Non-SSI/SSDI Qualifying Disabilities

When Too Disabled for Full-Time Work, Not Disabled Enough for SSI

Jordan's Story

Jordan Mitchell, 29, sustained a traumatic brain injury in a car accident five years ago at age 24. The details are vivid still: Jordan driving home from work on a Tuesday evening in November, a pickup truck running a red light at 50 mph, the impact on the driver's side door, the sound of metal crumpling, then nothing. Jordan woke up three days later in the ICU at Providence Portland Medical Center with a breathing tube, confused about where the lost days had gone, not yet understanding how much had changed permanently.

The TBI damaged executive function, the brain's frontal lobe capacity to plan, organize, manage complex tasks, and maintain attention across extended periods. Before the injury, Jordan had worked as a retail manager at a sporting goods store, handling complex inventory systems, supervising eight employees, managing scheduling conflicts, troubleshooting customer complaints, processing returns and exchanges, training new hires. The job required rapid decision-making when customer situations escalated, multitasking across competing priorities when sales floor needed help while supplier deliveries arrived while the district manager called about quarterly numbers.

After the injury, those tasks became impossible. Not difficult. Impossible. Jordan tried returning to work after three months of medical leave. The district manager was supportive, offered gradual return accommodations, reduced hours initially while rebuilding capacity. The first day back, Jordan was assigned to stock shelves, a simple task before the injury. But now the multi-step process—find the right product in the back room, check the inventory system, bring items to the correct aisle, arrange them on shelves according to planogram specifications, update the inventory count—kept getting lost mid-sequence. Jordan would forget which product needed stocking while walking to the back room. The inventory system screen was incomprehensible, numbers and codes that made no sense despite years of familiarity. The planogram showing where items belonged on shelves might as well have been written in another language.

By hour three of the shift, Jordan was crying in the employee break room, overwhelmed by tasks that used to be automatic. The occupational therapist had warned about this: executive function deficits mean familiar tasks require conscious effort, and conscious effort creates cognitive fatigue that accumulates rapidly. By week two of attempted work return, it was clear the retail manager position wasn't recoverable. The district manager was kind about it. Said the door was open if Jordan's condition improved. Both of them knew it wouldn't.

The neurologist explained what the brain scans showed: diffuse axonal injury, damage to the white matter connections enabling different brain regions to communicate. Executive function doesn't live in one location. It's a network distributed across frontal lobes, connecting to memory centers, attention systems, and motor planning regions. When the network gets damaged through shearing

forces during the accident's impact, you don't lose all function but you lose coordination between systems. You can still think but you can't organize thinking into action. You can remember what needs doing but can't sequence the steps. You can start tasks but can't maintain focus to completion. The neurologist showed Jordan the scans, pointing to areas where white matter density was reduced, explaining that these were the communication highways that no longer transmitted signals efficiently.

Jordan can work 15-20 hours weekly at jobs with clear routines and minimal decision-making. Stock shelves at a grocery store during slow morning hours when there's no rush and no customer questions. Clean rooms at a hotel following standardized procedures that never change. Sort mail at a distribution center where everything has a defined category and procedure. These jobs work because they're routine, predictable, and don't require sustained executive function. The hotel job has been Jordan's primary employment for three years now: 20 hours weekly, four 5-hour shifts, Tuesday through Friday mornings, cleaning vacant rooms according to a checklist the supervisor provides.

But Jordan can't work 40 hours weekly at these jobs. The cognitive fatigue accumulates. By hour 20 each week, concentration fails, mistakes increase, simple tasks become overwhelming. Push to 25 hours and the fatigue carries into the next day. Push to 30 hours and it takes a week to recover baseline function. The occupational therapist documented this pattern. The neuropsychologist tested it. Jordan's work capacity plateaus at 15-20 hours weekly, approximately 70 hours monthly when accounting for weeks with only three shifts due to holidays or illness.

The Medicaid work requirement is 80 hours monthly. Jordan works approximately 70 hours monthly at maximum sustainable capacity. The 10-hour gap between capacity and requirement creates a coverage problem. Jordan tried to find supplemental employment to fill the gap. Applied at three other hotels, two grocery stores, a warehouse. Most wanted 20-hour minimum commitments. One hotel offered 8 hours weekly but the shifts were Friday evenings, when Jordan's cognitive fatigue from the week's work makes even simple tasks difficult. Volunteer coordinator positions might accept 10 hours monthly but typically require 3-4 hour blocks weekly. Jordan's capacity works in 5-hour increments with rest between. Four hours in a single block produces overwhelming fatigue. The schedule that works is 5 hours daily, four days weekly. The employment market doesn't offer 10-hour monthly positions structured that way.

Jordan applied for SSI disability benefits two years ago. The application process took eight months from initial filing to denial decision. The process was exhaustive: multiple medical provider forms, neurologist reports with brain imaging interpretation, neuropsychological testing battery taking seven hours across two appointments, functional capacity evaluation at a physical therapy clinic, detailed work history documentation, activities of daily living questionnaire, pain and symptom diary, pharmacy records showing all medications tried.

The neurology reports confirmed TBI sequelae with executive function deficits documented on brain imaging. The neuropsychological testing showed processing speed in the 15th percentile compared to age-matched norms, working memory in the 20th percentile, executive function composite score indicating moderate impairment. The report stated: "Patient demonstrates significant deficits in executive function domains including planning, organization, task initiation, and sustained attention. These deficits would substantially impair ability to perform complex

occupational tasks or sustain full-time employment in positions requiring independent decision-making or multi-tasking."

The functional capacity evaluation concluded: "Patient can perform simple repetitive tasks for up to 5 hours daily with frequent breaks. Cognitive fatigue limits sustained work capacity to approximately 20 hours weekly. Patient cannot reliably perform tasks requiring rapid problem-solving, multi-step planning, or management of competing priorities. Work capacity is limited but not eliminated. Recommend simple, structured employment with reduced hours and supportive supervision."

The SSI application was denied. The denial letter explained that while Jordan has functional limitations, the limitations don't meet SSI's disability standard. SSI requires inability to engage in substantial gainful activity, currently defined as earning more than $1,470 monthly. Jordan can work part-time, earn approximately $900 monthly at $12 per hour for 75 hours, and maintain employment with appropriate job accommodations. This partial work capacity disqualifies Jordan from SSI despite the fact that partial capacity creates significant employment limitations.

The letter stated: "Evidence shows you are capable of performing simple, routine, repetitive work for up to 20 hours weekly with appropriate accommodations. This capacity exceeds the threshold for substantial gainful activity when calculated on a part-time basis. While your executive function impairments limit complex work, they do not prevent all work activity. Therefore, you are not disabled within the meaning of the Social Security Act."

Jordan appealed. The reconsideration took another five months. An administrative law judge reviewed the case. The judge's decision acknowledged Jordan's limitations but agreed with the initial determination: "While the claimant has genuine cognitive deficits limiting work capacity, he retains the residual functional capacity for simple work at reduced hours. The medical evidence does not establish inability to engage in any substantial gainful activity. The claim is denied."

Jordan now faced Medicaid work requirements designed assuming full work capacity. The requirement was 80 hours monthly. Jordan could achieve 70 hours. The state's medical exemption application asked whether the applicant was unable to work due to medical conditions. Jordan wasn't unable to work. Jordan was working 20 hours weekly. But not 21 hours weekly. The distinction between "unable to work" and "unable to work 80 hours monthly" wasn't captured by the exemption application.

Jordan called the Medicaid case manager. The case manager was sympathetic but clear: medical exemptions are for people who can't work at all. The state had reviewed Jordan's SSI denial. If SSI said Jordan could engage in substantial gainful activity, the state wasn't going to override that determination and approve a medical exemption. SSI had spent eight months reviewing Jordan's medical evidence. The state trusted that determination.

The case manager suggested volunteering to make up the 10-hour gap. Jordan explained the cognitive fatigue pattern, the inability to work more than 20 hours weekly sustainably. The case manager suggested trying harder, maybe pushing through the fatigue, giving the body time to adjust to higher hours. Jordan didn't know how to explain that this wasn't fatigue like being tired after a long day. This was neurological fatigue, brain exhaustion from damaged neural networks working overtime to accomplish tasks that used to be automatic.

Jordan's coverage terminated in October for failure to meet the 80-hour monthly requirement. The termination notice arrived by mail with instructions for appeal. Jordan appealed, submitting the same neuropsychological testing and functional capacity evaluation reports that SSI had reviewed. The appeal was denied in November. The denial letter referenced the SSI determination: the Social Security Administration had found Jordan capable of working. Meeting work requirements through actual employment was the expectation.

Three months without coverage, Jordan ran out of the medications managing TBI symptoms. The neurologist had prescribed medications for headaches, mood stability, and sleep regulation—all common TBI sequelae. The medications cost $380 monthly without insurance. Jordan had been managing on $900 monthly income, sending $400 to rent at a group house, spending $200 on food, $50 on phone service, $100 on bus passes for work commute, leaving $150 for everything else. The medications didn't fit.

Jordan stopped the headache medication first, trying to manage with over-the-counter alternatives that didn't work as well. Then the mood stabilizer, reasoning that feeling more depressed was better than not having coverage at all. Then the sleep medication, accepting that four hours of broken sleep nightly was now normal.

Without the medications, functioning deteriorated. The headaches that had been controlled returned, sometimes bad enough that Jordan would stand at the hotel linen cart trying to remember which room needed which towels while vision blurred at the edges. The mood dysregulation that the stabilizer had managed came back, depression and irritability cycling unpredictably. The sleep deprivation compounded everything, making the cognitive fatigue worse, the executive function deficits more pronounced.

In January, Jordan made a mistake at work. Cleaned a room marked "Do Not Enter" that a guest was still occupying, just stepped out briefly. The guest complained. The supervisor was understanding the first time. Jordan made another mistake in February, forgot to restock supplies in three rooms because the multi-step process of checking inventory, gathering supplies, and delivering them to correct rooms fell apart midway. The supervisor gave a warning. The hotel couldn't accommodate mistakes that affected guest satisfaction. March brought another error: cleaned the same room twice while leaving two other rooms uncleaned because the tracking sheet got confused in Jordan's exhausted brain.

The supervisor let Jordan go in early April. Said it wasn't working out. Recommended Jordan look for work with even simpler responsibilities, maybe dishwashing where mistakes didn't affect customers directly. Said to use the supervisor as a reference if Jordan found something appropriate.

Jordan lost the apartment in the group house in May. The $400 rent was manageable with employment income. Without it, impossible. Jordan moved to a shelter, then to a friend's couch, then to another friend's floor. The instability made job searching harder. How do you list a stable address on applications when you don't have one? How do you get to interviews when you're sleeping in a different place each week?

Jordan sits now in the Medicaid office appealing the second coverage termination, bringing the same medical records SSI denied two years ago. The appeals examiner asks why Jordan believes

inability to work 80 hours monthly warrants medical exemption when SSI determined Jordan could engage in substantial gainful activity. Jordan tries to explain: working 70 hours monthly, the cognitive fatigue preventing more hours, the employment market not offering 10-hour positions that fit the schedule constraints, the deterioration when pushing beyond sustainable capacity. The examiner sympathizes but explains that medical exemptions are for people who cannot work, not people who work but not enough hours to meet requirements.

The appeal is denied. Jordan's situation hasn't changed: still has executive function deficits from TBI, still capable of 15-20 hours weekly work, still experiences cognitive fatigue at 70 monthly hours, still denied SSI for partial capacity, now also denied Medicaid despite medical documentation confirming genuine functional limitations.

Jordan isn't exceptional among people with partial work capacity. The experience reflects structural patterns affecting 900,000 to 1.5 million expansion adults who fall into the disability gap: too disabled for full-time work, not disabled enough for SSI. The question isn't whether Jordan should work. Jordan was working at maximum sustainable capacity before coverage loss triggered medication discontinuation triggering job loss triggering housing loss. The question is whether work requirements should accommodate functional limitations that prevent meeting 80 monthly hours but don't qualify for SSI, or whether they should apply uniform requirements that systematically exclude people with partial but real disabilities.

Demographics and Scope

Functional limitations significant enough to limit work capacity but insufficient to qualify for SSI/SSDI represent 900,000 to 1.5 million expansion adults, approximately 5-8% of those subject to work requirements. These individuals occupy the disability gap between full work capacity and SSI-qualifying complete work inability.

SSI denial rates reveal the scale of partial capacity populations. Approximately 62% of SSI/SSDI applications are denied at initial application, with 84% denied at reconsideration. Many denials occur because applicants have partial work capacity that SSI's substantial gainful activity standard doesn't accommodate. Substantial gainful activity in 2025 is defined as earning $1,470 monthly or approximately 100 hours at federal minimum wage. Individuals who can work 40-60 hours monthly at minimum wage jobs earn $580-870 monthly, clearly below substantial gainful activity thresholds, yet don't qualify for SSI because they retain partial work capacity.

The partial capacity population includes diverse conditions. Traumatic brain injuries with executive function deficits affect approximately 150,000 expansion adults, creating cognitive limitations that reduce work capacity without eliminating it. Learning disabilities affecting processing speed and workplace functioning affect approximately 200,000. Chronic pain conditions including fibromyalgia, chronic fatigue syndrome, and back pain without objective imaging findings affect approximately 300,000, limiting sustained physical activity without eliminating all work capacity. Mental health conditions like anxiety and depression not severe enough for SMI classification but significantly impairing workplace performance affect approximately 250,000. Post-injury recovery with incomplete functional restoration affects approximately 100,000 as people regain substantial function but not complete capacity.

Cognitive impairments without intellectual disability create work limitations that SSI often doesn't recognize. Traumatic brain injuries, strokes with partial recovery, and learning disabilities not meeting intellectual disability criteria all create cognitive limitations affecting work capacity without eliminating it. These individuals can work but need simplified tasks, structured environments, reduced hours, and ongoing support. Their cognitive functioning isn't normal but doesn't meet SSI thresholds requiring inability to work.

Chronic pain without objective measures creates particular challenges for disability determination. Back pain, fibromyalgia, and chronic fatigue syndrome create real functional limitations that don't show on imaging or testing. SSI denies many chronic pain applications because medical evidence shows no objective impairment correlating with reported pain levels. MRI scans show normal spine structure. Blood tests show no inflammatory markers. Physical examinations reveal no observable dysfunction. Yet pain limits work capacity regardless of whether imaging confirms severity.

The disconnect between subjective pain experience and objective testing creates credibility challenges in disability determination. Someone reporting pain level 8 out of 10 daily, unable to sit for more than an hour without standing to relieve pressure, unable to stand for more than 30 minutes without needing to sit, experiences real work limitations. But when all tests come back normal, SSI questions whether the limitations are as severe as reported. Individuals can work part-time managing pain through positioning, frequent breaks, and pain medication, but cannot sustain full-time hours when pain accumulates over shifts.

Mental health conditions below SSI severity thresholds affect substantial populations. Anxiety disorders, moderate depression, PTSD not meeting severe criteria, and other mental health conditions create workplace limitations without eliminating all work capacity. Individuals can work reduced hours in low-stress environments but cannot handle full-time hours or high-stress positions. SSI requires marked limitations in multiple functional areas. Moderate limitations in some areas don't qualify.

Multiple moderate conditions create cumulative limitations that SSI evaluates condition-by-condition rather than assessing combined impact. Diabetes requiring careful management plus arthritis limiting physical stamina plus anxiety affecting concentration creates combined limitations preventing full-time work even though no single condition qualifies for SSI. The cumulative burden across multiple conditions produces functional limitations that SSI's single-condition evaluation framework doesn't capture.

Age intersecting with conditions creates a specific gap population. Adults approaching 60 with multiple chronic conditions experience work capacity limitations that will qualify for age exemption at 60 but don't qualify for disability exemption at 57. SSI rules recognize that age affects work capacity through different standards applying over age 55, but Medicaid work requirements often don't accommodate age-related capacity decline before age exemption thresholds. Three years in this gap creates coverage vulnerability for people with real but not SSI-qualifying limitations.

Workplace accommodations enable partial work for many in this population. Flexible schedules, reduced hours, simplified tasks, supportive supervision, and assistive technology all help people with limitations maintain employment. But accommodations enable partial work, not full-time employment. The Americans with Disabilities Act requires reasonable accommodations but doesn't require employers to create part-time positions or reduce job requirements below

essential functions. Individuals can find part-time work with accommodations but cannot reach 80 monthly hours when their capacity plateaus at 60 or 70 hours.

Failure Modes: When Partial Capacity Creates Systematic Exclusion

The interaction between SSI's all-or-nothing disability determination, work requirements' uniform hour thresholds, and employment market realities creates systematic exclusion for populations with partial work capacity. These failures aren't individual employment inadequacies. They're structural mismatches between policy assumptions and partial disability realities.

The SSI denial creating verification impossibility manifests because SSI denial becomes evidence against medical exemption. When someone applies for SSI claiming inability to work 80 hours monthly, undergoes extensive medical evaluation, and receives denial determining they can engage in substantial gainful activity, that denial undermines later claims that medical conditions prevent meeting 80-hour requirements. State Medicaid systems reasonably question why someone denied SSI disability benefits should receive Medicaid medical exemptions. The SSI denial letter specifically states the applicant can work, creating documentation that contradicts exemption claims.

But SSI denial doesn't mean full work capacity. It means capacity exceeding $1,470 monthly earnings or approximately 100 hours at minimum wage. Someone capable of 60 hours monthly gets the same denial as someone capable of 100 hours. The binary determination collapses diverse partial capacities into a single "not disabled" category, erasing functional distinctions between people who can almost meet requirements and people who can fully meet them.

The capacity-requirement mismatch creates uniform non-compliance despite varying effort levels. Work requirements typically specify 80 hours monthly. Individuals with partial capacity might sustainably work 40, 50, 60, or 70 hours monthly depending on condition severity. The gap between capacity and requirement varies but creates uniform non-compliance. Someone working 70 hours monthly terminates coverage the same as someone working 40 hours monthly. The verification system measures compliance against requirements, not effort against capacity.

This mismatch penalizes partial capacity the same as no capacity. Someone with TBI working maximum sustainable 70 hours monthly experiences the same coverage termination as someone choosing not to work at all. The system can't distinguish between won't work and can't work enough because verification measures binary compliance, not functional capacity or maximum effort.

The employment market inability to provide gap hours creates practical impossibility. When someone can work 70 of 80 required hours, finding 10 more hours seems simple logically but proves impossible practically. Employment markets don't operate in 10-hour monthly increments. Most positions require either 15-20 hours weekly (60-80 monthly), or full-time 40 hours weekly (160+ monthly). Few employers hire for precisely 10 hours monthly. Those that do typically need concentrated hour blocks that individuals cannot sustain due to cognitive fatigue or physical limitations.

Volunteer coordinator positions might accept 10 hours monthly but usually require 3-4 hour blocks weekly rather than fragmented 1-2 hour blocks that partial capacity populations can manage. The

Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

structural mismatch between how employment markets organize work and how partial capacity populations can sustain effort creates practical impossibility of filling small hour gaps.

The exemption documentation paradox occurs because medical exemptions traditionally require proving inability to work, but partial capacity populations can work. Documentation shows work capacity through actual employment, making exemption approval difficult. Yet capacity limitations are real and documented: neuropsychological testing shows cognitive deficits, functional capacity evaluations document hour limitations, physician statements confirm partial disability.

States face documentation interpretation challenges: does capacity for 60 hours monthly mean capacity for 80 hours with more effort, or does it mean genuine limitation at 60 hours? Without clear functional capacity assessment frameworks, states default to SSI standards: if someone didn't qualify for SSI, they don't qualify for medical exemption. This reasonable heuristic systematically excludes partial capacity populations whose limitations are real but don't meet SSI thresholds.

The reduced requirement absence creates binary choices: meet full requirements or lose coverage. Most state work requirement programs specify 80 hours monthly uniformly. Few states implement graduated requirements accommodating partial capacity. Without graduated requirements (40 hours for severe partial capacity, 60 hours for moderate limitations, 80 hours for full capacity), systems force binary compliance: meet full requirements or fail.

The absence of middle-ground requirements reflects administrative preference for simplicity over accommodation. Graduated requirements require functional capacity assessment infrastructure, standard assessment protocols, and fraud prevention measures ensuring assessments reflect actual capacity rather than claimed limitations. Building this infrastructure costs more than uniform requirements. But uniform requirements systematically exclude populations with real partial disabilities.

The vocational rehabilitation timing mismatch creates coverage gaps during service periods. Vocational rehabilitation services can help people with disabilities find appropriate employment matching their capacities. But VR involvement takes months: assessment, service plan development, job placement, follow-up support. Someone loses Medicaid coverage for non-compliance with 80-hour requirements in month one. VR services might place them in appropriate part-time employment by month six. The five-month gap without coverage undermines the employment VR is trying to facilitate.

State Policy Choices: Accommodation or Binary Compliance

The policy architecture states construct around partial work capacity reveals fundamental choices about disability recognition, graduated requirements, and whether systems should accommodate capacity between extremes or apply uniform standards designed for full capacity.

The first choice involves graduated hour requirements based on functional capacity assessment. Should states implement tiered requirements reflecting assessed capacity (40 hours for severe limitations, 60 hours for moderate limitations, 80 hours for full capacity), or should they maintain uniform 80-hour requirements regardless of capacity? Graduated requirements match expectations to capacity rather than forcing everyone to meet requirements designed for full

capacity. States refusing graduated requirements create systematic non-compliance for populations working at maximum capacity that falls short of uniform requirements.

The second choice involves functional capacity assessment protocols. Should states accept provider-based functional capacity assessments asking "how many hours monthly can this person sustainably work?" or should they rely solely on SSI determinations asking "can this person engage in substantial gainful activity?" Functional capacity assessment differs from SSI disability determination. Someone denied SSI for capacity above substantial gainful activity thresholds might have functional capacity of 60 hours monthly, below work requirements but above SSI thresholds. States refusing functional capacity assessment force binary categories that don't capture partial capacity realities.

The third choice involves vocational rehabilitation integration. Should individuals enrolled in VR services receive presumptive compliance during service periods, with VR assessment, training, and job placement hours counting toward requirements? VR coordination prevents coverage loss during months-long processes that produce employment outcomes. States refusing VR integration terminate coverage before VR can facilitate the employment work requirements supposedly promote.

The fourth choice involves workplace accommodation documentation recognition. Should individuals working with ADA accommodations receive credit for accommodation effort when reduced hours reflect documented capacity limits? Employers providing accommodations can attest that reduced hours reflect genuine functional limits rather than work availability. States refusing accommodation documentation as evidence of capacity limits treat accommodated employment as insufficient effort rather than maximum capacity.

The fifth choice involves presumptive partial exemption pending SSI appeals. Should individuals with SSI applications pending or appealing SSI denials receive presumptive hour reductions during application periods that often span 12-18 months? Presumptive accommodation prevents coverage loss during determination processes. States refusing presumptive accommodation terminate coverage while SSI evaluates whether the person can work, creating medical crisis during evaluation periods.

The fundamental tension is between administrative simplicity and capacity accommodation. Systems designed for full work capacity assume conditions that partial capacity populations violate. Binary compliance measures cannot capture effort maximization within constrained capacity. The policy question is whether states will build functional capacity assessment infrastructure and implement graduated requirements, or whether they will maintain uniform requirements and accept systematic exclusion of people working at maximum capacity that falls short of uniform thresholds.

Stakeholder Roles in Supporting Partial Capacity Populations

The structural failures in verification systems for partial capacity populations require multiple stakeholders to adapt their operations. Each occupies different positions in the ecosystem and can address different failure modes.

State Medicaid Agencies must build functional capacity assessment procedures, graduated hour requirement tracking, provider assessment acceptance protocols, and coordination with

vocational rehabilitation systems. This requires technical infrastructure tracking variable requirements by member, training eligibility workers in functional capacity concepts distinct from disability determination, and managing exemption transitions when capacity improves or declines.

Medical Providers and Specialists must develop functional capacity assessment expertise distinct from disability determination. Rather than answering "can this patient work?" providers answer "how many hours monthly can this patient sustainably work?" This requires clinical judgment about fatigue patterns, cognitive limitations, pain tolerance, and accommodation effectiveness distinct from medical diagnosis.

Vocational Rehabilitation Systems become critical assessment and support infrastructure. VR counselors have expertise in functional capacity assessment, job matching to capacity, and supported employment. States should expand VR eligibility to include partial capacity populations currently excluded because they don't meet VR disability thresholds while also not meeting SSI standards.

Disability Rights Organizations and Legal Services must provide advocacy for partial capacity populations applying for graduated requirements. These populations lack organized advocacy presence: they're not in developmental disability systems, not SSI recipients, not established disability community members. They need advocates who understand partial capacity distinctions and can articulate differences between SSI determinations and functional capacity assessments.

Employers and Workforce Development Systems should recognize partial capacity workers as valuable workforce members. Someone sustainably working 60 hours monthly provides reliable part-time labor. Workforce systems focusing exclusively on full-time placement miss partial capacity populations who need part-time positions matching their capacity rather than full-time positions they cannot sustain.

The common thread across stakeholders is creating frameworks that recognize capacity exists between extremes. Jordan's cascade, from TBI creating executive function deficits to SSI denial for partial capacity to inability to meet uniform 80-hour requirements to coverage termination to medication discontinuation to functional deterioration to job loss to housing loss, could have been interrupted at multiple points. A graduated requirement of 70 hours matching Jordan's assessed capacity. A functional capacity evaluation accepted as exemption documentation. VR services coordinated with work requirements during assessment and placement periods. The absence of any stakeholder building that accommodation infrastructure left Jordan working at maximum capacity while failing uniform requirements designed for full capacity.

Jordan's Situation as Structural Pattern

Jordan Mitchell's experience wasn't exceptional among people with partial work capacity. It was representative of structural patterns affecting hundreds of thousands. The TBI creating executive function deficits represents conditions that limit capacity without eliminating it. The neuropsychological testing documenting 70-hour monthly capacity represents objective assessment that SSI doesn't recognize as qualifying for benefits. The SSI denial based on partial capacity represents binary determinations that collapse varied capacities into single categories. The inability to find employment filling 10-hour gaps represents employment market realities that

Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

verification systems ignore. The coverage termination despite maximum effort represents systematic exclusion when requirements don't accommodate partial capacity.

The TBI didn't cause the catastrophe. Administrative rigidity did. A work requirement that couldn't recognize 70 hours of maximum effort as compliance. An SSI system that denied benefits because Jordan could work some without recognizing Jordan couldn't work enough. A medical exemption process that required proving inability to work when Jordan's documentation showed ability to work partially. A verification system measuring binary compliance rather than capacity maximization. The combination transformed manageable disability into cascading losses.

The financial calculus exposes the policy's counterproductive nature. Jordan's Medicaid coverage cost approximately $350 monthly. The three months without medications managing TBI symptoms led to functional deterioration, job loss, and housing instability. The emergency room visits, psychiatric hospitalization for mood dysregulation, and eventual need for intensive case management to re-establish housing and employment will cost approximately $45,000 over the next year. The coverage termination that was supposed to encourage work instead destroyed the employment Jordan was maintaining at maximum capacity.

The human cost exceeds financial accounting. Jordan lost not just coverage but the functional stability built over three years since the accident. The confidence that despite TBI, employment was possible. The independence of supported living. The dignity of working at capacity even when capacity was limited. The identity of being a productive worker rather than a failed disability applicant. The losses carried shame, feeling like personal failure when the system was actually designed to exclude people whose capacity falls between extremes.

The policy question is whether work requirements should apply uniform hour thresholds to populations whose defining characteristic is capacity below thresholds but above zero, or whether requirements should accommodate documented partial capacity through graduated requirements, functional capacity assessment, vocational rehabilitation integration, and accommodation documentation recognition.

The first approach maintains administrative simplicity but produces systematic exclusion of populations working at maximum capacity that doesn't reach uniform thresholds. The second approach requires investment in functional capacity infrastructure but maintains coverage for populations whose genuine limitations prevent meeting requirements designed for full capacity.

December 2026 implementation will reveal which approach states choose. The choices will manifest through outcomes: either verification systems accommodate partial capacity through graduated requirements and functional assessment, or they demand uniform compliance that partial capacity makes impossible, producing systematic exclusion of people working at maximum sustainable capacity. Jordan's situation, multiplied across 900,000 to 1.5 million partial capacity expansion adults, will demonstrate whether work requirements can accommodate disability realities between extremes or whether binary compliance measures will systematically exclude people in the gap between "can't work at all" and "can work full-time."

References

1. Social Security Administration. "Annual Statistical Report on the Social Security Disability Insurance Program, 2024."

Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

2. O'Neil and Bowman Disability Group. "Chances of Winning Social Security Appeals: 2024 Statistics." March 2025.
3. Urban Institute. "The SSA Says It's Reduced the Disability Claims Backlog." September 2025.
4. Atticus. "Social Security Disability Approval Rates by State." May 2024.
5. USAFacts. "What is the Approval Rate for Social Security Disability Benefits?" December 2023.
6. Disability Secrets. "Survey Statistics: Who Is Most Likely to Get Approved for Social Security Disability Benefits?" April 2023.
7. Social Security Administration. "Outcome Variation in the Social Security Disability Insurance Program." Social Security Bulletin Vol. 73, No. 2.
8. Social Security Administration. "Supplemental Security Income Program Description and Legislative History: Annual Statistical Supplement, 2024."
9. Brain Injury Association of America. "Traumatic Brain Injury and Employment." 2024.
10. National Institute of Neurological Disorders and Stroke. "Traumatic Brain Injury Information." 2024.
11. American Chronic Pain Association. "Chronic Pain and Work: Managing Employment with Pain Conditions." 2023.
12. Anxiety & Depression Association of America. "Anxiety, Depression, and Workplace Function." 2024.
13. Association of University Centers on Disabilities. "Supported Employment for People with Disabilities." 2024.
14. Council of State Governments. "Vocational Rehabilitation and Work Requirements Coordination." 2023.
15. National Disability Rights Network. "The Gap Between SSI Standards and Work Capacity." 2024.
16. American Association on Health and Disability. "Partial Work Capacity Assessment Guidelines." 2023.
17. U.S. Equal Employment Opportunity Commission. "The ADA: Your Responsibilities as an Employer." 2024.
18. Institute for Healthcare Improvement. "Functional Capacity Evaluation in Primary Care." 2023.
19. National Council on Disability. "Accommodating Partial Work Capacity in Benefits Programs." 2024.
20. Commonwealth Fund. "International Models for Partial Disability Recognition: Lessons from the UK and Australia." 2023.

Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*