I
Community Pediatrics: Welfare Reform and the Health of Women and Children

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This is the first of two didactic sessions on recent welfare policy changes in the United States and their relevance for the health of poor women and children.

History of Welfare in the US: I

- 1935: Social Security Act -- Aid to Dependent Children, like Mother's Pensions, promoted concept that maternal employment negatively affected child development and that 'deserving' women belonged in the home.
- 1962: Aid to *Families* with Dependent Children - goals were to strengthen family life and foster self-sufficiency.
- 1967: expanding welfare rolls and rising numbers of unwed mothers receiving aid led to 'welfare crisis'.

Abramovitz, M. Regulating the Lives of Women, South End Press, 1988.

"The Depression of the 1930s made federal action a necessity, as neither the states and the local communities nor private charities had the financial resources to cope with the growing need among the American people. Beginning in 1932, the federal government first made loans, then grants, available to states to pay for direct relief and work relief. After that, special federal emergency relief and public works programs were started. In 1935, President Franklin D. Roosevelt proposed to Congress economic security legislation embodying the recommendations of a specially created Committee on Economic Security. Passage of the Social Security Act, occurred on August 14, 1935. The law established other federal grants enabling states to extend and strengthen maternal and child health and welfare services. This became the Aid to Dependent Children (ADC) program, which was replaced in 1996 with a new block grant program known as Temporary Assistance for Needy Families (TANF)."

(http://www.usd.edu/elderlaw/socialsecurity.htm)

"In 1962, President John F. Kennedy signed The Public Welfare Amendments. Aid to Dependent Children was renamed Aid to Families with Dependent Children (AFDC). This federal law required states to provide assistance to all families who applied and met the eligibility criteria established by state and national policy."

(http://www.agi-usa.org/pubs/ib_welfare_reform.html)

From 1961 to 1967 the welfare rolls grew from just over 3.5 million recipients to almost 5 million. The family caseload jumped 50%, reaching 1.3 million. The sense of crisis also existed because the program cost increased from $994 million in 1960 to $2.2 billion in 1967. Enrollment no longer rose and fell with the state of the economy. Demographic and political forces accounted for much of the welfare explosion. Population growth, rising divorce and illegitimacy rates, a demographic excess of women relative to men and other such trends contributed to increased demand for assistance.

History of Welfare in the US: II

- 1987-1995: Most states had received waivers
- 1996: PRWORA passed (P.L. 104-193)
  - AFDC ⇒ TANF
  - Entitlement ⇒ block grants with time limits
  - Devolution to states
  - Separation from Medicaid, food stamps
  - Emphasis on work
  - Family life obligations
- 1997: Creation of CHIP

Beginning of "welfare reform": 1980s cutbacks, 1987+ waivers

(General Components of Welfare Reform Law)

The Aid to Families with Dependent Children program became Temporary Assistance to Needy Families". It shifted from a Federal entitlement program to a state block grants system with Federal restrictions, such as the 5-year lifetime limit, and working within 2 years or less in order to continue receiving cash assistance. Other changes included the introduction of sanctions associated with noncompliance with "Family Life Obligations" (eg, immunizations and pediatric health care, child school attendance, teen residency/school attendance, fertility [family cap and planning], paternity ID/child support). Requirements were explicitly enumerated in "Individual Responsibility Agreements" (IRAs), that TANF recipients had to stop.

In 1997, the state Children's Health Insurance Program (CHIP)represented $20.3 billion to states over 5 years to expand health insurance for children up to 19 years. It took the form of Medicaid expansions, separate CHIP plans, or a combination of the two. Enrollment has been inadequate, particularly in light of declining Medicaid enrollment.

1996 Welfare Reform: Congress' Findings

"The Congress makes the following findings:

1. Marriage is the foundation of a successful society.
2. Marriage is an essential institution of a successful society which promotes the interests of children.
3. Promotion of responsible fatherhood and motherhood is integral to successful child rearing and the well-being of children."

Personal Responsibility and Work Opportunity Reconciliation Act, Pub L No. 104-193 (1996).

These three "findings" were made by Congress in the Preamble to the PRWORA. (Personal Responsibility and Work Opportunity Reconciliation Act).

1996 Welfare Reform: Purpose

"Increase the flexibility of states in operating a program designed to:

1. Provide assistance to needy families so that children could be cared for in their own homes or in the homes of relatives
2. End dependence of needy parents on government benefits by promoting job preparation, work, and marriage"

Personal Responsibility and Work Opportunity Reconciliation Act, Pub L No. 104-193 (1996).

The preamble to the PRWORA stipulated four purposes of the legislation.

1996 Welfare Reform: Purpose

"Increase the flexibility of states in operating a program designed to:

3. Prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals toward these goals
4. Encourage the formation and maintenance of two-parent families"

Personal Responsibility and Work Opportunity Reconciliation Act, Pub L No. 104-193 (1996).

TANF Policies and "Family Life Obligations"

- Workfare
- Immunizations
- Other health visits (pediatric, family planning)
- School attendance
- Child exclusion/family cap
- Paternity identification
- Child support enforcement
- Teen residency requirements
- Drug screens
- Noncitizens, including legal residents

Teen requirements:

Teen requirements include adult-supervised residence and school attendance.

Drug screens:

Many states require compliance with drug treatment programs; and many others currently have proposed legislation to require drug screens of TANF applicants.

Noncitizens:

TANF regulations concerning immigrants are rather complex, with categories for legal noncitizens being either "qualified" (in US on 8/22/96) or "unqualified" depending on whether they are legal permanent residents, refugees, asylees, granted stays, etc. "Qualified" immigrants face new restrictions on benefits, while "unqualified" immigrants largely lose benefits altogether. A third category, "undocumented" (ie, not legal), are also considered in the law. These categories are used to determine, among other things, Medicaid eligibility. It has been projected that by the year 2002, 600,000 legal immigrants will be barred from Medicaid coverage.

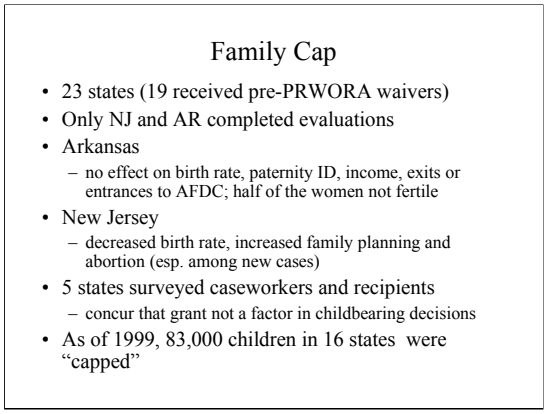
Drug felons:

Most states (35) consider persons with prior drug felony convictions ineligible for TANF. Many of these restrictions are specific to drug trafficking.

Health Insurance

- Medicaid drop (Families USA, AGI, Kaiser)
  - 21% in women of reproductive age between 1994-1998 (R. Gold. AGI report, 12/99)
  - 30.7% (10,093) of the US population was uninsured in 2001 (US Census, Annual Demographic Survey, 2001)
- CHIP enrollment slow and low
  - By 1999, only 2 million had been enrolled in the past year and
  - 11 million children remained uninsured
  - Currently, CHIP covers 3.5 million children (Kaiser Commission, December 2001) in addition to the 22 million covered by Medicaid.

Various sources have reported the chronological relationship between welfare reform, declines in Medicaid, and increase in uninsurance. Policies deterring TANF enrollment may contribute to these changes.



No proposed change in the welfare law better illustrated the intent to use welfare reform as a vehicle to change behavior and influence individuals' childbearing decisions than the family cap--a provision that would deny increased cash payments to a woman who conceives and bears another child while she is on welfare. At least 23 states have adopted family cap policies.

(From: The Alan Guttmacher Institute: Welfare Reform, Marriage and Sexual Behavior. Available at http://www.agi-usa.org/pubs/ib_welfare_reform.html)

Arkansas reported that the family cap had no effect on birth rates or on other outcome indicators, such as paternity identification, income, exits and entrances to AFDC. The investigators found that approximately half of the women were not even fertile, either because of previous sterilization or postmenopausal status (e.g. grandmothers caring for children).

The New Jersey analysis revealed a significant decrease in birth rates, especially for those newly joining AFDC, and an increase in both family planning utilization and abortion rates, again, especially for new welfare cases. In their five year evaluation study, the Rutgers University researchers also found that the family cap shaped New Jersey women's decisions on family planning. They estimated that between 1993 and 1996 there were about 14,000 fewer births, almost 1,500 more abortions, and roughly 7,000 more family planning visits in this population of low-income women (Camasso et al. 1999).

An additional five of the first fourteen states to implement family cap waivers surveyed AFDC caseworkers and recipients about their attitudes regarding the family cap. In Arizona, Delaware, and Indiana, many caseworkers reported doubts that the cap would influence fertility as they did not believe recipients' childbearing decisions had ever been motivated by the prospect of a grant increase. Client surveys in Arkansas confirmed this, as more than 90% said that the AFDC grant was not a factor in their decision about childbearing. The majority of NJ respondents reported that financial insecurity was a reason to avoid pregnancy, but did not see the loss of a grant increment in this light.

According to the Center for Law and Social Policy, as of 2/99 approximately 83,000 children had been born into family-capped households.

Illegitimacy Bonus

Illegitimacy Bonus Winners: 1999, 2000 and 2001						
1999			2000		2001	
Rank	State	% change out-of-wedlock births	State	% change out-of-wedlock births	State	% change out-of-wedlock births
1	CA	-5.7	DC	-4.1	DC	-3.98
2	DC	-3.7	AZ	-1.4	AL	-0.25
3	MI	-3.4	MI	-1.3	MI	-0.009
4	AL	-2.0	AL	-0.3	--	
5	MA	-1.5	IL	-0.02	--	

Data for 1999 represent the % change in out-of-wedlock births from 1994-95 to 1996-97; 2000, % change from 1995-96 to 1997-98; 2001, % change from 1996-97 to 1998-99. National Center for Health Statistics. State Rankings, 1999, 2000, and 2001.

The "illegitimacy bonus" provides a bonus of $20 million to states in which the out-of-wedlock birth rates show the greatest decline, without an increase in abortion rates. It derives from the sentiments expressed in the preamble to the PRWORA and was included in the law, although it does not solely pertain to the TANF population.

In 1999 and 2000, $20 million bonuses were awarded to the top five states, although the great majority of states experienced increases in out-of-wedlock births ranging from 0.4% to 10% in 1999 and 0.06% to 9.84 % in 2000. Most recently, the bonus winner for 2001 were announced and only two states (Alabama and Michigan) and the District of Columbia had declines (albeit miniscule) in their out-of-wedlock birth rates (0.25%, 0.009% and 3.98% respectively); each state received an augmented bonus of $25 million. The remaining 48 states had *increases* ranging from 0.725% (NY) to 8.4% (Vermont).

The ratio of out-of-wedlock to marital births could change for a variety of reasons that neither reflect the desired behavioral change nor any policy-related intervention on the part of the state. As Dye and Presser (1999) explain, potential extraneous variables affecting the out-of-wedlock birth ratio include changes in the numbers of nonmarital births to state residents, changes in the number of all births, or changes in the age structure of the population. Moreover, abortion reporting and assessment of marital status from birth certificates are known to be very imprecise. Forty-five states actually showed an increase in their out-of-wedlock birth rates. The abortion statistics that were used to ensure that bonus recipients did not have an increase in abortions were not included with the birth rates.

II
WIC, Medicaid, Welfare: Understanding Government Assistance in NYC

Developed by:
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This talk is part of a series of Community Pediatrics presentations focusing on social services for poor children and their families. The premise is that good medicine is not practiced in a vacuum. In order to be an effective pediatrician, one needs to understand the cultural and environmental context in which patients live. This includes considering cultural background, home and community environment, educational opportunities, and economic realities – all with the goal of improving the overall health of children on an individual, community, state, and national level.

Conditions of TANF:NYC

- Lifetime limit of 60 months
- Work Activities requirement
  - Education
  - ESL
  - Job search
  - Work (non-subsidized or Work Experience Program)
- Must comply with Child Support Services
- School attendance requirement

The welfare, or TANF, program in NYC stipulates that recipients must begin work activities within 1 month of receiving benefits. Recipients must also comply with several child support requirements, including the following:

-Provide documentation as to who the father is;
-Be a witness at paternity hearings

-Provide information as to the whereabouts of the father or attest to lack of knowledge under penalty of perjury.

A recipient's children must comply with the school requirement that there be no more than four unexcused absences per academic quarter for students in grades 1 through 6.

Work Requirement Exemption

- Caring for a child younger than 12 months
  - No more than 12 months of a caretakers life may be exempted for child care
  - No more than 3 months for any one child
    - Social service official may extend to 12 months
- Not job ready
- Fleeing domestic violence
- Ill or incapacitated person or person caring for an ill or incapacitated person.

This is by no means an exhaustive list. Other exemptions include dependants less than 16 years old and dependants who are greater than 19 years and in school. Unmarried teens are required to go back to school

NYC's Version: "NYC WAY"

- March 1998: converts welfare offices into "Job Centers"
- Core components:
  - Work experience program (WEP)
  - Eligibility verification review
  - Finger printing
  - Substance abuse program
  - SSI
  - Intensive case control

"In March 1998, HRA began converting welfare offices in New York City into Job Centers. This bold re-organization of NYC's welfare system emphasizes "work first." Applicants are assisted in exploring and pursuing alternatives to welfare. Those who do not find employment, and do receive welfare, participate in the Work Experience Program (WEP) to help them achieve self-sufficiency.

-WEP: One of the most important components of NYC WAY is a structured work assignment for each participant who can work. NYC operates the largest work experience program in the nation. --Eligibility Verification Review (EVR): EVR conducts individual assessments of every applicant and recipient's eligibility for public assistance. Key components are an office interview, a home visit and a data match to compare information against the data warehouse to determine identity, resources and income.
-Finger Imaging: to incorporates an automated finger imaging process into the NYC WAY program design confirm client identity and prevent fraud. All applicants, as well as those already receiving benefits, must comply with the state regulation requiring them to be finger imaged.

-Substance Abuse: All participants found to have a substance abuse problem are required to attend treatment. In addition, all substance abusers are required to work as a part of treatment after a brief stabilization period. During this time, the participant is tracked for compliance. Also, substance abuse providers will be monitored during the treatment phase and evaluated on their ability to move their participants to self-sufficiency.

-SSI Cases: Cases appropriate for Supplemental Security Income (SSI) or Disability and identified substance abusers are tracked through two specialized HRA units. These units ensure that participants have filed appropriate documents and attended interviews for SSI and Disability Benefits, and where appropriate, tracks enrollment and progress in treatment programs.

-Case Managment: A case manager is responsible for overseeing all aspects of an individual case and ensuring that participants move through required activities in compliance with program standards and regulations. HRA is implementing a system to better assist individuals in moving from welfare to work by providing more case management services."

(Human Resources Administration, NYC Government, available at : http://www.nyc.gov/html/hra/html/serv_welfarework.html)

*Can be cut off for 3-6 months if thought to be non-compliant with NYC WAY.

Who Qualifies for Family Assistance?

- Income of <185% of federal poverty level
- $2,138 per month for a family of 3

  = $25,666 per year

"The Census Bureau uses a set of money income thresholds that vary by family size and composition to determine who is poor. If the family's total income is less than the family's threshold, then that family, and every individual in it, is poor." (U.S. Census Bureau 2000)

Gross income test: Example for a family of 3, the 2000 poverty threshold level is approximately 13,874 dollars, in a family made up of one parent and two children. (13,861 for two parents and one child) Therefore, to qualify for family assistance, they have to make less than $25,666 per year or $2,138 per month.

Food stamps are not counted as income, but a portion of subsidized housing is counted as income. The minimum monthly TANF benefit is $10.

Food Stamps

- Average monthly allotment
  - $73 per person
- Uses
  - Food or food products
  - Seeds or food-producing plants
- Exemptions
  - Alcohol and tobacco
  - Food to be eaten in the store
  - Vitamins and medicines
  - Pet foods
  - Any non-food items

"The Food Stamp Program is designed to enable people with limited income to increase their purchasing power through the use of Food Stamps. Food Stamp credit is used in place of cash to purchase food items at participating grocery stores and supermarkets. The Program is federally funded under the U.S. Department of Agriculture. New York City authorizes over $850 million dollars a year in food stamp benefits. There are currently over 800,000 New Yorkers receiving food stamps in New York City (as of February, 2002)."
(Human Resources Administration, NYC GOV. Available at: http://www.nyc.gov/html/hra/html/serv_foodstamps.html)

-This program was started during the Depression era. People who do not receive public assistance can still qualify for Food Stamps. Recipients can get coupons or electronic benefits with a plastic card that can be used like money to help buy food. Restaurants can accept food stamps for homeless, elderly or the disabled.

"Participation in the Food Stamp Program in New York State is alarmingly low. Less than one-third of emergency food recipient households in New York are receiving Food Stamp Program benefits. These low numbers partially reflect immigrants dropped from the program several years ago during the wave of safety-net reform. (Members of Congress are currently trying to restore eligibility to legal immigrants.) However, many welfare recipients assume that their eligibility for Food Stamps ends when they stop receiving welfare benefits." Food bank for NYC.

(Available at: http://www.foodbanknyc.org/index.cfm/bay/content.view/pcat/179/catid/200.htm)

Food Stamps

- Who is eligible?
  - U.S citizens
  - Many child and elderly legal immigrants
  - ≤130% federal poverty limit

How is each household's Food Stamps allotment determined?

It is based on the Thrifty Food Plan (TFP), a low-cost model diet plan. The TFP is based on the National Academy of Science's Recommended Dietary Allowances, and on food choices of low-income households. An individual household's food stamp allotment is equal to the maximum allotment for that household's size, less 30% of the household's net income. Able-bodied adults must meet certain work requirements.

Who is eligible?

Currently, in NYC, there is a 16-page application for Food Stamps. Food Stamps cover households at up to 130% of the federal poverty level (FPL) for gross income and 100% FPL for net income ($1,533/month for a family of three). Children and elderly legal immigrants can still qualify. All household members must have a social security number or apply for one.

Information regarding other Emergency Food Programs that are available to anyone in need of food can be obtained at **1-(800) 486-4792 or (212) 533-6100.**

WIC

- Federal grants to states to provide
  - Supplemental foods
  - Health care referrals
  - Nutrition education
- Works through vouchers for use in stores

1. Get essential foods: milk, eggs,cheese, etc.
2. Formula Allotment: The equivalent of 403 fluid ounces per month: about 12 cans of concentrated formula.

"WIC is a federally funded, special supplemental food program for **W**omen, **I**nfants and **C**hildren, that offers nutritious foods, nutrition education and counseling, and referrals to health care and other social service agencies for low-income women, infants and children. WIC services are free for eligible women and children, and applicants may call the site nearest their home for an appointment.

Supplemental foods: Nutritionists counsel families to determine ideal food packages and provide information on the value and use of WIC foods. Food packages may vary depending on whether the women are pregnant, breastfeeding, or bottle-feeding, and on the age of the child. The packages may include formula, cereals, juice, eggs, peanut butter, or milk.

Health care referrals: WIC provides referrals to health and social services, such as prenatal care, well-child care, substance abuse treatment, and family planning, as well as Medicaid, TANF and Food Stamps.

Nutrition education: At least two nutrition education sessions are offered for each certification period by a nutritionist, and individualized nutrition care plans are designed for high-risk participants. Other education programs include smoking cessation; counseling for pregnant women; breastfeeding support; infant and child immunization screening; voter registration; and Farmers' Market coupons (at select sites) valued at $20.00 to purchase fresh fruits and vegetables. "

(Medical and Health Research Association of NYC. Available at: http://www.mhra.org/wic.htm#background)

WIC

- Eligibility
  - Low-income (≤180% FPL)
    - Pregnant women
    - Postpartum women
    - Infants and children to age 5 years "found to be at nutritional risk"
  - Automatic eligibility with Medicaid
  - Illegal immigrants can get WIC

"To be eligible for the WIC Program, applicants must satisfy categorical, income and nutritional risk* criteria.

Categorical: A **woman** is eligible for WIC if she is pregnant **or** breastfeeding for 1 year **or** has a child under 6 months of age. A **child** is eligible for WIC if he or she is under 5 years old.

Income: The participant's gross income must be no greater than 185% of the federal poverty level. Women and children who participate in Medicaid, PCAP, Food Stamps or other public assistance are automatically income eligible. Participants who live in a household where a pregnant woman or infant receives Medicaid you are automatically income eligible.

Nutritional risk: This is determined by the WIC nutritionist and is based on medical information provided by a health care provider and/or a dietary assessment done at the WIC site. Risk conditions include anemia, any patterns of poor diet, low birth weight, a history of difficult or problem pregnancies, failure to thrive as an infant or child, and a medical condition that can be improved with a good diet."

(Medical and Health research Association of NYC. Available at:http://www.mhra.org/wic.htm#background)

**Nutritional Risk* refers to conditions that predispose persons to inadequate nutritional patterns, including but not limited to homelessness, migrancy.

Other NYC Assistance Programs *

- Safety Net Assistance
- Emergency Assistance to Families
- Home Energy Assistance Program
- Child Care Subsidies
- Housing Services
- Refugee and Immigration Services
- Discount Telephone Service

*Limited eligibility

A. Safety Net Assistance- for single adults, childless couples, children living apart from any adult relative, families of persons abusing drugs or alcohol, families of persons refusing drug/alcohol screening, assessment or treatment, persons who have exceeded the 60-month limit on assistance, aliens who are eligible for public assistance but who are not eligible for federal reimbursement. Individuals can receive Safety Net Assistance in cash for a maximum of two years in a lifetime. After that, if eligibility continues, it will be provided in non-cash form. Unless mentally or physically unable, Safety Net recipients must engage in work activities.

B. Emergency Assistance to Families(EAF): is a non-recoupable grant for aid, care, and services issued to families with children. Its purpose is to help with emergency situations threatening the family and to meet urgent needs resulting from a sudden event or set of circumstances demanding immediate attention. Even people who make or have too much money to receive regular public assistance may still be eligible for these three programs, if they can show that without the money, they and their family will become homeless or that the stability of their family will be seriously threatened.

C. Home Energy Assistance Program (HEAP) -Provides grants for low-income individuals or families to help pay heating bills, or to provide funds for residential weatherization and other energy-related home repairs. Is available to renters and homeowners to meet emergency and non-emergency needs. Benefits targeted especially to households containing elderly, disabled or children under 8 years of age. Between $40 - $350/yr. ($315 on average). Call: 212-442-HEAP

D. Housing Services: The New York Housing Authority is no longer accepting Section 8 applications "EXCEPT" from victims of domestic violence, homeless,and intimidated witnesses. All other Section 8 applications received will be discarded. (Available at: http://www.nyc.gov/html/nycha/html/section8.html)

E. Refugee and Immigration Services- to help documented refugees obtain services.

F. The telephone company's LifeLine Program allows for basic dial-tone service for a nominal fee ($1/month) and installation for as little as $10. There is automatic eligibility if enrolled in HEAP, SSI, PA (public assistance), receives veteran's disability, Medicaid or Food Stamps. Outgoing calls are 10.6 cents each.

Available at: www.dfa.state.ny.us/otda_mission.htm

Child Care

- Transitional Child Care
  - Partial reimbursement of child care costs for up to one year.
- Low Cost Child Care:
  - Group or family day care available through another NYC agency. The cost is based on income and family size.

The Human Resources Administration pays for child care for eligible public assistance families and eligible families who have left public assistance for employment. Parents are eligible if they are: in an approved work-related activity, such as work experience, job search, training/education, or substance abuse treatment; employed and their public assistance case is still open; employed and their case is closed within one year, and they meet income and other eligibility criteria for Transitional Child Care (TCC), and children are under 13 years of age or under 19 if they are disabled or have special needs.

(Medical and Health research Association of NYC. Available at: http://www.nyc.gov/html/hra/html/serv_childcare.html)

Parents can get Transitional Child Care from HRA for up to one year after case is closed if they are working and not on public assistance,or if they were getting public assistance for at least 3 of the 6 months before the case was closed. Also, if their children are younger than 13 years, or if children between the ages of 13-19 are unable to care for themselves (in which case they need a letter from the doctor).

Income eligibility, for example, for a family of three must be less than $2,387.00/month.

Subsidized (low-cost child care) through the Agency for Child Development (ACD)

Fee depends on income and family size. To apply, parents should call ADC or pick up an application at an ADC borough office. When the parent calls they are scheduled for an interview and told what documents to bring. If the person is eligible and a vacancy exists a reservation is made immediately. If there is no vacancy, they are placed on waiting lists for up to 3 sites.

To pick a child-care provider, parents can call the NYC Child Care Resource & Referral Consortium at 1-(888) 469-5999 (the counselors speak several languages).

SSI

Background:

- Supplemental Security Income
- Enacted 1972 to care for elderly or disabled Americans with limited resources
- 1997 - 965,000 people receiving SSI

Eligibility:

- Low-income people > 65 years of age
- Low-income people who are blind or disabled (includes children)
- Does not include most immigrants
- Asset limitations

SSI is Supplemental Security Income. It was enacted in 1972 to care for elderly or disabled Americans with limited resources. Thus, children with certain medical conditions are eligible for SSI. It is a monthly added income to help supplement other family resources.

In 1997, there were 965,000 people in the US receiving SSI. With the change in the definition of disability in children under the welfare reform act of 1996, approximately 135,000 children are estimated to loose their SSI benefits.

Children receive $512 in federal funds and a NYS supplement per month if they are eligible for the full SSI benefit.

Eligibility is based on age, disability status and income. Low-income elderly (>65 years of age), or people with blindness or other disability are eligible.

For children, income eligibility is based on percent of the FPL and how many workers there are in the family. For a family of three with 2 workers in the family, a child will receive the full benefit up to 140% FPL; between 140% and 185% FPL the family will receive a reduced amount. For a family of three with one worker in the family, a child will receive full benefit up to 120% FPL, or receive a reduced amount between 120% and 160% FPL.

In addition, an applicant must be either an American citizen, or in a specific category of documented immigrant.

There are income and asset limitations that are factored into the income calculator. A person can not have more than $2000 in assets per person, and $3000 per married couple. The cost of a home and usually a car can be excluded from the asset calculator.

SSI

Definition of Disability in Children

- Changed under welfare reform of 1996
- Must have a medically-proven physical and/or mental condition resulting in marked and severe functional limitations
- Must be expected to last >12 months or result in death

The definition of disability in children, which was previously the same as adults, changed under the welfare reform act of 1996. The new definition of disability in children is as follows: A child is considered disabled if he/she has a medically-proven physical and/or mental condition resulting in marked and severe functional limitations that are expected to last more than 12 months, or result in death.

SSI

How Do Parents Get SSI?

- Social Security office has specific guidelines
- Paperwork sent to the Disabilities Determination Service for decision
- Must bring information about child's medical and day-to-day care to the appointment

How do parents get SSI for their children?

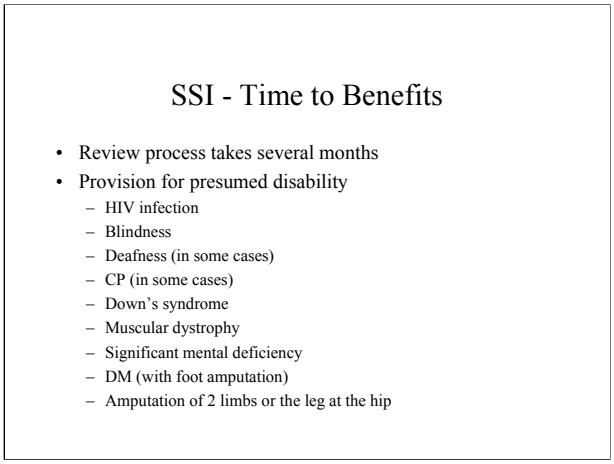
The Social Security Office has very specific guidelines-- a list of signs, symptoms or lab lab findings for over100 physical and mental problems. If the child's problem is not specifically one of the listed diseases, their signs and symptoms are matched to the ones specified and assessment is done in this fashion.

The paperwork is sent to the Disabilities Determination Service for a decision. Each case is reviewed by a disabilities evaluation specialist and a physician. If they feel that there is not enough data to make a decision, they may ask that the child be taken for a special evaluation appointment, which is paid for by the Social Security Office.

The parent must bring information about the child's medical and day-to-day care to the application appointment (as much information as is available concerning the child's physicians, other health professionals, teachers, counselors, therapists and social workers). The evaluation is a comprehensive one.

For information on SSI, call the Social Security national hotline at 1-800-772-1213 (M-F 7am-7pm).

The Washington Heights NYC Social Security Office number is 212-923-2570.



The review process for SSI benefits can be up to 4 months, and the parents are supposed to be told this at the initial application appointment. There are certain illnesses that are considered presumed disabilities, and therefore SSI payments begin immediately(listed in slide). This is something pediatricians should be aware of as advocates for their patients.

Under present law, a child is disabled if he or she has a medically determinable physical or mental impairment causing "marked" and "severe" functional limitations. There are slightly different standards for children under the age of 3, but for children between the ages of 3 and 18, five areas of function are evaluated:

1. Cognition/Communication
2. Motor
3. Social
4. Personal
5. Concentration, Persistence, or Pace

In order to be "disabled" a child must have an extreme limitation in one area of functioning or a marked limitation in two areas of functioning.

What is an extreme limitation? An extreme limitation when standardized tests are used as a measure of functional abilities, is a valid score that is three standard deviations or more below the norm for the test. When no standardized tests are used as a measure of functional abilities, an extreme limitation is one where there is no meaningful functioning in any given area.

What is a marked limitation? A marked limitation when standardized tests are used as a measure of functional abilities, is a valid score that is two standard deviations or more below the norm for the test. A marked limitation is more than moderate and less than extreme. A marked limitation is one which interferes seriously with a child's functioning.

Continuing Disability Review

- Reviewing disability
  - If improvement is expected -- case review q6-18 months
  - If improvement is possible but not predicted -- case review q3 years
  - If improvement is not expected -- case review q5 - 7 years
- Must present evidence of compliance with medical treatment

SSI benefit review is dependent on the child's condition.

If the child has a condition that is expected to improve, there is a case review every 6-18 months. If improvement is uncertain, review is every 3 years. And if no improvement is anticipated, review is every 5-7 years. The payee (typically the parent) is expected to present evidence that the child is receiving treatment considered medically necessary for the child's condition; and if the parent can not, the benefit may be taken away and assigned to another payee.

Major Developments Since 1996

- Biggest drop in welfare rolls since inception
- Racial disparity in those leaving the rolls
- Varied employment and income experiences
- Drop in Medicaid, Food Stamps, WIC
- Increased lack of health insurance
- Increased reports of hunger and homelessness
- Privatization of services
- Widespread lack of child care

Welfare rolls have dropped almost 60% nationwide since 1996. There is racial disparity among those leaving and remaining on welfare. Between 1995-96 and 1998-99, the number of Hispanic families on TANF nationwide dropped by almost 300,000, a decline of 31.5%. However, in comparison, during the same period, the number of White and Black families declined by 50.6% and 39.6%, respectively*. Employment (mentioned in previous slides): issues around types of jobs obtained, which typically have low wages and lack benefits.

Medicaid (and Food Stamps): Although Medicaid enrollment grew on average 11.3% per year between 1990 and 1992, enrollment growth slowed to 5.3% between 1992 and 1995. This has resulted in absolute reductions in Medicaid enrollment to date. In NYS, between January 1995 and 1998, there was a 26% decline, and it is estimated that 4.5 million children who are eligible for Medicaid are not enrolled. Federal investigation of NYC found in 1999 that welfare offices had illegally denied Medicaid and Food Stamps. In some cases, people were told that they couldn't get food stamps or Medicaid unless they qualified for public assistance, a clear lie. (Available from Community Service Society of New York at : http://www.cssny.org/reports/urbanagenda/urban-agenda38.htm)

Hunger and Homelessness: A 2001report from the *US Conference of Mayors* found a 23% increase in requests for emergency food assistance. According to the NYC Coalition Against Hunger, requests for emergency food in New York City grew by 28% from January 1999 to January 2000. The emergency food providers are unable to keep up with demand. More than 47,000 people were turned away without assistance in NYC in January 2000 alone, and almost half were children.

*Rodriguez E, Kirk K. Welfare Reform, TANF Caseload Changes, and Latinos: A Preminary Assessment: National Council of La Raza; 2000.

Finding Common Ground: Overall Conclusions

- Dramatic declines in benefit programs; mixed findings regarding income, job retention, poverty status
- Limited evaluations of behavior-related TANF policies
- State health personnel largely uninvolved in welfare policies and report welfare policymakers not focused on health
- Association between uninsurance and state TANF policies
- Association between maternal health problems and ability to work, and child chronic illness and mothers' ability to work
- Need more health-related data to contribute usefully to post-welfare reform programs

Some of the increase in uninsurance has been related to state TANF policies. The implications for women's and children's health should not be ignored, particularly as time limits continue to advance. It is our view that concerted collaboration is necessary among health-careproviders and human service agencies, so that the economic and employment needs of families are not achieved at the expense of the health and well-being of these same poor women and children.