



Disability Determination Services: A Federal and State Government Partnership

August 20, 2008

**A report on the process for Social
Security/Supplemental Security Income disability
determinations in South Dakota
As of September 30, 2007**

**Prepared by:
The SD Department of Human Services
Disability Determination Services Task Force**

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Executive Summary

In each state and US territory, a designated state agency is responsible for the adjudication of Social Security Disability and Supplemental Security Income claims. In South Dakota, this agency is Disability Determination Services (DDS). DDS is part of the Division of Rehabilitation Services in the state's Department of Human Services. Authority for the establishment of the DDS is based upon federal law and is 100% federally funded with considerable oversight remaining with the federal government.

This report has been prepared to help remedy significant public misconception of the Social Security Disability Determination process. There are many definitions for what constitutes a disability, even among different federal disability programs. For instance the Veteran's Administration can approve disability benefits based upon a percentage of disability and the Social Security Administration (SSA) uses a strict total disability definition for approval of benefits. In addition, the Social Security Administration utilizes a work threshold as the final factor for eligibility for benefits. Other misunderstandings include the perception that claimants are routinely denied three times before being awarded benefits, the level of responsibility a claimant must take in the development of their own claim, and the necessity to meet the deadlines imposed by the claims process. This report has been developed to address this public misconception.

The process begins by an applicant applying for benefits online, calling SSA, or applying in person at an SSA office. Claims examiners request information from claimants to prepare their file, review the information, and prepare it for medical review by a medical consultant. After these reviews have taken place, the examiner will make a determination based upon their review as well as other factors such as past work history, the ability to do other work, age and education. The claimant is informed of the outcome of their claim and if unfavorable, explanation is provided as to the reconsideration and appeals processes.

Annually, an average of 7,982 South Dakotans approach SSA to apply for Social Security disability benefits because they have a disability. Over 93% of these cases are resolved within six months of their initial application. Less than 400 remaining cases request an appeal of a negative determination. These are the individuals who come to the attention of public officials and the legal system because of the negative determination. The times tables and statistical information contained in this report will show the work performed by the SD DDS staff is conducted in a timely, efficient and accurate manner.

In South Dakota, citizens with disabilities often work. We are the second highest ranked state in the percentage of our citizens who have a work disability who continue to work. Census data reveals that over 60% of South Dakotans who have a work disability are working. In our state, citizens with disabilities do work.

The information gathered for this report has been used to address concerns raised by claimants and the general public. Disability Determination Services has implemented a

Customer Service Implementation Plan to demonstrate our commitment to continuous improvement.

I. Preface

Task Force Members: Candi Byllesby, Communications Network Analyst; Joanna Fischer, Disability Claims Specialist; Lloyd Gaarder, Senior Examiner; Rich Gardner, Program Specialist; Jerry Hofer, DHS Secretary; Grady Kickul, DRS Director; Dan Lusk, DHS Deputy Secretary; Dawn Ochs, Program Specialist; Angela Schelske, Senior Examiner; Doug Soule, Ph.D., Medical Consultant; Doreen Turner, Office Supervisor and Dave Tschetter, DDS Manager

In April of 2007, Governor Rounds directed the Department of Human Services to explore improving the efficiency and timeliness of the system for determining eligibility for Social Security Disability (SSD) benefits for citizens of South Dakota. Secretary Jerry Hofer appointed a task force of department employees to research the issue and prepare a report.

The task force has determined there is a significant public misconception of the Social Security Disability Determination process. One misconception is that people are routinely denied three times before being awarded benefits. The fact is that over 75% of individuals awarded disability benefits were determined eligible by the state disability determination service office. This report will correct many of these misconceptions. There is also room for improvement in creating a process that is more clearly understood, more timely, and more customer responsive.

Annually, an average of 7,982 South Dakotans approach the Social Security Administration to apply for Social Security disability benefits because they have a disability. Over 93% of these cases are resolved within six months of their initial application. Less than 400 remaining cases request an appeal of a negative determination. These are the individuals who come to the attention of public officials and the legal system.

Other factors that lead to misunderstanding and misconception:

- Federal regulations define disability by federal programs versus a universal definition. The task force identified at least 5 different laws that define disability. Congress has given Social Security Disability the strictest definition of all disability definitions. Less stringent definitions in other programs lead to a significant misunderstanding by the public.
- Social Security only accepts total disability as a qualifier for the entitlement benefits. All other programs allow for partial eligibility for cash benefits or services. This all or none definition of eligibility is also misunderstood.
- Federal law for Social Security disability uses a work threshold as the final factor in eligibility for benefits. No other disability definition uses the ability to work as an eligibility threshold. This is a significant misunderstanding by the public.
- In South Dakota, citizens with disabilities often work. We are the second highest ranked state in the percentage of our citizens who have a work disability who

continue to work. Census data reveals that over 60% of South Dakotans who have a work disability are working. In our state, citizens with disabilities do work.

This paper will detail the portion of the disability determination process that the Department of Human Services performs, as well as, the portion that the federal government performs. It will be a foundation with which to recommend changes to our internal state system as well as suggestions for the federal system.

II. Background Information

In each state and US territory, a designated state agency is responsible for the adjudication of Social Security Disability and Supplemental Security Income claims. In South Dakota, this agency is Disability Determination Services (DDS). DDS is part of the Division of Rehabilitation Services in the state's Department of Human Services. Authority for the establishment of the DDS is based upon federal law and is 100% federally funded with considerable oversight remaining with the federal government. The SD DDS is responsible for the adjudication of claims filed by someone residing in the state at the time of the application. The DDS may also receive a transferred claim from another state DDS because the individual has moved and is expected to reside in SD for an extended period of time.

Disability was not part of the original Social Security Act; however, it was part of the 1954 Social Security Act amendments. Initially, the disability aspect of the program was an income freeze at the time the individual met SSA disability criteria. The intent of the freeze was to not penalize workers if they had an overall decreased income because of their disability prior to being able to draw benefits. The first cash benefits were paid to disabled workers in 1958.

Perhaps the most significant change was the 1972 amendments to the Social Security Act which created Title XVI and a needs-based national cash benefit called Supplemental Security Income (SSI). Establishment of Title XVI doubled the SSA disability workload and required a massive expansion of state agencies across the country. The South Dakota DDS staff grew from eight in 1971 to 23 in 1975. The present staff includes 32 full-time employees and a part-time staff of contracted consultants comprised of physicians, clinical psychologists, and a speech and language pathologist.

For administrative purposes, SSA has divided the country into ten regions. SD is part of SSA's Region VIII based in Denver. Included in Region VIII are Colorado, Wyoming, Utah, Montana, North Dakota and South Dakota. The Denver Region has the smallest population of SSA's ten regions and accounts for only two percent of the national workload. Colorado adjudicates 50% of the claims generated in the Denver Region. This being said, the Denver Region encompasses a vast geographical area and has a very diverse population.

Claim Types Processed by Disability Determination Services

During the last three and a half years, the SD DDS has averaged 5,329 new initial claims per year. The DDS administers two programs: Social Security Disability Income (SSDI, also known as Title II), and Supplemental Security Income (SSI, also known as Title XVI).

Social Security Disability Income Benefits

SSDI funds come from SSA's trust fund, which in turn is financed by contributions made by workers. According to federal law, once an individual becomes eligible for benefits, they must wait five months before payment commences. Also according to federal law, an individual will qualify for Medicare benefits no sooner than two years after being allowed Title II benefits. Within the Title II program there are several different types of benefits for which disabled individuals might be eligible.

SSDI - Title II claim types

Disability Insurance Benefits (DIB) – These benefits pertain to those people under retirement age who have insured status based on their own earnings.

Disabled Widow(er) Benefits (DWB) – These benefits pertain to people whose deceased spouse paid into the system. This benefit is restricted to people between age 50 and 60. Upon reaching age 60, a widow(er) is no longer eligible for benefits under the DWB category as they are eligible for survivor benefits.

Child Disability Benefits (CDB) – These benefits pertain to people whose parent paid into the system. Eligibility for CDB benefits can begin at age 16, but in most cases people will not be eligible for CDB benefits until they are 18. In order to receive CDB benefits, a person must be found to have been disabled prior to his or her 22nd birthday.

Supplemental Security Income Benefits

SSI funds come from general tax revenues – not the SSA's trust fund. SSI benefits are meant to help those who have little or no income or resources, and for those who might not be qualified for SSDI benefits. Individuals found to have excess resources cannot apply for SSI. There is no waiting period for SSI benefits – payment status commences as soon as an individual is found to be eligible for SSI benefits. Immediately upon qualifying for Title XVI benefits, an individual is eligible for Medicaid benefits. Within the Title XVI program there are several different types of benefits for eligible individuals.

SSI - Title XVI claim types:

Disabled Individual (DI) benefits – These benefits pertain to people over 18 whose Income and Resources fall below a level set by the SSA. Blind Individual (BI) benefits pertain to people who are eligible for DI benefits because of blindness.

Disabled Spouse (DS) benefits – These benefits pertain to those people who have a spouse who qualifies for Title XVI benefits.

Disabled Child (DC) benefits – These benefits pertain to children from birth to age 18 whose family income and resources fall below a level set by the SSA. Blind Child (BC) benefits pertain to children who are eligible for DC benefits because of blindness.

An Overview of How a Claim is Handled at the DDS

The majority of case processing is done electronically with a high dependency upon the computer system for almost all job functions. Approximately 177 cases are assigned to a current staff of 18 examiners each week.

Examiners review the case once it is assigned. This includes reviewing the application, the allegations and the release of information. After becoming familiar with the case, the examiner completes development of the case by sending out requests for medical evidence, function reports from the claimant and third parties, work history from the claimant if needed, and may order a consultative exam (CE).

The examiner reviews the evidence as it is received and initiates the decision-making process. If evidence is sufficient to make a favorable determination, regardless of whether all medical evidence is received, the examiner has the authority to find eligibility subject to a medical consultant's (MC) signature and/or review. If the evidence does not lead to a favorable determination, the examiner will wait until all evidence is obtained. In the event there is a delay in receiving evidence, the examiner will determine if follow up is necessary or if it would be more beneficial to order a CE.

If a CE is needed, an appointment is set, a letter is sent to the claimant and an authorization is sent to the CE provider. If the claimant misses the appointment or is a "no show" and the examiner doesn't hear from the claimant needing a physical examination, the examiner will continue to adjudicate the case without the CE. If the claimant has psychological or mental health problems, the examiner will give the claimant a second chance to attend a CE and will reschedule the CE with a repeat of the above process.

Once all of the evidence is available, the examiner will review the evidence and prepare the case for medical review by a consultant. The examiner and medical consultant(s) work closely together to complete assessments or an analysis of the case.

When the medical consultant has completed their review, the examiner reviews the assessment and makes a determination. Other factors taken into consideration at this step include the claimant's past work or the ability to do other work, age, and education. Sometimes the examiner will finish adjudication by preparing a rationale regarding the decision. This is helpful for quality assurance (QA) or if the case goes forward to reconsideration. If the determination is favorable, the claimant is notified by letter and benefits commence. If the determination is not favorable, a letter is created that outlines for the claimant the evidence that was obtained and the reasons why they were not found to be eligible. The letter also provides information for the appeals process if they do not agree with the determination. The examiner then releases the case for

closure and the case will either be selected for internal QA, external QA, or returned to the field office as a final determination.

Once a file is closed it is subjected to a random sampling by SSA regional review units. There are two type of sampling. One sample is Quality Assurance (QA) and the other sample is Preeffectuation Review (PER). SD DDS quality is graded by the data produced from the QA sample. The selection process is based upon a statistical database designed to assure consistency from state to state. PER is weighted more towards allowances and different disease types that have a high probability of error. Nearly 23% of cases are reviewed under this process prior to final adjudication.

Reconsideration Process

If a claimant does not agree with the initial decision they may file for reconsideration. Reconsideration can be filed on any claim that is not fully favorable to the applicant. The most obvious reconsideration filing would be on an initial denial; however, an individual may also file for reconsideration if they disagree with the disability onset date established on the initial determination. A reconsideration claim is assigned to a different claims examiner and is reviewed by different medical consultant. The evaluation process remains the same as the initial claim but special emphasis is placed on the evidence to assure that all information related to an individual's claim is evaluated and any new evidence is considered in the evaluation of the claim. The claimant is allowed to submit any new evidence they deem appropriate. During the past three and a half years the agency has averaged 1,565 reconsideration claims per year which equals 29.3% of all initial claims.

Administrative Appeals Process

Once the DDS has rendered a reconsideration decision, the next level of appeal is to file for a hearing before an SSA Administrative Law Judge (ALJ). The ALJ is an attorney specially trained to conduct administrative hearings and decide disability based upon interpretation of Social Security law. South Dakota is extremely fragmented when it comes to case assignment at this level. Northeast SD is part of the Hearings Office workload in Fargo, North Dakota. Southeast SD (except Union County) is part of the Sioux Falls hearing office and West River is handled by the Rapid City office. The Sioux Falls office has a resident ALJ with administration out of Fargo. The Rapid City office has two resident ALJ's and is administered by the Denver hearing office. Union County claims are handled by the Omaha Hearing Office.

There are three parts to the hearing process. First is the claimant's request for a hearing and the claim being sent to the hearing office. Second is review of the file to determine if a decision can be based upon the record. If not, the case is prepared and a hearing is scheduled. ALJ's have certain hearing sites and usually travel to these sites quarterly. The third part of the process is the hearing and decision. Once a hearing is concluded, the ALJ can either make a decision upon the record or request additional medical evaluations from the DDS. Normally, an ALJ makes the decision and either a senior attorney in the office or special decision writing units prepare the formal decision

rationale. The average national processing time for a hearing claim is about 500 days. For FY2007, the average processing time for an ALJ decision in SD is 390 days. Presently there are 881 hearing claims pending for SD residents with 501 decisions adjudicated this year.

If a claimant does not agree with the ALJ's decision, they may request their claim be reviewed by the Appeals Council. The Appeals Council is responsible for both quality review of ALJ decisions and reviews requested by the claimant. The Appeals Council cannot overturn an ALJ decision but can only remand the claimant to the ALJ for additional action.

The Appeals Council is the last administrative appeal process. If the claimant continues to disagree with the determination they may challenge the final administrative decision in US District Court.

One of the common misconceptions related to the Social Security Disability process is that in order to receive benefits you must get to the ALJ appeals level before you will be granted benefits. Statistics from 2006 reveal 73% of the benefit allowances are made by the DDS and 27% are made at the administrative appeals level. The data also supports 68% of allowances are made at the initial level. In South Dakota, this equates to 68% of the allowed claims being adjudicated in less than an average of 12 weeks. The time tables shown in this report further define the above statement. What statistical information shows is that if 100 applications are taken for benefits, 57 individuals will be eventually denied at all levels, 37 will be allowed by the DDS at either the initial level or at the reconsideration level, leaving only 6 of every 100 individuals being allowed at the ALJ level.

III. Disability Definition

Disability is defined in Social Security law as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment (or combination of impairments) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. *Note that there is a prohibition against entitlement to disability benefits if drug addiction or alcoholism is a contributing factor material to the determination of disability.*

Duration of Disability

The definition is strict in that it is not a partial disability and the disabling impairment must be expected to result in death or to have lasted or be expected to last for a continuous period of not less than 12 months. The duration requirement as specified in the disability definition must be met in order to award benefits.

Substantial Gainful Activity (SGA)

The inability to perform substantial gainful activity (SGA) is a part of the definition of disability. Substantial work activity involves doing significant physical or mental activities, while gainful activity is done for pay or profit. It is significant if the earning levels meet or exceed the levels determined by the Commissioner of Social Security.

The SGA amounts are adjusted annually. Current monthly SGA amounts are \$900.00 and \$1,500 for people who are blind.

Medically determinable physical or mental impairment

A medically determinable physical or mental impairment (or combination of impairments) is established through the use of medical evidence from acceptable medical sources and in conjunction with collateral information provided by third party sources. A medically determinable physical or mental impairment (or diagnosis) alone does not establish disability. It is necessary to evaluate the impact that the disabling impairment(s) poses in order to determine if the disability is severe enough to meet the listings level severity defined in the Listing of Impairments is met or if residual functional capacity needs to be addressed. Regulations may be published to interpret this law and to establish administrative guidelines and procedures for administering it. For example, the Listing of Impairments (Subpart P, Appendix 1 of Part 404) has been published in the regulations since 1968. The Listings describe medical conditions that meet the severity necessary to be found "under a disability". The listings are constantly being revised through the regulatory process as medical treatment progresses and diagnostic studies improve.

Acceptable medical sources are:

- Licensed physicians (medical or osteopathic doctors);
- Licensed or certified psychologists. (Included are school psychologists or other licensed or certified individuals with other titles who perform the same function as a school psychologist in a school setting, for purposes of establishing mental retardation, learning disabilities, and borderline intellectual functioning only.);
- Licensed optometrists, for purposes of establishing visual disorders only;
- Licensed podiatrists, for purposes of establishing impairments of the foot, or foot and ankle, depending on whether the State in which the podiatrist practices permits the practice of podiatry on the foot only, or the foot and ankle; and
- Qualified speech-language pathologists (SLPs), for purposes of establishing speech or language impairments only.

Sequential Evaluation Process

A sequential evaluation process is followed to determine if a claimant is eligible for disability benefits under Social Security rules. The definition of disability for children varies slightly from that for adults; however, the determination process is practically the same.

1. The first step is determining whether the claimant is performing substantial gainful activity (SGA). Substantial Gainful Activity (SGA) is defined as work that involves significant physical or mental activity for payment or profit as determined by SSA. If the claimant is working at the SGA level, the claim is denied. If the claimant is not working at the SGA level, proceed to the next step.

2. The second step is deciding whether the claimant has a medically determinable impairment(s) that is severe. A medically determinable physical or mental impairment (or combination) is established through medical evidence from acceptable medical sources. The presence of a medically determinable physical or mental impairment alone does not establish meeting SSA's definition of disability. If the claimant's impairments are determined to be non-severe, the claim is denied. If the impairments are determined to be severe, proceed to the next step.
3. The third step is establishing if the impairment(s) meet or equal a listing as described in The Listing of Impairments. The Listings of Impairments describes impairments for each of the major body systems that are considered severe enough to prevent an adult from doing any gainful activity regardless of age, education or work experience. Within each listing, the objective medical and other findings that are needed to satisfy the criteria of that listing are specified. An impairment meets the requirements of a listing when it satisfies all of the criteria of that listing and meets the duration requirement. If the impairment does not meet the criteria of a listing, it may become a medical equivalent to the criteria of a listing. An impairment is medically equivalent to a listed impairment if it is at least equal in severity and duration to the criteria of any listed impairment.

The claim is allowed if the person has an impairment(s) which meets or equals a listing in SSA's Listing of Impairments. If the claimant does not meet or equal a listing, proceed to the next step.

4. The fourth step entails determining if the claimant is able to perform past relevant work. The claimant's residual functional capacity is utilized at this step. The claim is denied if the claimant is able to meet the physical and mental demands of past relevant work. If the claimant is not able to return to past relevant work proceed to the next step.
5. The final step in the sequential evaluation process is determining whether the claimant is able to perform other work. If the claimant's residual functional capacity, considered with other factors such as age, education, and work experience, allows the claimant to perform other work, the claimant is denied benefits. If all necessary criteria are met, the claimant may be allowed.

IV. Timeline and Graphs

Each column of the "General Time Line" is broken out into separate pages to provide further detail of each part in the process.

Key:

Green = Federal

Blue = State

Yellow = Claimant

General Timeline for South Dakota Applicants for the Social Security Disability Programs (SSI - SSDI)							
Agency with jurisdiction	SSA Field Office Application	DDS Initial Adjudication / Determination	Claimant Application Reconsideration	DDS Reconsideration Adjudication / Determination	Claimant Application ALJ Hearing	ALJ Adjudication & Determination	Federal Appeals Counsel / Federal District Court
Cases within jurisdiction	7982	5329	1565	1565	352	352	***
Allowances		33.1.% - 1764		11.% - 172		60% - 211	***
Tech Denials	Tech Denial 33% - 2653						
Claimant needs or asks for further adjudication	5329	29.3% - 1565	1565	Best estimate per FO reports 6.6% - 352	352	***	***
Claimant accepts decision of DDS		70.6% 3764		93.4% - 4977			
Average Time	21 days	77.1 day	30 up to 60 days	74 days	30 up to 60 days	390 days	***
	Claimant makes contact with SSA field office by phone, over the internet, or in person. SSA checks for income and eligibility status.	This time includes information gathering, medical consultation, consultive exams, review by examiner, internal review and Federal Regional Office Quality review.	This time is given to the claimant to work on his or her request for a reconsideration by the DDS.	This time includes the gathering of new information, medical consultation by a different consultant, consultive exams, review by a different examiner, internal review and Federal Regional Office Quality review.	This time is given to the claimant to work on his or her request for a hearing with an ALJ.	ALJ Adjudication / Determination	Adjudication and Determination at Federal Level
*** This information not available from SSA.							

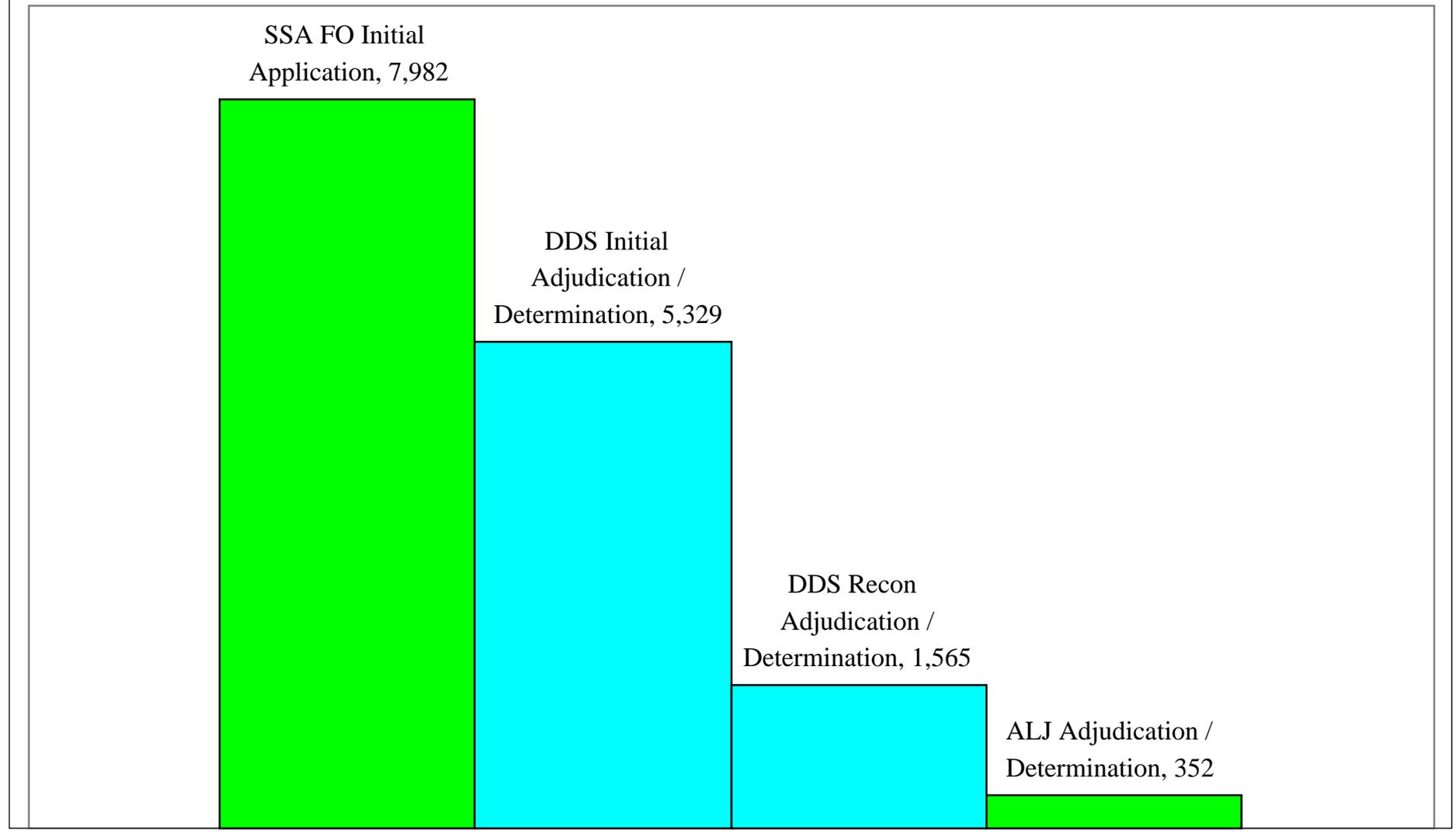
SSA Field Office Application Process			
Initial Contact	Information Provided	Application Interview	Signed Application
Applicants use the telephone, internet, federal 800 number or in person. There are six SSA Field Offices in SD: Sioux Falls, Aberdeen, Watertown, Yankton, Huron and Rapid City.	A packet is sent or information is referred to on the internet from the applicant. It generally takes 3 weeks until the applicant has an interview time either by phone or in person.	Information is entered into the SSA system during the interview. A determination is made in regards to technical eligibility at this time.	Once the application is complete, and is not a technical denial, the application is electronically transferred to the DDS for medical development, review and determination.

DDS Initial Adjudication / Determination						
Medical Records	Examiner Review	CE or Med Consult	CE Report/MC Completion	Internal QA	External QA	Determination
2-6 weeks	2-3 days	CE=53 days MC=45 days	Report=2-4 weeks MC-21 days	2 days	Average time 16.4 days	Notification of Decision
It takes approximately 2-6 weeks to receive medical records. According to SSA policy, 4 weeks is considered an excessive time delay and an examiner may continue with adjudication of a claim at this time.	The examiner will review the evidence and annotate, bookmark and highlight significant evidence. If it appears that the evidence is sufficient for a determination, the case will be sent for review by a medical consultant. If not, a Consultative Examination (CE) will be ordered.	28% of cases need a CE. The time for scheduling and obtaining a CE west river takes much longer than east river. Medical consultants review the evidence for a case by their medical speciality. Different medical consults in the office include physical, mental or speech. If the evidence is sufficient, the medical consultant completes an assessment. If the evidence isn't sufficient they may ask for a CE.	A call is made to follow up on whether the clmt attended the CE. If the CE was broken, the examiner follows policy to either go forward with adjudication of the claim based on the evidence in the file or reschedules the CE. If the CE is kept, a report is received 2-4 weeks after the appointment date. The case is then sent for medical consult. With the age of the case at this point, the average time before medical consult is complete is 21 days. Upon completion of the assessment by the medical consultant, an action item appears on the examiner worksheet. The examiner reviews the assessment, completes a determination with a decision made within 7 days.	When a claim is ready for clearance, the system automatically selects an internal Quality Assurance Sample. Approximately 10% of the claims ready for clearance are selected for review. Quality review is completed equally by the three agency Disability Claims Specialists.	DDS decisions are subject to review by a SSA unit called the Disability Quality Branch (DQB). DQB are located in the regional office and in SSA Central Office Headquarters. SD claims are reviewed by the DQB's in Denver, Boston and Central Office. SSA reviews about 24% of determinations based on stats and targeted areas (PER). The selection process weighs heavily on allowances. The average processing time for a federal review is 16.4 days. The overall DDS accuracy rate is 95%. Reviews are completed prior to the decision becoming final.	Once the claim has been finalized, denial notification is released by either by the DDS or DQB. Allowance notification is released after the Field Office completes any pending non-disability action.

SSA FO Application Reconsideration			
Denial Letter	Clmt Responds	Application	Signed Reconsideration Application
The claimant receives a letter that provides information on the reason they were not found to be disabled. This letter also provides information on requesting a reconsideration.	The claimant has 60 days or longer if there is good cause, to request a reconsideration.	The field office generates a 3441, application for reconsideration. The claimant submits new evidence or asks to have a new review completed on the evidence in the file. New allegations may be added. The information is entered into the SSA system.	The field office electronically transfers the case to the DDS.

ALJ Adjudication / Determination					
Denial Letter	Case Assignment	Info Gathered	Hearing	Decision	Determination
The claimant receives a denial letter that provides information on the hearing and appeals process. The claimant has up to 60 days to file a request for a hearing. This letter also provides information on the process and that legal assistance is available.	Cases are assigned to the appropriate hearings office. Claimants are placed on the hearings docket in the order of which there are filed.	The hearings office is given new information by the claimant or their attorney. New information may also be requested by the judge at which time a request is sent to the DDS to assist in the procurement of this evidence.	A hearing is usually 60 to 90 minutes long. The claimant and/or their representative presents evidence of how they are disabled by SSA criteria. The judge may hear expert testimony from a vocational and/or medical expert as well.	The judge makes a decision and the office staff completes the formal written decision report. It takes about 30 days for the formal decision to be completed.	The claimant receives a letter in regards to the decision. If the claimant is not found to be disabled, the letter will provide additional information on the appeals process to either the Appeals Counsel or Federal District Court.

Cases Assigned Per Jurisdiction Per Year



Total Cases Worked to Completion by Agency

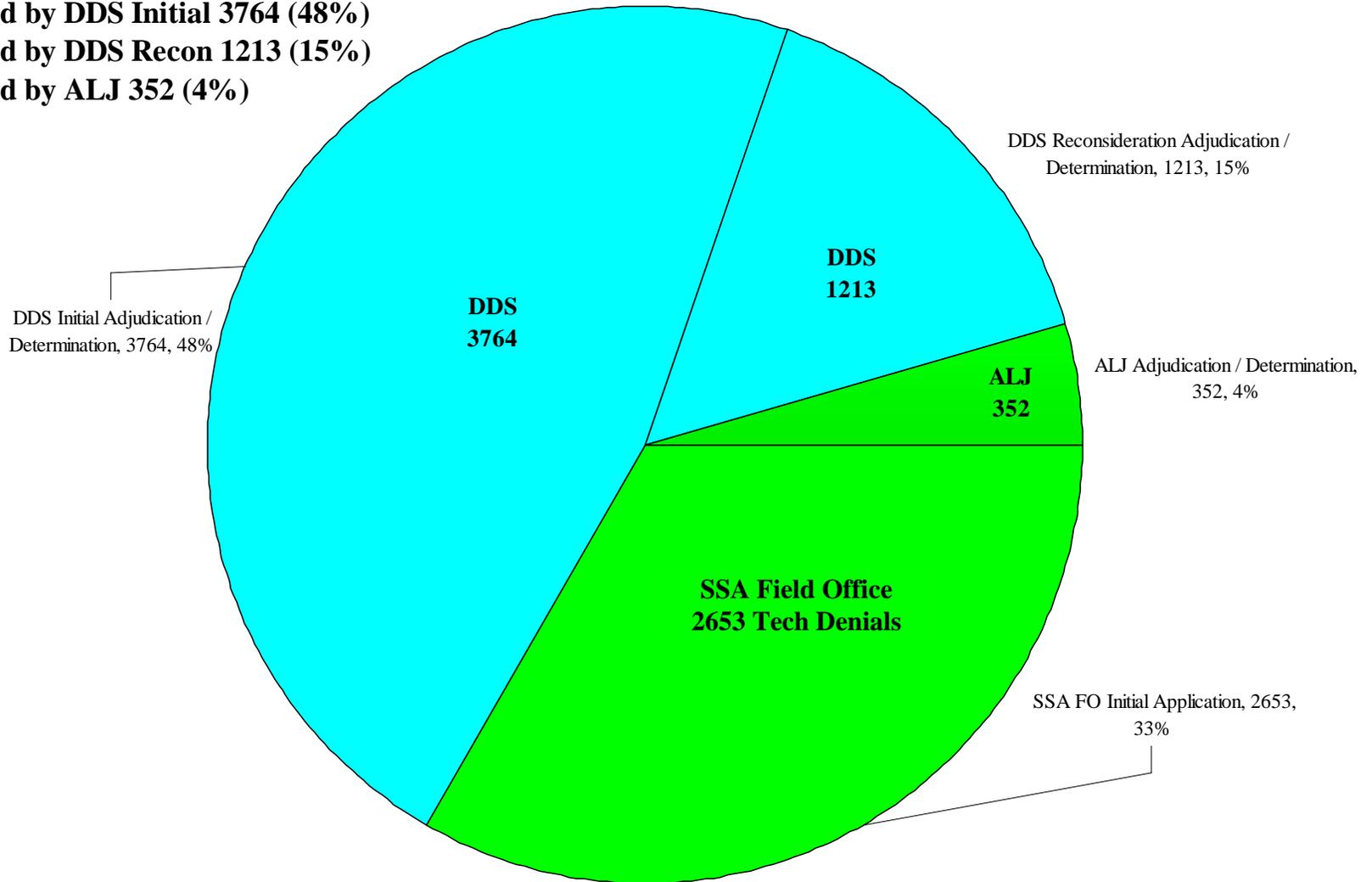
Total Average Annual Cases 7982

Total Completed by SSA FO 2653 (33%) Tech Denials

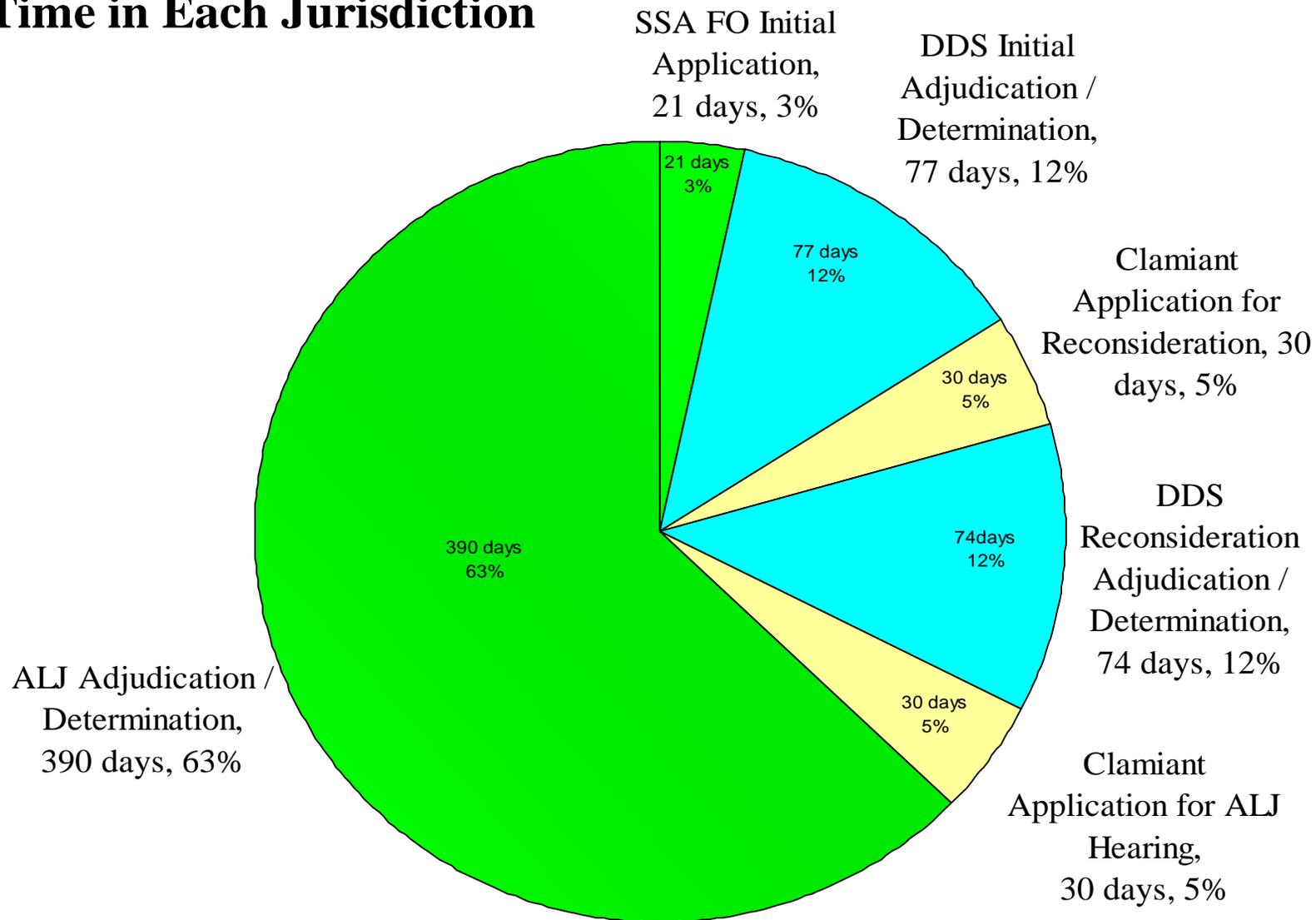
Total Completed by DDS Initial 3764 (48%)

Total Completed by DDS Recon 1213 (15%)

Total Completed by ALJ 352 (4%)

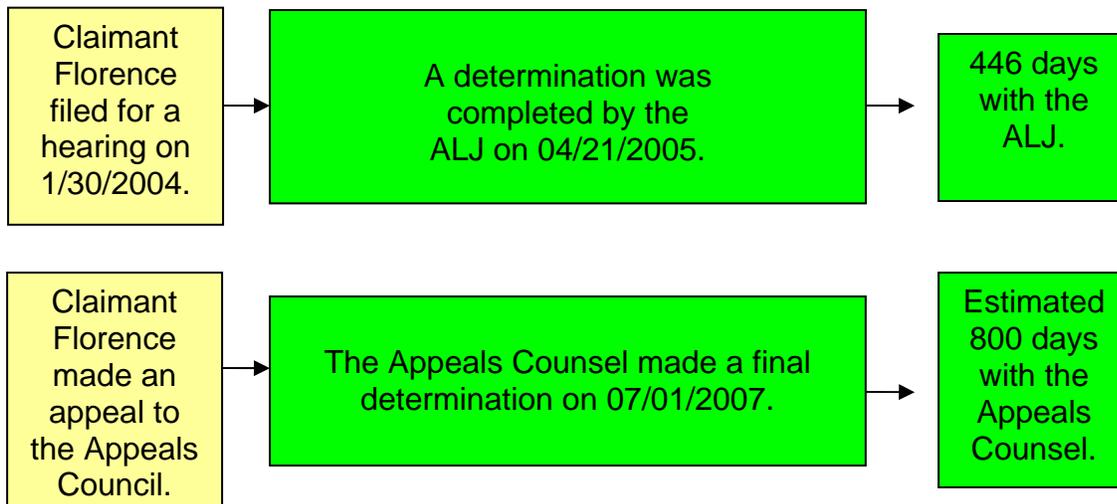
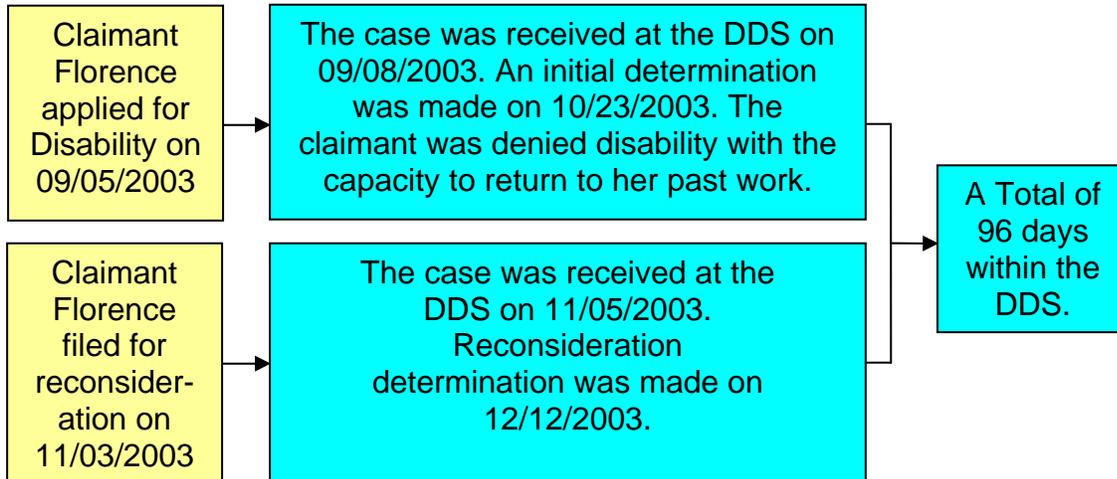


Time in Each Jurisdiction



V. Actual Claimant Timeline Example

Correspondence Log #34899



VI. Conclusion

The initial charge of the task force was to take a critical look at the DDS operation and to identify the operational areas that may have the greatest affect upon the disability adjudication process. This report is a detailed analysis of the Social Security Disability process with emphasis on the DDS role in the process. This comprehensive review of the DDS operation is the basis for the following conclusions.

- In South Dakota an average of 7,982 people seek to apply or reapply for disability benefits each year. Over 90% of these individuals receive and accept the decision rendered within six months of the initial application. They do not come to the attention of the public in terms of complaints.
- There is a significant misconception by the general public that in order to receive Social Security Disability a person must be denied benefits up to three times before an Administrative Law Judge will allow the claim. Data collected for this report shows that if 100 people file for disability benefits only 6.3 actually have to file for a hearing before an Administrative Law Judge. Of those 6.3, four are found eligible by an Administrative Law Judge.
- Individuals who file for disability benefits need to be an active partner in the process. The disability process can be very intimidating and complex. It becomes the responsibility of the applicant to respond to requests for information from either Social Security or DDS and to provide updates in medical treatment, etc. as they take place. State DDS staff welcomes inquiries at any time.
- The need for additional consultative examinations significantly increases case processing time. Reasons include limited providers willing to do the examinations at the reimbursement rate paid and missed appointments. The task force believes that there are possibilities for improved service and will evaluate various options for improvement.
- The time spent by the DDS on a claim is a small portion of the total processing time. The age of a claim can increase significantly once an appeal is made for a hearing before an Administrative Law Judge.
- There is a significant misconception by the public and by public officials concerning key outcomes of this process. In fact, there is a significant misrepresentation portrayed that may discourage individuals who are entitled from applying or following through once in the process.

This report concludes phase one of the task force assignment. The task force has since developed a Customer Service Implementation Plan to address improvement. This plan can be viewed at the DRS website at <http://dhs.sd.gov/drs/>

VII. Appendix One – Expediting Your Claim

How Can You Expedite Your Claim

- Make certain that you have proper identification when you make your claim: Birth Certificate, Social Security Card, Driver's License, etc.
- Take time to go over your work history and try to list all of your employers for the last 15 years. Company names, addresses where you worked, supervisors' name, and any proof you have of how much you were paid will all be helpful.
- Know the date that you stopped working due to your impairment. Know the date that your work changed due to your impairment if that is different from the date when you finally quit. Explain any special working conditions that may have been provided by your employer to keep you on the job.
- Write down the names, addresses, and telephone numbers of any medical source you have seen. We may be able to find "Dr. Smith in Sioux Falls" but we will be more certain and much quicker if you provide accurate names, addresses, and telephone numbers.
- We recommend that you bring copies of your medical records to SSA and have the records faxed into your application file to assure the best turnaround time.
- If your doctor has given you any written instructions that limit your activities, have a copy placed in your file. The date the restriction started and the date it might end are very important to your decision.
- Send forms back to Social Security and the Disability Determination Service as quickly as possible. The vast majority of the time it takes us to complete a claim is spent waiting on forms and medical reports.
- Keep yourself informed about your claim. Ask questions if something is not clear to you. If we or SSA are waiting for something, see if you can make a call to help expedite the claim. Many times a doctor will respond to a patient before they will respond to a government agency. If you have additional treatment or see a new medical source during the adjudication of your claim, notify Disability Determination Service about the new treatment or medical provider.
- We may ask you to explain your "Daily Activities." Answers to these questions are very valuable and may make the difference as to whether your claim is allowed. It is not the length of the answer that helps. What helps is how specifically you answer the questions. Give examples. Mention any limitations. If we ask "Can you go grocery shopping?" an answer of "I can go to the grocery store, but I have to use the electric carts and have people place items in the basket because I can't hold on to anything heavier than a soup can" help more than just writing a long paragraph explaining every detail of your experiences.
- If you are scheduled for a medical/mental evaluation by the Disability Determination Services, it is very important that you keep this appointment. Failure to attend the examination or notify the DDS that you have to reschedule your appointment can result in a significant delay in processing your claim or may result in a decision being made with the evidence of record which often results in your claim being denied.

VIII. Appendix Two – Example of Denial Letter

The following is an example of a denial letter for SSDI (Title II) claim that would be sent to the claimant.

SOCIAL SECURITY NOTICE

From: SOCIAL SECURITY ADMINISTRATION

NOTICE OF DISAPPROVED CLAIM

ROSE O SUNSHINE

Date: June 29, 2007

999 COUNTRY ROAD

SIOUX FALLS, SD 57105

Claim Number: 999-99-9999

We are writing about your claim for Social Security disability benefits. Based on a review of your health problems you do not qualify for benefits on this claim. This is because you are not disabled under our rules.

THE DECISIONS ON YOUR CASE

The following reports were considered in deciding your claim:

ORTHOPEDIC INSTITUTE report received 06/05/2007

You state that you are disabled due to lower back pain. There is no indication of nerve or muscle damage which would result in severe weakness or loss of function. The x-rays do not show severe damage. Although you may have some discomfort, it does not severely limit your ability to move about and use your back in a satisfactory manner. The evidence shows this condition does not severely limit the ability to work. Considering medical records, age, education and work history, we have concluded that you are able to do work that is less physically demanding.

ABOUT THE DECISION

Doctors and other trained staff looked at this case and made this decision. They work for the state but used our rules.

Please remember that there are many types of disability programs, both government and private, which use different rules. A person may be receiving benefits under another program and still not be entitled under our rules. This may be true in this case.

THE DISABILITY RULES

DISABLED WORKER'S BENEFITS:

You must meet certain rules to qualify for Social Security benefits. You must have the required work credits and your health problems must:

- o keep you from doing any kind of substantial work (described below), and
- o last, or be expected to last, for at least 12 months in a row, or result in death.

INFORMATION ABOUT SUBSTANTIAL WORK

Generally, substantial work is physical or mental work a person is paid to do. Work can be substantial even if it is part-time. To decide if a person's work is substantial, we consider the nature of the job duties, the skills and experience needed to do the job, and how much the person actually earns.

Usually, we find that work is substantial if gross earnings average over \$900 per month after we deduct allowable amounts. This monthly amount is higher for Social Security disability benefits due to blindness.

A person's work may be different than before his/her health problems began. It may not be as hard to do and the pay may be less. However, we may still find that the work is substantial under our rules.

If a person is self-employed, we consider the kind and value of his/her work, including his/her part in the management of the business, as well as income, to decide if the work is substantial.

OTHER BENEFITS

Based on the application you filed, you are not entitled to any other benefits, besides those you may already be getting. In the future, if you think you may be entitled to benefits you will need to file again.

IF YOU DISAGREE WITH THE DECISION

If you disagree with this determination, you have the right to appeal. We will review your case and consider any new facts you have. A person who did not make the first decision will decide your case.

- o You have 60 days to ask for an appeal.
- o The 60 days start the day after you get this letter. We assume you got this letter 5 days after the date on it unless you show us that you did not get it within the 5-day period.
- o You must have a good reason for waiting more than 60 days to ask for an appeal.
- o You have to ask for an appeal in writing. We will ask you to sign a form SSA-561-U2, called "Request for Reconsideration." You may request this form online at <http://www.socialsecurity.gov/online/ssa-561.pdf>. Contact one of our offices if you want help.
- o In addition, you have to complete a "Reconsideration Disability Report" to tell us about your medical condition since you filed your claim. You may contact one of our offices or call 1-800-772-1213 to request this form. Or, you may complete this report online at

www.socialsecurity.gov/disability/recon.

Please read the enclosed pamphlet, "Your Right to Question the Decision Made on Your Social Security Claim." It contains more information about the appeal.

NEW APPLICATION

You have the right to file a new application at any time, but filing a new application is not the same as appealing this decision. If you disagree with this decision and you file a new application instead of appealing,

- o You might lose some benefits, or not qualify for any benefits, and
- o We could deny the new application using this decision, if the facts and issues are the same.

So, if you disagree with this decision, you should ask for an appeal within 60 days.

IF YOU WANT HELP WITH YOUR APPEAL

You can have a friend, lawyer, or someone else help you. There are groups that can help you find a lawyer or give you free legal services if you qualify. There are also lawyers who do not charge unless you win your appeal. Your local Social Security office has a list of groups that can help you with your appeal.

If you get someone to help you, you should let us know. If you hire someone, we must approve the fee before he or she can collect it. And if you hire a lawyer, we will withhold up to 25 percent of any past due Social Security benefits to pay toward the fee.

IF YOU HAVE ANY QUESTIONS

If you have any questions, you may call us at 1-800-772-1213, or call your local Social Security office at (605) 330-4334. We can answer most questions over the phone. You may also write or visit any Social Security office. The office that serves your area is located at:

OXBOW CTR ONE, 2400 W 49TH ST

SIOUX FALLS, SD 57105

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly.

Nancy Berryhill

Regional Commissioner

Enclosure: SSA Pub. No. 05-10058
SSA-L443-U2

IX. Appendix Three – Meeting with Judge Maxwell

Meeting with Judge Maxwell

Judge Robert Maxwell was invited to the Task Force meeting on June 19th, 2007 and provided insight on the workflow process of an ALJ (Administrative Law Judge) for ODAR (Office of Disability Adjudication and Review). He noted that most of the hearings he conducts are on disability claims. ODAR is a team of an ALJ and about four to five staff that prepares a file, conducts a hearing, and writes a final decision. Judge Maxwell has been conducting hearings for the past 19 years. His territory is mainly the eastern half of South Dakota, but also extends into surrounding States and occasionally assists the Denver, CO ODAR office. There are five judges in the office in Fargo, which is currently down two. The Fargo office often conducts hearings for the Aberdeen area because they have more ALJs. The western half of South Dakota is covered by a satellite office in Rapid City administered by the Denver ODAR office. Rapid City has two judges that handle South Dakota cases as well as cases from Wyoming, Nebraska and Denver.

The claimant has 60 days to request an ALJ hearing after being denied at the reconsideration level. This means that by the time an ALJ is sent a disability claim file, the claimant has been denied twice. The appeal is filed at the regions ODAR office. After the request to appeal is filed at the ALJ office, a letter is sent to the claimant informing them that a hearing will be scheduled. There is no indication of how long they will have to wait for the hearing. The letter also indicates that they may have representation. It is taking nine to eleven months to get a hearing scheduled. Judge Maxwell has had approximately 600 cases on his docket each of the last two years. The ALJ staff spends the time prior to the hearing obtaining the claimants updated medical records. Cases are scheduled in chronological order based on case age. A 20 to 30 day notice is given of the scheduled hearing. Judge Maxwell did note that there is a pilot running that provides the claimant with a 70 day notice. This is being tested to see if this increased time actually helps the claimant be better prepared for the hearing. Another letter is sent to the claimant asking if they wish to waive representation. Judge Maxwell noted that the claimant will get a more thorough hearing if they have representation versus representing themselves. He stressed the importance of having a representative because a well prepared representative is able to provide the most pertinent information in a summarized and timely manner. The representative will ensure that all of the evidence is in so a decision can be made within the week of the hearing. He said sometimes claimants do not realize the formality of a hearing and then recognize they need representation by an attorney. This causes an additional delay because an extension is made for the claimant to find representation and preparation time for the attorney.

Judge Maxwell was asked a series of questions pertaining to the months leading up to the hearing. He was asked his thoughts on why it is taking so long to get a hearing scheduled. He said that the delays have not been this bad in the past. Cases used to be scheduled in about 6 months. He noted that this could be contributed to the baby boomers coming through, changes in the economy or various other reasons. Judge

Maxwell was asked what he would suggest telling claimants when they call for a status check and they are awaiting a hearing with an ALJ. He said to tell them that each claim will be given individual time and attention; they need to be patient, and to "hang in there." He expressed understanding that with each individual claimant's personal situation, any delay is very hard for claimant's to deal with. It was asked if claimants should be directed to call the Fargo, ND or Sioux Falls office for these status requests. Judge Maxwell indicated that these calls can be directed to the Sioux Falls office instead of Fargo. He was asked if his office has any personal contact with the claimant's prior to the hearing. He indicated that his staff is in touch with the claimant or attorney closer to the time of the hearing. Although contact is made, their time is limited due to the staff being so busy. It was asked whether pre-hearing reviews are still completed. This would be when the judge's staff starts preparing the decisional paperwork prior to the hearing. Judge Maxwell said that these reviews are not done anymore. The volume of cases is just too great. The attorney adviser just writes the decisions after the hearing is held.

Judge Maxwell generally has five hearings a day, five days a week. He noted that no shows and postponements are less than 10%. Claimants are pretty serious at this point and will comply so they can be heard before the ALJ. It was felt that at least 3/4 of claimants are represented by an attorney. The time spent on each case is really dictated by the volume of cases. Judge Maxwell felt that an hour was normally an adequate amount of time for a hearing with an organized presentation by an attorney as well as expert witnesses such as vocational and medical experts. Judge Maxwell was asked how much vocational issues play a role at the hearing level. He said that vocational factors play a big factor in the decisions that are made at this level. Vocational experts are contracted for the ALJ to provide testimony as to what types of jobs the claimant can still perform that exists regionally and nationally. Testimony by medical experts is optional. Most treating doctors will not testify as the payment for service is lean and not worth leaving their practice. Sometimes a doctor will come to a hearing if they feel strongly about their patient. The assessments that the DDS complete are often used to frame questions for the vocational expert as well as represent a good medical read for the time the case was in the DDS. Very often the case the DDS saw is extremely different from the one the ALJ sees, due to duration and other health problems that were not noted at the DDS levels. More weight is given to the claimant's treating source at this level. This more detailed information is helpful when determining the type of work the person could do. When attorneys are involved, they get more detailed accounts from the physician prior to the hearing. Consultative examinations (CE's) can be obtained at this level. These are completed with the assistance of the DDS. A basic request for information is sent to DDS as to what kind of CE is needed. DDS schedules the CE and sends the completed report back to the ODAR office. Judge Maxwell feels that CE's are just a snapshot of the claimant's condition on that particular date and not a substitution of the claimant's medical history. Hearings can now be conducted by using teleconferencing. This is something that is taking place nationwide to assist backlogged ODAR offices and save travel time for the judges.

Decisions are best made during the same week of the hearing. It may take 30-45 days for the decision to be completed due to the formal writing of the report. ALJs are now

allowed to make bench decisions at the time of the hearing if all the medical evidence is available and the judge feels it's appropriate. It still takes the same amount of time to process the decision, but it eases the anxiety for the claimant by hearing the decision right away. He averages about 5 to 10 bench decisions a month. On a yearly basis the Judge Maxwell and his staff complete about 500 cases. It was felt that approximately 60% of claims are allowed at the ALJ level. When asked whether Judge Maxwell makes many decisions without the claimant wanting a face-to-face hearing, he responded saying most claimants want a face-to-face hearing. He does very few decisions without the claimant present. Judge Maxwell noted that the face-to-face encounter with the claimant allows for follow-up questions and helps to eliminate doubts. When the decision is completed, it is sent to the claimant, their representative and the payment center for T2 claims. It goes to the FO for T16 and their letter goes to the claimant and representative. The time spent in the payment center is unknown. Claimants won't hear from the payment center until about 3 weeks prior to their first payment.

X. Appendix Four – Meeting with Randy Lueking, SSA

Meeting with Randy Lueking

Randy Lueking, manager of the Sioux Falls area SSA field office, visited with the Task Force on July 17th, 2007 about the role field offices play in the disability adjudication process. Mr. Lueking has been the manager of the Sioux Falls Field Office for the past seven years and performed other functions at the same office prior to his becoming manager.

Mr. Lueking noted that the disability adjudication process begins when the field office receives word that an individual has contacted the SSA via telephone, the internet, or directly. The field office then sends a packet to the claimant which includes information describing how the process works, tips to the claimant for making the process work more quickly and smoothly, a description of the various benefits for which the claimant might be eligible, a description of the types of information the SSA asks claimants to provide – names and addresses of medical treating sources, work/earnings information, etc. – and a “homework” sheet which encourages claimants to complete as much of the application as they can through the SSA’s web site prior to their interviews with the field office’s claims representatives (or ‘technicians’). Anyone who expresses an interest in disability benefits will be encouraged to go through with the application process.

Mr. Lueking stated that about ten percent of claimants are now completing at least part of the application process via the internet. He thinks that claimants in the Sioux Falls area, being more urban, are probably more comfortable with computers and the internet and are thus using the SSA’s web site more frequently than are claimants from elsewhere in the state. Claimants are encouraged to start their claim using the SSA’s web site for a couple of reasons: the claimants who do this tend to provide better, more complete information; and, the claimants get to state their cases in their own words, rather than having SSA Claims Representatives interpret or rephrase what they have said.

Whether claimants use the SSA’s web site to start the process or fill out the paper forms they are provided, the next step of the process brings claimants to their interviews with SSA technicians at the field office. Interviews can be conducted either by phone or in person. In-person interviews will be arranged for those who prefer this option. Most people prefer to have an in-person interview, rather than interviewing over the telephone. Mr. Lueking indicated of the 85 interview appointments pending in the Sioux Falls office, 49 were in-person interviews and 36 were telephone interviews.

During the interview the SSA technician will review the information provided by the claimant, ascertain its accuracy, review the claimant’s work and earnings information, and then prepare the file for transfer to the DDS. SSA technicians will also make notes of claimants’ behavior and appearance during their interviews, as these observations can sometimes be used by the DDS when assessing claimants’ credibility. It currently takes about two to four days, depending on the complexity of the claimant’s income and

resources, other issues, and office workflow factors, for SSA technicians to process files before they are sent to the DDS.

Mr. Lueking stated that most people who apply for disability benefits have no knowledge of the disability process. Some will first contact the SSA while still employed at SGA level, thinking that they might be approved for disability prior to quitting their jobs. Some do not understand that the SSA does not provide benefits if their disability has or is expected to be less than 12 months in duration. Many have heard and believe the rumor that nobody is allowed benefits upon their first application. Some people do not understand that they are responsible for getting their claim started, providing information related to their disability and cooperating with the SSA and the DDS in the development of their claim – that they need to be actively involved in their own claims. Many people have difficulty understanding the difference between SSDI and SSI benefits, and the various eligibility criteria that pertain to these programs. Most people do not think to investigate in advance what might be available for them in the event that they become disabled.

It is standard practice in the Sioux Falls Field Office to take SSDI and SSI claims with all claimants, even though many people will not qualify for one or the other. Among the technicians in the Sioux Falls office, three are qualified to deal with both SSDI and SSI claims, three deal only with SSDI claims and five deal only with SSI claims. The trend in South Dakota, and nationwide, is for Claims Representatives to become ‘generalists’ – to be able to process both SSDI and SSI claims. Field offices around the country and within South Dakota have lost personnel over the past several years. This has been a strain on office workflows and on the claims representatives themselves.

It is policy in the Sioux Falls field office to automatically send out reconsideration applications and related materials to claimants who were denied on the initial level by the DDS. Also, for claimants who are then denied at the reconsideration level, the Sioux Falls field office will send out the materials that would allow them to file for ALJ hearings. Mr. Lueking is not sure how many other field offices do this. This is not a practice that is required by policy, but he said his office does it because he thinks more people will go through with the appeals process if it is made easier for them to do so. However because this is not an SSA-mandated procedure, and because with staffing changes they have less time to complete required tasks, the Sioux Falls field office might quit doing this as well as some of the other things they do that are above and beyond what they are required to do.

Mr. Lueking noted several demographic trends he is seeing among claimants in South Dakota. The population of the state is shifting away from rural areas and toward the Rapid City area and the ‘I-29 corridor’ – Sioux Falls and the urban areas of eastern South Dakota. The other trend noted is that claimants as a group are getting older as the ‘baby boom’ generation approaches retirement. These changes are causing some shifting of workloads among the field offices within the state. For instance, the Huron field office has been assisting the Rapid City field office in its claims work lately. It is anticipated that in the future workloads will be more easily shared among SSA field offices nationwide. The geographical locations of claimants and the SSA technicians

with whom they deal are becoming less relevant with the technology changes that have and are undergoing implementation. It was pointed out that in the future a claimant in South Dakota who opts for a telephone interview might end up speaking with a SSA technician in an Alabama Field Office.

There are currently 13 claims representatives in the Sioux Falls, eight to ten in Rapid City, seven in the Aberdeen, eight to nine in the Huron, three in the Watertown and four in the Yankton field offices. In addition to taking disability claims, field office technicians must also take claims for retirement and keep track of changes in status – medical condition, work status, etc. – for those who have been awarded disability benefits. In 2006 the Sioux Falls field office dealt with 2,800 retirement claims and 2,500 disability applications. It takes approximately three times as much time for an SSA technician to process a disability claim versus the time it takes to process a retirement claim because of the amount of information that must be obtained, reviewed and processed in disability claims.

The Task Force's meeting with Randy concluded with a discussion of ways that the SSA and the DDS might better cooperate with each other in the future. Randy and those present agreed to be open to any ideas for improving the process.

XI. Appendix Five - Links

Helpful Websites

www.SSA.gov

<http://www.ssa.gov/disability/>

<http://www.disabilitydoc.com/>

http://www.ssa.gov/disability/disability_process_welcome.htm

http://www.ssa.gov/disability/disability_process_welcome_2005.htm

http://www.ssa.gov/disability/disability_process_chart.html

XII. Appendix Six – SD SSA Field Offices

South Dakota Social Security Administration Field Offices

ABERDEEN – District Manager: (Mr.) Kerry Wenbourne
Federal Building, Rm 111
115 Fourth Ave SE
Aberdeen SD 57401
Phone: (605) 226-7481

Counties: Brown, Campbell, Corson, Day, Dewey, Edmunds, Faulk, Marshall, McPherson, Perkins, Potter, Roberts, Spink, Walworth and Ziebach

HURON – District Manager: Adam Harrington
Federal Building, Rm 105
200 Fourth Street SW
Huron SD 57350
Phone: (605) 353-1115

Counties (Including Pierre Resident Station): Aurora, Beadle, Brule, Buffalo, Charles Mix, Davison, Douglas, Gregory, Hand, Hanson, Hughes, Hyde, Jerauld, Jones, Kingsbury, Lyman, Mellette, Miner, Sandborn, Stanley, Sully, Todd and Tripp

PIERRE – Resident Station -- Manager: Adam Harrington
Open Tuesday and Wednesday 9:00-12:00 and 1:00-4:00 Central Time
Federal Building, Rm 221
Pierre SD 57501
Phone: (605) 224-9076

RAPID CITY – District Manager: Will Ouellette
605 Main St Ste 201
Rapid City SD 57701
Phone: (605) 342-9275

Counties: Bennett, Butte, Custer, Fall River, Haakon, Harding, Jackson, Lawrence, Meade, Pennington and Shannon

Sioux City – District Manager: Doug Keane
3555 Southern Hills Dr.
Sioux City IA 51106
Phone: (712) 255-5525

Counties: Union

SIOUX FALLS – District Manager: Randy Lueking

DHS SSA TASK FORCE
August 20, 2008

Oxbow Bldg. 1 Ste 100
2400 W 49th St
Sioux Falls SD 57105
Phone: (605) 330-4473

Counties: Brookings, Lake, Moody, McCook, Minnehaha, Turner and Lincoln,

WATERTOWN – District Manager Judy Dahl
514 10th Ave SE
Watertown SD 57201
Phone: (605) 886-7832

Counties: Clark, Codington, Duel, Grant, Hamlin

YANKTON – Jackie Kofoid, District Manager
121 W 3rd St Ste 101
Yankton SD 57078
Phone: (605) 665-0726

Counties: Clay, Yankton, Bon Homme

SD Contacts for Office of Hearings and Appeals

Field Offices: Aberdeen, Huron, Sioux Falls, Watertown and Yankton

Garrett Martell, Hearing Office Director
SSA, Office of Hearings & Appeals
Quinten Burdick U.S. Courthouse, Suite 150
655 First Avenue, North
Fargo, North Dakota 58102-4971
Telephone: (701) 239-5311

Field Office: Rapid City

Dave Wells, Hearing Office Director
SSA, Office of Hearings & Appeals
Suite 752
1244 North Speer Boulevard
Denver, Colorado 80204-3584
Telephone: (303) 844-5800