are computed without the "no decision" cases.

Source: Office of Disability Programs, January 2007

EXHIBIT 3

SocialSecurityOnline
www.socialsecurity.gov

POMS Section DI 23020.045

TN 2 (01-08)

DI 23020.045 Terminal Illness (TERI) Cases

A. Policy - TERI Case

Cases with an indication of a terminal illness (TERI) must be handled in an expeditious manner because of their sensitivity. These cases may be identified by the Teleservice Center (TSC), Field Office (FO) or the Disability Determination Services (DDS). TERI cases may share common traits with other types of cases but are distinct, as they are indicative of a terminal illness. Military Service Casualty Cases (MSCC) are processed under expedited TERI procedures, but cannot be classified as TERI without the indication of terminal illness. Other types of cases involve a high probability of allowance, but **DO NOT** necessarily meet the TERI criteria including:

- Compassionate Allowance (CAL);
- Quick Disability Determination (QDD);
- Presumptive Disability/Presumptive Blindness (PD/PB);
- Impairment meets or equals listing level severity;
- Determination of less-than-sedentary capacity.

DDS management is responsible for tracking the cases during the DDS review process (whether at the initial or reconsideration level). TERI cases identified in the FO will be flagged in the Electronic Disability Collect System (EDCS) per "Messages and Flags" (DI 80801.095B). EDCS exclusion cases will be flagged per "Exhibit - SSA-2200" (DI 23020.045E) in this section, and mailed to the DDS in a priority mail envelope with a TERI designation identified on the outside of the envelope.

NOTE: Do not use the words *terminal* or *terminal illness* on any material in the case folder that might be disclosed to the claimant. Make every effort to ensure that the claimant sees no material, which would indicate that he or she has a terminal illness, especially in those cases where the claimant did not allege a terminal illness.

1. Identifying TERI Cases

TERI cases are identified either directly by the claimant or indirectly by the TSC, FO, and DDS staff through use of TERI descriptors.

All claims representatives and disability examiners must be on the alert to identify possible TERI cases. See, in this section, "List of Descriptors" (DI 23020.045B.).

TERI cases must be flagged, tightly controlled, and expedited throughout DDS processing. The FO will use simultaneous development of TERI cases. For Title II cases see DI 11005.601D.3.b. for Title XVI cases see SI 00603.002C. and SI 00603.004.

2. FO Tracking and Follow Up

FOs are responsible for tracking and controlling TERI cases through the initial and reconsideration levels of review. If the DDS has not completed its actions within 30 days, contact the DDS examiner. If the DDS has not completed its actions within 60 days, contact the DDS management.

3. DDS Management Responsibility for TERI Cases

DDS management is responsible for tracking and controlling TERI cases through the initial and reconsideration levels of review at the DDS. Management is instructed to ensure Quality Assurance (QA) or supervisory follow-up at the following intervals:

- 10 days after receipt.
- Every 10 days thereafter until the DDS has completed its actions.

B. List of Descriptors

A case may be identified as a TERI case by using the following criteria.

1. Situation - TERI Cases

The following situations provide information that can be used to identify a case for TERI processing:

- There is an allegation (e.g., from the claimant, a friend, family member, doctor or other medical source) that the illness is terminal.
- An allegation or diagnosis of Amyotrophic Lateral Sclerosis (ALS), known as Lou Gehrig's Disease;
- There is an allegation or diagnosis of Acquired Immune Deficiency Syndrome or Acquired Immunodeficiency Syndrome (AIDS).
- The claimant is receiving inpatient hospice care or is receiving home hospice care e.g., in-home counseling or nursing care.

2. Condition - TERI Cases

The claimant alleges or medical records indicate an impairment which is untreatable (i.e., the impairment cannot be reversed and is expected to end in death) including but not limited to the following list of descriptors:

a. Chronic dependence on a cardiopulmonary life-sustaining device.

b. Awaiting a heart, heart/lung, liver, or bone marrow transplant (excludes kidney and corneal transplants).

c. Chronic pulmonary or heart failure requiring continuous home oxygen and is unable to care for personal needs.

d. Any malignant neoplasm (cancer) which is:

   - Metastatic (has spread);

- Stage IV;
- Persistent or recurrent following initial therapy; or
- Inoperable or unresectable.

e. An allegation or diagnosis of:

- Cancer of the esophagus;
- Cancer of the liver;
- Cancer of the pancreas;
- Cancer of the gallbladder;
- Mesothelioma;
- Small Cell or Oat Cell lung cancer;
- Cancer of the brain; or
- Acute Myelogenous Leukemia (AML) or Acute Lymphocytic Leukemia (ALL).

f. Comatose for 30 days or more.

g. Newborn with a lethal genetic or congenital defect.

The above list, shown on the back of the TERI Flag (i.e., SSA-2200 (TERI Case)), is not intended to be all-inclusive. It should be used to provide general guidance in the identification of TERI cases. The remaining category of: *Other:* _____ allows for cases which are not identified in the list of descriptors to be included as well, as long as the medical condition is untreatable and is expected to end in death.

C. DDS Receives TERI Case Identified By the FO

1. TERI Case Receipt

Upon receipt of TERI cases from the FO:

- Record the case for special control and processing as a TERI case. (Controls are manual or automated.) Use study list code (SLC) U to identify TERI cases. Use SLC Q to identify TERI/Zebley cases. See "How to Complete the Receipt (DREC) Data Input Screen" (SM 06001.120B.20.). Include the name of the assigned examiner on the control.
- Expedite assignment of the case for review no later than the next business day.
- Hand-carry TERI EDCS exclusion cases to the assigned examiner for expeditious review.

2. TERI Case Processing

The assigned examiner will:

- Develop and adjudicate as a priority. Handle any development or follow-up actions by telephone, fax, or other electronic means. Expedite Form SSA-448 (Request for Medical Advice) or other locally used form, if Medical Consultant (MC) review is required.
- Retain the TERI designation throughout the process, even though medical evidence may show the

designation is questionable.

- List all TERI cases using disability-related list code 153 per "Completion of Item 26 (List Number)" (DI 26510.070) and "Disability-Related List Codes (Active)" (DI 33530.005).

NOTE: Medical deferment to assess response to treatment or level of residual impairment is rarely applicable to a TERI case. In many TERI cases, a favorable determination can be immediately made based on an *equals or medical-vocational basis*. Should an examiner feel that medical deferment is warranted, obtain documented approval from a MC using Form SSA-416 (Medical Evaluation) for inclusion in the medical record.

D. DDS Identifies TERI Case during Development

1. Identifying TERI cases in the DDS

- Identify TERI cases according to DI 23020.045B. and process according to DI 23020.045C.
- Flag the case as TERI per DI 80801.095B., or for EDCS exclusions per DI 23020.045E.
- Do not remove the TERI flag from the folder.
- Ensure that DDS controls show the name of the assigned examiner.
- Notify the FO by telephone or other electronic means, to initiate simultaneous development and to begin tracking the case per (DI 11005.601D.3.d.).

2. EDCS Exclusion TERI Case Allowances

When the DDS processes an allowance on an EDCS exclusion TERI case, send the case folder to the FO by priority mail with a TERI designation on the envelope. If the case is selected for Disability Quality Branch (DQB) for Preeffectuation or Quality Assurance (QA) review, send the case in a specially marked envelope by priority mail to the designated office for an expeditious review.

3. TERI Case Denials

The DDS QA Unit or the unit supervisor will conduct a special review of the determination when a denial or reconsideration affirmation is made on a TERI case.

NOTE: Military Service Casualty Cases (MSCC) are processed under expedited TERI procedures, but cannot be classified as TERI without the indication of terminal illness. Mandatory DDS QA does not apply to MSCC cases unless they are also classified as TERI.

E. Exhibit - SSA-2200 (TERI CASE)

See OS 15020.301 for an exhibit of the TERI Case.

EXHIBIT 4

COMPLETING THIS FORM TO APPOINT A REPRESENTATIVE

Choosing To Be Represented

You can choose to have a representative help you when you do business with Social Security. We will work with your representative, just as we would with you. It is important that you select a qualified person because, once appointed, your representative may act for you in most Social Security matters. We give more information, and examples of what a representative may do, on the back of the "Claimant's Copy" of this form.

Privacy Act Notice

Sections 206(a) and 1631(d) of the Social Security Act authorize the collection of information on this form. Providing the information is voluntary. However, if you want to appoint someone to act on your behalf in matters before the Social Security Administration, then you and that individual must complete the appropriate sections of this form. The information is needed to verify your appointment of the individual as your representative and his/her acceptance of the appointment.

We may provide information collected on this form to another Federal, State, or local government agency to assist us in verifying any information you provide, or if a Federal law requires the release of information. We may also use the information you give us when we match records with those of other Federal, State, or local government agencies. The law allows us to do this even if you do not agree to it.

With your permission, your representative may designate an associate or other party to request and receive information from your claim file on your representative's behalf.

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

How To Complete This Form

Please print or type. At the top, show your full name and your Social Security number. If your claim is based on another person's work and earnings, also show the "wage earner's" name and Social Security number. If you appoint more than one person, you may want to complete a form for each of them.

Part I Appointment of Representative

Give the name and address of the person(s) you are appointing. You may appoint an attorney or any other qualified person to represent you. You also may appoint more than one person, but see "What Your Representative(s) May Charge" on the back of the "Claimant's Copy" of this form. You can appoint one or more persons in a firm, corporation, or other organization as your representative(s), but you may not appoint a law firm, legal aid group, corporation, or organization itself.

Check the block(s) showing the program(s) under which you have a claim. You may check more than one block. Check:

- Title II (RSDI), if your claim concerns retirement, survivors, or disability insurance benefits.
- Title XVI (SSI), if your claim concerns supplemental security income.
- Title XVIII (Medicare Coverage), if your claim concerns entitlement to Medicare or enrollment in the Supplementary Medical Insurance (SMI) plan.

If your representative has your permission to designate an associate, such as a clerk, other party, or entity, such as a copying service, to receive information for him or her from us about your claim(s), check the block to authorize this release.

If you will have more than one representative, check the block and give the name of the person you want to be the main representative.

Sign your name, but print or type your address, your area code and telephone number, and the date.

If you are appointing a representative to replace a representative you discharged or who withdrew from representing you, you must notify us in writing that the prior appointment has ended.

Part II Acceptance of Appointment

Each person you appoint (named in part I) completes this part, preferably in all cases. If the person is not an attorney, he or she must give his or her name, state that he or she accepts the appointment, and sign the form.

Part III (Optional) Waiver of Fee

Your representative may complete this part if he or she will not charge any fee for the services provided in this claim. If you appoint a second representative or co-counsel who also will not charge a fee, he or she also should sign this part or give us a separate, written waiver statement.

Part IV (Optional) Waiver of Direct Payment by an Attorney or a Non-Attorney Participating in the Direct Payment Project

Your representative may complete this part if he or she is an attorney or a non-attorney who does not want direct payment of all or part of the approved fee from past-due retirement, survivors, disability insurance, or supplemental security income benefits withheld.

Paperwork Reduction Act Statement - This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** The office is listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). *You may send comments on our time estimate above to: SSA, 6401 Security Boulevard, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*

References

- 18 U.S.C. §§203, 205, and 207; and 42 U.S.C. §§ 406(a), 1320a-6, and 1383(d)(2)
- 20 CFR §§404.1700 et. seq. and 416.1500 et. seq.
- Social Security Rulings 88-10c, 85-3, 83-27, and 82-39
- 26 U.S.C. §§ 6041 and 6045(f)

INFORMATION FOR REPRESENTATIVES

Fees For Representation

An attorney or other person who wants to charge or collect a fee for providing services in connection with a claim before the Social Security Administration must first obtain our approval of the fee for representation. The only exceptions are if the fee is for services provided:

- when a nonprofit organization or government agency will pay the fee and any expenses from government funds and the claimant incurs no liability, directly or indirectly, for the cost(s);
- in an official capacity such as legal guardian, committee, or similar court-appointed office and the court has approved the fee in question; or
- in representing the claimant before a court of law. A representative who has provided services in a claim before both the Social Security Administration and a court of law may seek a fee from either or both, but neither tribunal has the authority to set a fee for the other.

Obtaining Approval Of A Fee

To charge a fee for services, you must use one of two, mutually exclusive fee approval processes. You must file either a fee petition or a fee agreement with us. In either case, you cannot charge more than the fee amount we approve.

- Fee Petition Process

  You may ask for approval of a fee by giving us a fee petition when you have completed your services to the claimant. This written request must describe in detail the amount of time you spent on each service provided and the amount of the fee you are requesting.

  You must give the claimant a copy of the fee petition and each attachment. The claimant may disagree with the information shown by contacting a Social Security office within 20 days of receiving his or her copy of the fee petition. We will consider the reasonable value of the services provided, and send you notice of the amount of the fee you can charge.

- Fee Agreement Process

  If you and the claimant have a written fee agreement, either of you must give it to us before we decide the claim(s). We usually will approve the agreement if you both signed it; the fee you agreed on is no more than 25 percent of past-due benefits, or $5,300 (or a higher amount we set and announced in the Federal Register), whichever is less; we approve the claim(s); and the claim results in past-due benefits. We will send you a copy of the notice we send the claimant telling him or her the amount of the fee you can charge based on the agreement.

  If we do not approve the fee agreement, we will tell you in writing. We also will tell you and the claimant that you must file a fee petition if you wish to charge and collect a fee.

After we tell you the amount of the fee you can charge, you or the claimant may ask us in writing to review the approved fee. (If we approved a fee agreement, the person who decided the claim(s) also may ask us to lower the amount.) Someone who did not decide the amount of the fee the first time will review and finally decide the amount of the fee.

Collecting A Fee

You may accept money in advance, as long as you hold it in a trust or escrow account. The claimant never owes you more than the fee we approve, except for:

- any fee a Federal court allows for your services before it; and
- out-of-pocket expenses you incur or expect to incur, for example, the cost of getting evidence.

If you are not an attorney and you are ineligible to receive direct payment, you must collect the approved fee from the claimant. If you are interested in becoming eligible to receive direct payment, you can find information on the procedures for becoming eligible for direct payment on our "Representing Claimants" website: http://www.ssa.gov/representation/.

If you are an attorney or a non-attorney whom SSA has found eligible to receive direct payment, we usually withhold 25 percent of any past-due benefits that result from a favorably decided retirement, survivors, disability insurance, or supplemental security income claim. Once we approve a fee, we pay you all or part of the fee from the funds withheld. We will also charge you the assessment required by section 206(d) and 1631(d)(2)(C) of the Social Security Act. You cannot charge or collect this expense from the claimant. You must collect from the claimant:

- the rest he or she owes
  if the amount of the fee is more than the amount of money we withheld and paid you for the claimant, and any amount you held for the claimant in a trust or escrow account.
- all of the fee he or she owes
  if we did not withhold past-due benefits, for example, because there are no past-due benefits, or the claimant discharged you, or you withdrew from representing the claimant; or

  if we withheld, but later paid the money to the claimant because you did not either ask for our approval until after 60 days of the date of the notice of award or tell us on time that you planned to ask for a fee.

Conflict Of Interest And Penalties

For improper acts, you can be suspended or disqualified from representing anyone before the Social Security Administration. You also can face criminal prosecution. Improper acts include:

- If you are or were an officer or employee of the United States, providing services as a representative in certain claims against and other matters affecting the Federal government.
- Knowingly and willingly furnishing false information.
- Charging or collecting an unauthorized fee or too much for services provided in any claim, including services before a court which made a favorable decision.

References

- 18 U.S.C. §§203, 205, and 207; and 42 U.S.C. §§406(a), 1320a-6, and 1383(d)(2)
- 20 CFR §§404.1700 et. seq. and 416.1500 et. seq.
- Social Security Rulings 88-10c, 85-3, 83-27, and 82-39
- 26 U.S.C. §§ 6041 and 6045(f)

INFORMATION FOR CLAIMANTS

What a Representative May Do

We will work directly with your appointed representative unless he or she asks us to work directly with you. Your representative may:

- get information from your claim(s) file;
- with your permission, designate associates who perform administrative duties (e.g. clerks), partners and/or parties under contractual arrangements (e.g., copying services) to receive information from us on his or her behalf. By signing this form, you are providing your permission for your representative to designate such associates, partners, and/or contractual parties,
- come with you, or for you, to any interview, conference, or hearing you have with us;
- request a reconsideration, hearing, or Appeals Council review; and
- help you and your witnesses prepare for a hearing and question any witnesses.

Also, your representative will receive a copy of the decision(s) we make on your claim(s). We will rely on your representative to tell you about the status of your claim(s), but you still may call or visit us for information.

You and your representative(s) are responsible for giving Social Security accurate information. It is wrong to knowingly and willingly furnish false information. Doing so may result in criminal prosecution.

We usually continue to work with your representative until (1) you notify us in writing that he or she no longer represents you; or (2) your representative tells us that he or she is withdrawing or indicates that his or her services have ended (for example, by filing a fee petition or not pursuing an appeal). We do not continue to work with someone who is suspended or disqualified from representing claimants.

What Your Representative(s) May Charge

Each representative you appoint can ask for a fee. To charge you a fee for services, your representative must get our approval. (Even when someone else will pay the fee for you, for example, an insurance company, your representative usually must get our approval.) One way is to file a fee petition. The other way is to file a fee agreement with us. In either case, your representative cannot charge you more than the fee amount we approve. If he or she does, promptly report this to your Social Security office.

- Filing A Fee Petition

  Your representative may ask for approval of a fee by giving us a fee petition when his or her work on your claim(s) is complete. This written request describes in detail the amount of time he or she spent on each service provided you. The request also gives the amount of the fee the representative wants to charge for these services. Your representative must give you a copy of the fee petition and each attachment. If you disagree with the information shown in the fee petition, contact your Social Security office. Please do this within 20 days of receiving your copy of the petition.

  We will review the petition and consider the reasonable value of the services provided. Then we will tell you in writing the amount of the fee we approve.

What Your Representative(s) May Charge, continued

- Filing A Fee Agreement

  If you and your representative have a written fee agreement, one of you must give it to us before we decide your claim(s). We usually will approve the agreement if you both signed it; the fee you agreed on is no more than 25 percent of past-due benefits, or $5,300 (or a higher amount we set and announced in the Federal Register), whichever is less; we approve your claim(s); and your claim results in past-due benefits. We will tell you in writing the amount of the fee your representative can charge based on the agreement.

  If we do not approve the fee agreement, we will tell you and your representative in writing. Then your representative must file a fee petition to charge and collect a fee.

After we tell you the amount of the fee your representative can charge, you or your representative can ask us to look at it again if either or both of you disagree with the amount. (If we approved a fee agreement, the person who decided your claim(s) also may ask us to lower the amount.) Someone who did not decide the amount of the fee the first time will review and finally decide the amount of the fee.

How Much You Pay

You never owe more than the fee we approve, except for:

- any fee a Federal court allows for your representative's services before it; and
- out-of-pocket expenses your representative incurs or expects to incur, for example, the cost of getting your doctor's or hospital's records. Our approval is not needed for such expenses.

Your representative may accept money in advance as long as he or she holds it in a trust or escrow account. We usually withhold 25 percent of your past-due benefits to pay toward the fee for you if:

- your retirement, survivors, disability insurance, and/or supplemental security income claim(s) results in past-due benefits;
- your representative is an attorney or a non-attorney participating in the direct fee payment project; and
- your representative registers with us for direct payment before we effectuate a favorable decision on your claim.

You must pay your representative directly:

- the rest of the fee you owe

  if the amount of the fee is more than any amount(s) your representative held for you in a trust or escrow account and we withheld and paid your representative for you.

- all of the fee you owe

  if we did not withhold past-due benefits, for example, because your representative waived direct payment, or you discharged the representative, or the representative withdrew from representing you before we issued a favorable decision; or if we withheld, but later paid you the money because your representative did not either ask for our approval until after 60 days of the date of your notice of award or tell us on time that he or she planned to ask for a fee.

Social Security Administration
Please read the instructions before completing this form.

Form Approved
OMB No. 0960-0627

Name (Claimant) (Print or Type)	Social Security Number - -
Wage Earner (If Different)	Social Security Number - -

Part I APPOINTMENT OF REPRESENTATIVE

I appoint this person, _____ .
(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under:

☐ Title II (RSDI) ☐ Title XVI (SSI) ☐ Title XVIII (Medicare Coverage) ☐ Title VIII (SVB)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☐ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☐ I appoint, or I now have, more than one representative. My main representative is _____ .
(Name of Principal Representative)

Signature (Claimant)	Address	
Telephone Number (with Area Code) ( ) -	Fax Number (with Area Code) ( ) -	Date

Part II ACCEPTANCE OF APPOINTMENT

I, _____ , hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part II satisfies this requirement.)

Check one: ☐ I am an attorney. ☐ I am a non-attorney who is participating in the direct fee payment demonstration project.

☐ I am a non-attorney . I am not participating in the direct fee payment demonstration project.

I have been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ Yes ☐ No

I have been disqualified from participating in or appearing before a Federal program or agency. ☐ Yes ☐ No

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative)	Address	
Telephone Number (with Area Code) ( ) -	Fax Number (with Area Code) ( ) -	Date

Part III (Optional) WAIVER OF FEE

I waive my right to charge and collect a fee under sections 206 and 1631(d)(2) of the Social Security Act. I release my client (the claimant) from any obligations, contractual or otherwise, which may be owed to me for services I have provided in connection with my client's claim(s) or asserted right(s).

Signature (Representative)	Date

Part IV (Optional) WAIVER OF DIRECT PAYMENT

by Attorney or Non-Attorney Eligible to Receive Direct Payment

I waive only my right to direct payment of a fee from the withheld past-due retirement, survivors, disability insurance or supplemental security income benefits of my client (the claimant). I do not waive my right to request fee approval and to collect a fee directly from my client or a third party.

Signature (Representative Waiving Direct Payment)	Date

EXHIBIT 5

Approved, SCAO | Delridge Corporation (586) 294-4600 | Original - Court 1st copy - Subject | 2nd copy - Return Additional copies as needed | PROBATE DSM CODE: MOT, OSC

STATE OF MICHIGAN JUDICIAL DISTRICT JUDICIAL CIRCUIT OAKLAND COUNTY PROBATE	MOTION AND ORDER TO SHOW CAUSE	CASE NO. [redacted]

Court address: 1200 N. Telegraph, Pontiac, MI 48341 — Court telephone no.

Plaintiff(s)/Petitioner(s)	v	Defendant(s)/Respondent(s)/Probationer

☒ Probate In the matter of [redacted] a Protected Person

☐ Juvenile In the matter of _____

MOTION AND AFFIDAVIT

1. I am interested in this matter as Conservator, Attorney and Trustee of the Special Needs Trust F/B/O [redacted].
2. The Social Security Administration and [redacted], District Representative (Name (type or print)) has not complied with an order dated December 20, 2006 by failing to recognize Patricia E. Kefalas Dudek as Conservator in order to allow her appointment as Representative Payee As is required by both State and Federal law. See attached Brief in Support.
3. I request an order directing The Social Security Administration and [redacted], District Representative (Name (type or print)) to show cause why:
   - ☒ a. s/he should not be found in ☒ civil ☐ criminal contempt of court.
   - ☐ b. judgment should not be entered against him/her (as surety/agent) for the full amount of recognizance.
   - ☐ c. judgment should not be entered against him/her for failure to file a garnishee disclosure.

Patricia E. Kefalas Dudek
Signature Patricia E. Kefalas Dudek

Subscribed and sworn to before me on 2/23/07 (Date) Oakland County, Michigan.

My commission expires: 3/16/2013 (Date) Signature: [signature] Notary L. Notary

Notary public, State of Michigan, County of Oakland, Acting in Oakland County

ORDER

TO: The Social Security Administration
[redacted] District Representative
1280 Pontiac Road
Pontiac, MI 48340

If you require special accommodations to use the court because of disabilities, please contact the court immediately to make arrangements.

IT IS ORDERED:

4. You are ordered to appear before this court _____ (Date) at _____ (Time) m.
   - ☐ the court address above.
   - at ☐ courtroom number
   - ☐ _____

   to show cause why
   - ☐ you should not be held in ☐ civil ☒ criminal contempt for failure to comply with the order of this court
   - ☐ a judgment should not be entered against you
   - ☐ your case should not be dismissed
   - ☐ other:

   for the reasons stated in the motion.
5. Failure to appear for a contempt hearing may result in a bench warrant being issued for your arrest.
6. A copy of this must be served ☐ personally ☐ by mail on the person ordered to appear at least _____ days before the hearing.

Date _____ Judge _____ Bar no.

STATE OF MICHIGAN
IN THE PROBATE COURT FOR THE COUNTY OF OAKLAND

IN THE MATTER OF [redacted]
A PROTECTED INVIDUDUAL

Hon.
File No.

Harley D. Manola (P40453)
THE MALL MALISOW FIRM, P.C.
Attorney for Petitioner
30445 Northwestern Highway, Suite 250
Farmington Hills, Michigan 48334
(248) 538-1800

Brief in Support of the Motion and Order to Show Cause for Failure to Recognize Representative Payee

NOW HERE COMES, Patricia E. Kefalas Dudek, Conservator for [redacted] a Protected Individual, by and through her attorneys, THE MALL MALISOW FIRM P.C., through attorney Harley D. Manola, to bring this Brief in Support of the Motion and Order to Show Cause for as to why the Social Security Administration (hereafter referred to "SSA") and its District Representative, [redacted] should not be held in civil contempt of court for failure to comply with the Order of Conservatorship dated December 20, 2006, and recognize Patricia E. Kefalas Dudek as Representative Payee for [redacted]

According to CFR §404.2015, when determining whether to appoint a Representative Payee, the SSA will consider a Court determination that a beneficiary is legally incompetent as a relevant factor in making that decision. Moreover, in deciding who shall be the Representative Payee, the SSA will "try to select the person, agency, organization or institution that will best serve the interest of the beneficiary", and will

consider "any legal authority the person, agency, organization or institution has to act on behalf of the beneficiary." CFR §404.2020(c).

In the immediate case, this Honorable Court appointed Patricia B. Kefalas Dudek as Conservator for [redacted] on December 20, 2006. The Order appointing Ms. Dudek as Conservator, as well as the Letters of Conservatorship, were sent to [redacted] on February 6, 2007. Per CFR §§404.2015 and §404.2020, Ms. Dudek's appointment as Conservator to manage [redacted] assets should serve as sufficient evidence of [redacted] status as legally incompetent in making financial decisions, and as Ms. Dudek's position as the person best situated to act as Representative Payee on [redacted] behalf. However, amidst compelling evidence to support Ms. Dudek's position, the SSA and its District Representative, [redacted] have failed to recognize Ms. Dudek as Representative Payee. The Honorable Kenneth L. Tacoma, Wexford County Probate Court, in an article from the Winter 2006 Michigan Probate and Estate Planning Journal show that this is a widespread and ongoing problem. The Article is attached to this brief.

WHEREFORE we respectfully request this Court:

1) Order the Social Security Administration and its District Representative, [redacted] to Show Cause as to why it should not be held in civil contempt of court for failing to comply with the Order of Conservatorship dated December 20, 2006, and recognize Patricia B. Kefalas Dudek as Representative Payee for [redacted].

Signed: _____

Harley D. Manela (P40453)

Dated: 2-23-07

Swatting Gnats, Ignoring Elephants[1]

By Hon. Kenneth L. Tacoma

A cyber-riot nearly erupted on probate@groups.michbar.org this spring when it was reported that a task force looking at problems of fiduciary infidelity in Power of Attorney (POA) situations was suggesting that electronic registration of POAs, or other similar policing steps, be required by state law.[2] It certainly would not be wise for me to opine one way or another on the merits of the proposals, and it is not necessary for me to do so to make the point that there must be an extant perception that abuse occurs at some level in POA cases, or there would not be a task force looking into solutions.

In a similar vein, in 2003 the Michigan Office of the Auditor General released a report of its performance audit of selected probate court conservatorship cases, creating quite a stir in the media and the impression of widespread abuse in conservatorship cases supervised in the Michigan probate courts. In 2005, the State Court Administrative Office released its final report in response to the OAG report, and that report tracked the conclusion of an interim report that had preceded it. That conclusion, the reader will recall, was that with certain not-to-be-minimized exceptions, Michigan's probate courts complied with statutory requirements for monitoring conservatorship cases.[3] That brought to a close the "scandal" uncovered by the Auditor General, hyped by the media, and ridden into the ground by court detractors of various stripes.

I reflected on these concerns in light of several cases presented in the court over which I presided in the past several months. The most recent involved an older gentleman who had petitioned to establish guardianship and conservatorship over his even-older brother. Evidence showed that the subject of the petitions had been plucked clean by a nephew—a low-level criminal who had dispossessed the now impoverished ward of most of his property and wasted the same. The thing that struck me, however, was how the nephew had obtained, and continued to retain, the old gentleman's income source as his Social Security system representative payee.

It was not the first case I have seen where the representative payee system was used to support the aberrant lifestyles of our culture's enterprising youth. A few months ago, a case was started by one of our local nursing homes on behalf of a resident when the institution had gone unpaid for her care for several months. It turned out that the elderly lady's grandson had been named her representative payee long ago, moved into grandma's house with some fellow drug-abusing hangers-on, and used her social security income to support the bunch. When her health turned for the worse, grandma was sent to the hospital and then to the nursing home, but the Social Security money stayed with her representative payee grandson (and his partying pals) until the home was ready to roll grandma out into the street.

The final case, which I will note, involved a high functioning mentally ill fellow for whom, in regular proceedings, a sister had been appointed conservator. The sister got her brother's affairs in order and stabilized his financial situation, doing a very good job under court supervision for a few years. At a review hearing, which she requested, it was disclosed that her brother had met a woman, and he and his new girlfriend had gone to the Social Security office where the girlfriend had been appointed representative payee for the ward, and off they went to Florida. The annoying part of this was that the conservator-sister had received no prior notice of the change, and after finding out what had happened, had been given the bums' rush by the Social Security Administration with the assertion that they do not honor state court fiduciary appointments in the face of a representative payee designation

by the ward. Whether the fellow and his girlfriend will live happily ever after, or whether he will end up homeless in Florida while the girlfriend goes to Disney World, has yet to be seen, but the window is open if you want to place your bets.

I have every reason to believe that these are not isolated incidents. If this kind of activity is as common as I believe, then a lot of effort is put into investigating and exposing the wrong areas of fiduciary misconduct. There is really no way to know how many Michigan citizens have prepared and executed Powers of Attorney, but I'd wager the number of active situations involving the agency so granted is quite low. However, we do have data sources involving guardianships and conservatorships. In 2003, Michigan had about 33,000 conservatorship cases, when adult and minor ward cases are combined. Add guardianships of developmentally disabled persons where the fiduciary would be responsible for the ward's financial affairs for another 19,000 cases, and we are up to about 52,000 cases supervised in the probate court system.[4]

On the other hand, according to Social Security Administration (SSA) statistics, in 2003 about 1,700,000 Michigan citizens received some form of OASDI[5] benefits. Nationally, about 10.5 percent of these beneficiaries have representative payees; assuming this ratio holds in Michigan, this means about 178,500 people. Add to this the recipients of SSI[6] (about 217,000 souls in Michigan) of which 99.3 percent of the minors[7] and 33 percent of adults have representative payees, and we are talking about at least 71,000 more. Conservatively, then, over 250,000 Michigan citizens have their social security benefits paid to these representative payees, and SSA reports over 6.6 million representative payee cases nationwide.[8]

The logical questions in this context: How are representative payees chosen? And, how are they supervised? The realistic answers: haphazardly and not at all. SSA publishes pamphlets (and other stuff is available online) to guide representative payees. Basically, you become a representative payee by asking and having the benefit recipient agree to have you appointed. Analytically this is a little curious, since by definition, if a person needs a representative payee, he or she is at some level unable to exercise appropriate judgment, but never mind. As for reporting, apparently once a year the SSA requests that Form SSA-623 (or SSA-6230 for payees for minors) be filed. I won't spoil the suspense by attaching this form; if you've read this far, you really must look up this fraud-buster on your own.

The cases first noted motivated the Intrepid Probate Register for Wexford County to pay a visit to the local Social Security office to see how things worked in the real world. She reported a very nice visit with the SSA office representative and the following general conclusions:

- SSA has a meeting with representative payees at the time of appointment.
- SSA tries to appoint a family member as representative payee.
- The wishes of the recipient generally trump other considerations.
- They are basically happy to appoint anyone who is willing to step forward.
- The representative payee is informed of his or her duties at the time of appointment and instructed on the proper way to set up accounts, but there is no confirmation to see if the instructions are followed.
- The only supervision is to ask the ward if everything is okay. The SSA has no procedure to see if the money is actually being spent on the ward other than the annual payee self-report.
- They concede that a lot of fraud and misappropriation may be going on.

I did find one piece of practical information in the course of this review that I now routinely pass on to Court-appointed fiduciaries. When faced with the kinds of cases first noted, the Court-appointed fiduciary should contact the Office of the

Inspector General, Fraud Hotline, which is set up for receiving reports of Social Security fraud of all kinds. Although it may not bring results, at least the fiduciary has put SSA on notice of the problem.[9]

I'm not holding my breath for a press exposé on the above, as there is no glory for an investigative reporter nor headlines for a paper in dealing with problems without an easy, apparent villain. Given an issue where the problem is structural, nuanced[10], and without simple sound-bite solutions, the reporters will flee. Frankly, so long as the human condition persists, no number of ineffectual bureaucrats will be able to police a system as big as the Social Security program in the United States. A little perspective, however, would be nice when the reporters do create their stories and then hype them for the brief public attention they gain.

Notes

1. This is an update and revision of an article originally published in *Inter-Com*, the Probate Court Judicial Section's Journal in March 2006.

2. See *Probate Digest*, Vol 23, Issue 34 (March 31, 2006) and the postings a few days before and after that date.

3. "In sum, the statewide review revealed that the vast majority of probate courts were either following the Estates and Protected Individuals Code (EPIC), and had appropriate procedures, or had minor issues that were quickly corrected following SCAO's review." "Final Report on Investigative Follow-up Review," *Statewide Phase to the Michigan Office of the Auditor General Performance Audit of Selected Probate Court Conservatorship Cases*, (January 2005), 2.

4. Data taken from SCAO 2003 Annual Report, Probate Court Statistical Supplement.

5. Old-Age (retirement), Survivors, and Disability Insurance—what most people think of as Social Security with the accumulated entitlements added over the years.

6. Supplemental Security Income - the cash assistance program for low-income, aged, blind, or disabled persons administered by the Social Security Administration.

7. I won't parse this beyond noting the observation of a jaded local protective services worker who refers to the efforts of his clientele in this area as the Social Security lottery in which the jackpot is to have a child designated disabled, making tha him or her a valuable asset for the custodial parent.

8. Social Security statistical information is available at www.ssa.gov on the Internet and is voluminous. The specific information I cite is derived from Michigan Congressional Statistics, (December 2003), Tables 1 and 2; SSI Annual Statistical Report, Table 27; and Annual Statistical Supplement, (2003), Table 5.L1.

9. "Your information is important, however, without sufficient facts it is unlikely that we will be able to provide assistance." SSA, OIG website, Representative Payee Misuse. At least they're honest that nothing is likely to be done.

10. A word (actually newly-minted-to-make-us-sound-sophisticated word, as historically "nuance" was allowed to exist as a noun) with which the media chatterers are currently infatuated—rapidly moving up on this curmudgeon's Dumbwords list.

Hon. Kenneth L. Tacoma has served as Judge of Probate for Wexford County since 1994 and also as Presiding Judge of the Family Division, 28th Circuit Court since 1998. A graduate of the Indiana University School of Law - Bloomington, he has also been in the private practice of law in Cadillac, served as Domestic Relations Referee for the 28th Circuit, and served as Wexford County Prosecuting Attorney prior to assuming judicial office. Judge Tacoma is a member of the Michigan Probate Judges Association (executive board) and the Top O' Michigan Judges Association (president). He also serves on the Committee on Professional and Judicial Ethics of the State Bar of Michigan and on the Michigan Court Forms Committee (Probate and Family Division Section). He has served as a presenter at training programs throughout Michigan both when a member of the Prosecuting Attorney's Association of Michigan and currently for the Michigan Judicial Institute.