

The Unhoused Beneficiary

The Intersection of Homelessness, Disability, Public Benefits, and
Special Needs Planning

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OVERVIEW

Individuals with disabilities are disproportionately vulnerable to homelessness, and homelessness in turn worsens health, disability, and access to legal protections. I will address the relationship among housing instability, Supplemental Security Income (SSI), Medicaid, Special Needs Trusts (SNT), caregiver succession, and supportive services. I will also provide practical recommendations for attorneys, trustees, and multidisciplinary teams.

Who is the “Unhoused Beneficiary?”

The phrase, “unhoused beneficiary”, captures an apparent contradiction. A beneficiary is a person who is legally chosen to benefit from a will, trust, life insurance policy, etc. In a perfect world, Social Security, Medicaid, housing assistance, or a special needs trust, addresses all the needs of a disabled beneficiary. Yet, a person may possess all or one of these resources and still become homeless.

Throughout this presentation, I will be discussing how disability, homelessness, public benefits, Medicaid, and special needs planning interact. So, the central inquiry is this: How can a person qualify for disability benefits, Medicaid, housing assistance, or have a special needs trust and still become homeless? Once housing instability occurs, what can an elder-law attorney, trustee, or other advocate do to restore the disabled beneficiary’s housing?

First, we must broaden our meaning of “homelessness.” We often picture a person sleeping on the sidewalk of a busy city. However, that is not the whole picture – a client may be in a shelter, sleeping in a vehicle, hotel/motel hopping, staying temporarily with family/friends, or couch surfing. It also includes clients who are soon to be evicted or discharged from a hospital, correctional facility, or nursing facility with no stable destination.

This broadened definition is important because Social Security recognizes that homelessness can include the absence of a fixed, regular, and adequate residence; sleeping in unorthodox places; and temporarily staying with other people. Furthermore, clients do not always describe themselves as “homeless.” So, if we only ask “are you homeless?” we may miss the imminent problem.

According to The U.S. Department of Housing and Urban Development (HUD)’s 2024 Annual Homelessness Assessment Report to Congress, they estimated about 771,480 people experience homelessness on a single night. (U.S. Dep’t of Hous. & Urb. Dev., 2024 Annual Homelessness Assessment Report to Congress, Part 1 (2024)). Roughly 1-in-5 were age 55 or older, and nearly half of those older adults were unsheltered. (*Id.*). People with disabilities are significantly overrepresented in the homelessness population. Nearly one-quarter of all homeless individuals have disabilities and meet chronic homelessness criteria. (U.S. Dep’t of Hous. & Urb. Dev., 2024 Annual Homelessness Assessment Report to Congress, Part 1 (2024)). Additionally, research estimates that about 18 million people with disabilities qualify for housing assistance but do not receive it, and less than one percent of the nation’s housing stock is accessible to wheelchair users. (Urban Institute &

The Kelsey, *People with Disabilities Living in the U.S. Face Urgent Barriers to Housing* (2022)).

These numbers show us that it is not simply a failure by an individual to budget, follow rules, or ask for help. Rather, it is a collision among inadequate income, scarce housing, disability, fragmented service systems, and legal rules that are extremely difficult to navigate without stability.

A running hypothetical with a fictional client illustrates these issues: John Doe is 58 years old and has an intellectual disability, diabetes, and increasing mobility limitations. He has lived with his mother for his entire adult life. His mother never enrolled John in the local DD system, and she provided housing, transportation, meals, medication reminders, help with finances, and communication with government agencies. John Doe receives Medicaid and SSI, but his mother handled everything else. John Doe's mother unexpectedly dies. She leaves John Doe a modest inheritance outright. The house must be sold to pay expenses and divide the estate. John Doe stays with relatives for a few weeks, but no one can provide permanent housing or the level of daily support his mother provided. As a result, John Doe misses mail from Social Security, does not understand the Medicaid renewal process, and moves between couches, motels, and shelters. Within months, John Doe is not simply a person with a disability who lost his mother – he is an unhoused beneficiary.

As we work through today's issues, I want you to keep asking: At what point could this outcome have been prevented? And after the crisis begins, what combination of legal advice, benefits, housing, and human support might restore stability?

Why Disability and Homelessness Reinforce Each Other

The relationship between disability and homelessness runs in both directions. Disability can increase the risk of homelessness because it may limit employment, reduce income, create medical costs, and/or require a type of housing that is both accessible and near transportation, health care, and services. A psychiatric, cognitive, or intellectual disability may make it harder to understand a lease, complete recertification, respond to a notice, keep an appointment, or identify a scam. Additionally, a physical disability may make an available shelter bed unusable because the building, bathroom, or sleeping arrangement is inaccessible.

Then homelessness worsens disability because medication is harder to obtain, store, and take consistently; sleep is interrupted; nutrition suffers; medical appointments are missed; loss of assistive equipment or identification documents; anxiety, depression, trauma, and chronic health conditions worsen etc. The individual becomes less able to complete their basic daily needs to obtain benefits and housing.

The result is a cycle: disability increases housing instability; housing instability worsens health and functional capacity; and worsening disability makes it even harder to leave homelessness.

Many adults with disabilities may appear stably housed because a parent or other family member is quietly supplying an entire support system. The family caregiver is supplying housing, transportation, food, medication management, supervision, advocacy, bill payment, appointment scheduling, managing benefits, and emotional regulation. Much of this work goes unpaid and is invisible.

Thus, when the family caregiver dies, becomes ill, develops dementia, or simply cannot continue to provide, the disabled individual loses every single service at once. Although living with a parent caregiver may be the best option for a disabled adult child at present, the longer the parent-caregiver delays developing a plan, the more vulnerable their disabled adult child becomes to housing insecurity in the future.

This is why estate planning should include more than the question, “who should be the beneficiaries?” For a family caring for an adult with a disability, we also need to ask: Where will the beneficiary live when the caregiver is gone or unable to care for them anymore? What services is the disabled individual receiving? Who will communicate with benefit agencies? Who will coordinate among the trustee, family, and providers? What happens if the first housing arrangement fails?

Often, families run into affordability issues. According to CareScout’s 2025 Cost of Care Survey, the national average monthly cost of long term care is between \$9,581 and \$10,798, assisted living is \$6,200, and adult day care is \$2,058. (Care Scout, *Calculate the cost of long-term care near you*, <https://www.carescout.com/cost-of-care> (last visited Sept. 10, 2026)). Without the support of Medicaid, this monthly bill may be a ruinous

expense. But even if housing is affordable for some families, it may still be physically inaccessible. Or, may be accessible, but isolated from transit. Or near transportation, but lacks the staffing or services that allow the individual to remain there. A lease alone does not ensure that a person can shop for food, manage medication, avoid exploitation, or respond to notices.

This creates the need for disability-forward housing: housing that is affordable, accessible, inclusive, integrated into the community, and connected to the supports a person needs. (Urban Institute & The Kelsey, *People with Disabilities Living in the U.S. Face Urgent Barriers to Housing* (2022)). Individuals with disabilities should not be forced to make a false choice between institutionalization and homelessness.¹

Ensuring that disability-forward housing exists is only part of the solution. People with disabilities must also have sufficient financial resources to access and remain in that housing. Yet, public benefits intended to provide financial stability are inadequate, leaving individuals caught between the need for safe, accessible housing and the limited resources available to afford it.

¹ We may soon see the loss of choice between institutionalization and community integration. On August 31, 2026, the Department of Justice (DOJ) and the Department of Health and Human Services (HHS) joined Texas, Florida, and Alaska in filing a [proposed settlement](#) in *Texas v. Kennedy*. The states sued HHS over 2024 regulations implementing Section 504 of the Rehabilitation Act. Specifically, their challenge focused on the rule's requirement that people with disabilities be served in integrated community settings. If approved, the settlement would strike every mention of community integration from the Section 504 regulations.

Public Benefits: A Safety Net That Often Is Not Enough

Supplemental Security Income (SSI) is a means-tested program for people who are aged, blind, or disabled and who have limited income and resources. In 2026, the federal benefit rate for an individual is \$994/month, subject to reductions and possible state supplementation, and the countable resource limit for an individual is \$2,000. (Social Security Administration, *2026 Cost-of-Living Adjustment Fact Sheet*.)

For individuals who receive SSI or other Social Security benefits, the Housing Choice Voucher (HCV) Program, or “Section 8,” can theoretically bridge the gap between limited monthly income and the cost of housing. The program generally requires a participating household to contribute approximately 30% of its adjusted monthly income toward rent and utilities (their Total Tenant Payment, “TTP”), with the local Public Housing Agency (“PHA”) subsidizing the remaining eligible housing cost. (Housing Choice Voucher Program Guidebook, *Calculating Rent and Housing Assistance Payment (HAP)* (2019). Tying the tenant’s contribution to income makes housing that would otherwise be unaffordable potentially sustainable for a person whose primary or sole source of income is Social Security.

However, the principal obstacle is obtaining the voucher for the HCV program. The demand for Section 8 housing substantially exceeds the available supply. Fewer than one in four households eligible for federal rental assistance actually receive it because of funding limitations. (Sonya Acosta and Brianna Guerreo, Center on Budget and Policy Priorities, *Long Waitlists for Housing Vouchers Show Pressing Unmet Need for Assistance*,

(Oct. 6, 2021). Of the families who received the HCV, the average time they spent on the waitlist was two and a half years, and unfortunately, many households placed on waiting lists never receive a voucher at all. (*Id.*).

As of April 2026, HUD reported approximately 2.38 million HCV were leased nationwide. (U.S. Dep’t of Hous. and Urb. Dev., Office of Public and Indian Housing, *Housing Choice Voucher Dashboard*, (April 2026). Although that is an 11% increase from 2015, the cost of providing voucher assistance has risen much more rapidly. (*Id.*). HUD reports that the average per-unit cost increased from \$646.75 in 2015 to \$1,187.18 in 2026 which is an increase of about 84%. (*Id.*). Thus, although the number of households receiving voucher assistance has grown over the past decade, the cost of providing that assistance has increased substantially faster. (*Id.*).

Even receiving a voucher does not necessarily mean that an individual has secured housing. As of April 2026, HUD reported about 47,739 uncontracted vouchers, or “vouchers on the street,” meaning vouchers had been issued but had not yet resulted in a lease. (*Id.*). Thus, for an unhoused beneficiary, access to subsidized housing involves (1) obtaining a voucher through the waitlist process and (2) finding an eligible rental unit and successfully completing the PHA approval process.

This process may be particularly difficult for individuals with disabilities who are experiencing homelessness. It requires applicants to maintain contact with the PHA, receive and respond to notices, provide documentation, comply with deadlines, and navigate administrative requirement all of which are complicated by lack of consistent

mailing address, reliable transportation, or necessary support. Consequently, even when subsidized housing is financially affordable and a voucher becomes available, practical and administrative barriers may prevent the unhoused beneficiary from successfully converting that assistance into stable housing.

These statistics illustrate the disconnect between public-benefit eligibility and housing stability. A person with a disability may receive SSI and qualify for federal rental assistance, yet neither benefit guarantees access to affordable housing. SSI alone is generally insufficient to meet market-rate housing and other living expenses – it cannot cover rent, utilities, food, transportation, and other disability-related needs. Thus, there is no direct correlation between benefit eligibility and housing stability because a person can be fully eligible, receive the correct benefit, but still be unable to afford the appropriate housing and care needed.

Obtaining SSI or SSDI can also be difficult, especially for someone who does not have stable housing. Disability determinations depend on forms, medical records, examinations, and reliable communication which become significantly more difficult to complete when an individual lacks a mailing address, phone service, internet access, transportation, identification, or consistent treatment records. Records may be scattered among hospitals, clinics, shelters, and emergency departments. It is also important to recognize that individuals may not fully understand or cannot effectively describe their limitations. Certain disabilities affect insight, memory, judgment, and the ability to provide a coherent work history.

SSA guidance does provide for identifying and flagging homeless disability cases. (SSA, POMS DI 11005.004 and SI 00835.060). This alerts the agency to the claimant's circumstances and the need for appropriate case handling. Despite this guidance, homeless disability cases are undercounted because a claimant may give a friend's address that they are temporarily staying at, so the file will look ordinary. Thus, it is important for claimants and advocates to affirmatively disclose housing instability and request appropriate case handling.

The POMS defines someone as homeless or transient if they do not have a fixed, regular and adequate nighttime residence, or if they expect to lose their current accommodation within 14 days. (POMS DI 11005.004 B.) When an individual is flagged as homeless, Social Security must make a reasonable effort to identify a third party who will be contacted if the field office is unable to reach the claimant. (POMS DI 23007.010)

Maintaining benefits can be equally difficult. Social Security may suspend SSI under "whereabouts unknown" status when it cannot locate a recipient and determine continuing eligibility or the correct benefit amount. (SSA, POMS SI 02301.240). Returned mail, unreported address change, disconnected phone, or a missed review can therefore cause a serious interruption of SSI. Hence, creating a reliable mailing plan like the address of a shelter, trusted friend or family, social service agency, or general delivery at a post office that will be checked consistently, can recognize agency mail, and has the ability to respond, is essential to maintaining benefits.

Transient living arrangements can also raise SSI living-arrangement and in-kind support and maintenance (ISM) issues. Shelter provided by another person or trust may reduce SSI payment, which is more thoroughly explained in SSA, POMS SI 00835.060 which provides specific guidance for transient and homeless individuals. Some of the assistance the person receives may not count as ISM to the individual. In-kind food and shelter provided by charitable nonprofit organizations is not income when the requirements listed in SI 00830.605 are met. ISM may be determined to be of no value, such as discarded food, sleeping in an abandoned building, park or vehicle. (SI 00835.060 B.2.). The caseworker must determine all the places the individual has stayed during a month, and determine which resulted in countable ISM. For example, if the individual was living in their car, but moved in with their sister for 2 weeks during a severe cold spell, the ISM provided by the sister must be counted. If ISM is counted, the individual must be advised of their rebuttal rights. (SI 00835.320.).

Trustees should not automatically avoid shelter payments merely because they may reduce SSI. ABLE accounts may add flexibility because housing is a qualified disability expense and can be coordinated with a special needs trust and public benefits. Appointing a representative payee may also be an option so the payee can manage benefit payments and reporting without having to control every aspect of the beneficiary's life.

Because obtaining and maintaining benefits is difficult, no tool should be used in isolation. For the unhoused beneficiary, the public-benefits checklist is essential: identify the correct benefit; establish reliable communication; affirmatively disclose housing instability; document functional limitations and transient living arrangements; respond

quickly to agency notice; and analyze the real effect of shelter support. Public benefits provide essential income but do not by themselves create an accessible way of life.

Medicaid: Health Coverage and a Platform for Community Living

Medicaid is the next essential layer. A permanent conventional address is not necessarily required for Medicaid because eligibility turns on state residency; homelessness does not mean a person lacks a state of residence. In Ohio, for example, the residency rule permits self-declaration unless the state has information contradicting it. A reliable contact address is still important, but it can be a shelter, trusted person, county agency, or another location the client can regularly check.

Medicaid generally does not pay rent or mortgage. But, it may fund services that make housing possible and sustainable, including personal care, behavior-health treatment, case management, habilitation, transportation, and other home- and community-based services, depending on the program. Medicaid is not only an “insurance card” but also a potential platform for community living. The goal is to avoid the cycle of street, emergency department, hospital, shelter, and institution.

During the previous four presidential administrations, Medicaid §1115 waivers expanded to address beneficiary health-related social needs, including supported housing, nutrition supports, medical respite care and employment supports. But in 2025, the administration announced that §1115 waivers may no longer include job supports or job training (just as the new Medicaid work requirements are going into effect), and prohibited federal support for “housing first” programs. (Addressing Health-Related Social Needs

Through Medicaid Section 1115 Waivers: Challenges and Opportunities, “Health Affairs Brief, March 12, 2026).

In certain states, Medicaid §1115 waivers have financed certain services designed to address health-related social needs. For example, an individual experiencing homelessness who was hospitalized may no longer require inpatient hospitalization but may still be too medically fragile to safely recover in a shelter or on the street. Medical respite can provide a temporary setting in which an individual experiencing homelessness can recover while receiving medical and supportive services. Some states have received Medicaid §1115 authority to cover medical respite as a health-related social need. Although this is not a permanent housing solution, it can help bridge the gap between hospitalization and a safe return to the community, reducing the risk that housing instability will result in another emergency room visit.

Special Needs Planning When Housing Is Unstable

A special needs trust is a tool, not a housing plan. It cannot create an accessible unit, guarantee cooperation with a landlord, supply unavailable caregivers, or coordinate disconnected systems. When the parent of an disabled adult dies and leaves their inheritance outright to their disabled adult child, the inheritance will likely exceed their SSI’s resource limit and interrupt means-tested benefits until the money is spent down or otherwise addressed. Crisis planning may involve a first-party special needs trust, a pooled trust, spend-down strategies, etc. But even if these were established, the trustee would still need an actual housing strategy.

Our first-party special needs trust emphasize that no property belonging to the beneficiary should be added to the trust after they turn 65, once funded the trust is irrevocable, and that the distribution is based on the Trustee's sole, absolute, and uncontrolled discretion for the beneficiary's benefit. This is to ensure that the Trust does not interfere with the beneficiary's benefits. Then we advise Settlers and Trustees how to use the Trust Property for the benefit of the beneficiary. For example, the trust should not be the first payer for everything, rather, use income benefits like SSI or SSDI, use Medicaid for health coverage and services, use rental assistance or supportive-housing programs, then use the ABLE account and Trust Property to fill gaps, improve quality of life, and then whatever else those resources cannot cover. We have also encourage clients to write a letter of intent to the acting Trustees to preserve their knowledge about their routines, communications, health needs, triggers, preferences, providers, and benefits for their disabled adult child. This coordinates the Settlor of the trust and potential Trustees who will be managing the disabled adult's Trust Property. Notably, this first-party special needs trust contains a Medicaid payback provision. Consequently, at the death of the beneficiary, if there are any assets remaining in the trust, Medicaid is the first to be reimbursed because the trust was funded with the beneficiary's own assets.

Alternatively, another important planning tool is a wholly discretionary trust, commonly referred to as a third-party special needs trust. This type of trust is generally established and funded by the parent, grandparent or other family member of the disabled beneficiary. It is solely funded with assets that never belonged to the beneficiary either upon the death of the Settlor or during the life of the beneficiary. The critical aspect of this

trust is the control the Trustee has over the distributions to the beneficiary. The trustee has the sole, absolute discretion in all the distributions made from the Trust to the beneficiary. Because the beneficiary cannot revoke or terminate the trust, compel distributions, or otherwise direct the use of the trust assets, the trust is not treated as a countable resource for the purposes of Medicaid and thus preserves the beneficiary's eligibility for needs-based benefits.

Often times, family members want to leave assets to a disabled family member, but directing the assets outright to the disabled beneficiary may be detrimental to their eligibility for needs-based benefits. So instead of leaving assets outright to the beneficiary, family members can direct assets to the beneficiary's wholly discretionary trust. Accordingly, this type of planning can preserve a source of supplemental support without family members jeopardizing the beneficiary's eligibility for needs-based benefits.

Unlike the first-party special needs trusts, properly drafted third-party special needs trusts are not subject to the Medicaid payback provision because the trust was never funded with the beneficiary's own assets. Thus, there is more flexibility for the Settlor to direct the remaining assets to other family members or charities.

For the unhoused beneficiary, the practical value of a third-party trust is it gives the Trustee the flexibility to respond to needs that public-benefit programs may not adequately address. However, the Trustee must be cautious in making distributions related to certain things like shelter because the distribution may be treated as "income" for SSI purposes, therefore risking the reduction or termination the beneficiary's SSI benefits.

With any trust, the biggest challenge may be to maintain contact with the beneficiary if the beneficiary is not in a secure living situation. The Trustee may need to develop a relationship with a local agency who serves the homeless. These agencies often keep rosters of individuals with information about where they are sheltering and their most recent contact with the individual.

What Works: Housing First, Supportive Housing, and Coordinated Teams

In 2022, The U.S. Interagency Council on Homelessness (USICH) created a national strategic plan to prevent and end homelessness, titled “All In.” The plan emphasized the necessity of “Housing First” approaches to improve stability for those experiencing housing instability. Housing First treats stable housing as the platform for addressing medical, behavioral-health, and substance-use needs – not a reward earned only after those issues are resolved. Permanent supportive housing combines long-term housing with individualized services. Housing First increases time in stable housing, and the intensive case management provided improves housing outcomes. (Munthe-Kaas et al., *Effectiveness of Interventions to Reduce Homelessness* (2018)). One systematic review found that high-intensity case management roughly halved the number of people remaining homeless after 12 to 18 months compared to usual services.

The Housing First model reduces repeated and costly emergency-department visits, hospitalizations, crisis interventions, police contacts, shelter stays, and institutional placements. Those systems respond to the immediate event but do not necessarily change the condition producing the next event.

Thus, stable housing changes the sequence. It produces a permanent address improving agency communication, consistent medication storage and management, improved sleep, consistent meals, and provider access and coordination. Consequently, with the stability and consistency of housing, the beneficiary can meet deadlines, attend appointments, and maintain a routine.

However, the support in housing must match the person's needs because a lease without adequate services may simply delay another housing failure and put the beneficiary back into the homelessness cycle. This reiterates disability-forward housing – housing should be affordable, accessible, inclusive, integrated into the community, and connected to necessary supportive services.

Thus, multidisciplinary practice is essential. Lawyers address rights, trusts, benefits and agency advocacy; housing professionals locate and sustain placements; social workers and care managers coordinate services; providers document needs; fiduciaries manage funds. A law practice that incorporates social-work expertise can ensure that the legal solution and social-service solution can occur at the same time. It allows the attorney to address the trust, Medicaid, SSI, estate plan, guardianship while the social worker/care coordinator can identify housing resources, communicate with providers, help organize applications, and coordinate transportation all under the same company.

No professional can do all of this alone. A coordinated team turns separate fragments into a plan that further prevents the beneficiary from reentering the homelessness cycle.

Practical Approach for Attorneys and Trustees

1. Planning.

Planning begins before the beneficiary's caregivers death. Set up their estate plan and discuss SNT, third-party trusts, pooled trust for their disabled adult child; needs, routines, and preferences are documented in a letter of intent; successor supports are identified; trust, housing, benefits and services are coordinated.

But if it is too late...

2. Ask about housing.

"Where are you staying right now, and how stable is that arrangement?"

3. Protect access to benefits.

Ensure agencies have reliable contact information and properly identify homelessness/housing instability. Verify current benefit and verify that the individual is enrolled in the important programs that serve their needs

4. Make housing part of the special needs plan.

Do not wait until the beneficiary loses a caregiver or residence.

5. Coordinate resources rather than viewing programs in isolation.

Combine public benefits, Medicaid services, housing programs, trust/ABLE funds, and community supports.

6. Build a multidisciplinary team.

Attorneys, trustees, social workers, care coordinators, housing advocates, benefits specialists, health providers, and family/support networks each play a role.

Closing

Homelessness is often followed by the loss of a caregiver, an unprotected inheritance, inadequate income, scarce appropriate housing, missed agency communication, and absent succession planning.

We professionals can prevent this by communicating the benefits and importance of a special needs trust, early program applications, preserving agency communication, coordinated services, and successor support team.

The unhoused beneficiary reminds us that a benefit is not a security, a trust is not a plan, and an address is not a home. Stable housing is often the foundation that allows benefits, health care, services, and autonomy to function.

The goal is broader than preserving eligibility, it's coordinating income, health coverage, housing, services, advocacy, and human support so the beneficiary can live safely and with dignity. We can prevent the homelessness cycle for disabled beneficiaries through advocacy and multidisciplinary practice.