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## Immigration and Social Services

Contributing agencies in order of presentation:

Introduction prepared by:  
U.S. Immigration and Naturalization Service  
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From data furnished by:  
U.S. Bureau of the Census  
Population Division

U.S. Department of Health and Human Services  
Office of the Secretary  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

Social Security Administration  
Office of Policy  
6401 Security Boulevard  
Baltimore, Maryland 21235

U.S. Department of Agriculture  
Food and Consumer Service  
3101 Park Center Drive  
Alexandria, Virginia 22302

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## Introduction

The impact of immigration on social services in the United States is commonly discussed in fiscal terms: What proportion of the cost of social programs can be attributed to the participation of immigrants in those programs? Most of the Federal social programs that serve immigrants are administered by the Department of Health and Human Services (DHHS), the Social Security Administration (SSA), and the U.S. Department of Agriculture (USDA). They include programs that serve a broad range of U.S. citizens and lawful permanent residents, such as Medicaid, Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), and food stamps; and programs aimed at special populations, such as recently arrived refugees and migrant farmworkers. The program descriptions in this chapter were contributed by the departments responsible for them. Particular emphasis is given to the changes in the program eligibility of non-citizens that were enacted in the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, commonly known as *welfare reform*.

Many social programs are designed to provide income support for needy persons or to alleviate poverty in other ways. In all but a few instances, programs that provide direct benefits to individuals or households have eligibility criteria that disqualify persons who are not legally present in the United States. Programs that determine eligibility on an individual basis often collect data on the country of birth and/or the immigration status of applicants and are able to report on their participation and the cost of benefits paid to them. Other programs provide a more general range of services and do not maintain records on the immigration status of persons who benefit.

In 1999 the U.S. Census Bureau published a report on the characteristics of the resident foreign-born population as shown in the March 1997 Current Population Survey (CPS).<sup>1</sup> The report includes information on the money income, wages, poverty status, and means-tested program participation of foreign-born individuals and of households headed by foreign-born persons. That information is summarized here to provide a context for the program information that follows. The reference year for the income-related information is 1996, since the questions refer to the most recent calendar year at the time of the survey. The reader should keep in mind that the CPS and the decennial census locate and count some people who are present in the United States without legal authorization, as well as some long-term alien residents such as students and executives of multinational corporations. Because of this, the surveyed population reflects extremes of wealth and poverty to a greater extent than a survey limited to lawful permanent residents would.

This introduction concludes with information on Federally sponsored research that is under way to measure the effects of welfare reform on immigrant use of social programs.

## Income and Earnings

Money income<sup>2</sup> is lower among foreign-born households than among native households.<sup>3</sup> In 1996 the median income for foreign-born households was \$30,000 compared with \$36,100 for native households. Among foreign-born households, the median income ranged from \$33,100 when the householder's length of residence in the United States was 20 years or more to \$25,900 for householders whose length of residence was less than 10 years. The average size of foreign-born households in 1997 was 3.32 persons, and these households averaged 1.6 wage earners. Native households had an average size of 2.56 persons with 1.39 wage earners. The lower proportion of earners among members of foreign-born households reflects the higher proportion of household members under age 18 in the foreign-born households.

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<sup>1</sup> Schmidley, A. Dianne and Campbell Gibson, U.S. Census Bureau, Current Population Reports, Series P23-195, *Profile of the Foreign-Born Population in the United States: 1997*. U.S. Government Printing Office, Washington, DC, 1999. The detailed tabulations on which this report was based are available from the U.S. Census Bureau as PPL-115.

<sup>2</sup> The income data does not include the value of non-cash benefits such as food stamps, medicare, medicaid, and other types of non-cash benefits.

<sup>3</sup> Households are classified as native or foreign-born according to the nativity of the householder. Nearly one-third of the members of foreign-born households were born in the United States.

Full-time, year-round workers who are foreign-born had median earnings in 1996 of \$25,000 for males and \$20,800 for females, compared to \$33,200 and \$24,100, respectively, for native male and female workers. As with household income, earnings were highest for workers who had resided in the United States for the longest period of time. The median earnings of workers who resided for 20 years or more was \$35,200 for males and \$24,200 for females, compared to \$19,900 for males and \$16,800 for females with less than 10 years in the United States.

## Poverty Status

The poverty<sup>4</sup> rate is higher among the foreign-born population than among the native population. In 1996 the poverty rate was 21.0 percent for the foreign-born population and 12.9 percent for the native population. Despite this contrast, the patterns of poverty within each group by characteristics such as gender, age, and family type are similar. Among the foreign-born population, the poverty rate ranged from 11 percent for those who had lived in the United States for 20 years and over to 29 percent for those who had lived in the United States for less than 10 years.

Poverty rates are high for children living in families with foreign-born householders, regardless of whether the children are foreign-born or native-born. For the children in these families who were foreign-born, the poverty rate in 1996 was 39 percent, and for the children who were native-born, it was 30 percent. Native children accounted for nearly three-fourths of the related children under 18 years old living below the poverty level in families with foreign-born householders. Poverty rates would be lower under an alternative definition of income that includes the value of means-tested non-cash benefits, but the contrast between foreign-born and native-born persons would remain.

## Means-Tested Program Participation

The participation rate in means-tested programs<sup>5</sup> is higher among foreign-born households than among native households. In 1996 (just before the provisions of the PRWORA took effect), 24 percent of households with foreign-born householders participated in one or more means-tested programs providing noncash benefits, compared to 17 percent of native households. For participation in one or more of the means-tested programs providing cash benefits, the corresponding figures were 10.6 percent for foreign-born households and 7.5 percent for native households. (Nearly all of the households receiving cash benefits were also receiving non-cash benefits.) Among foreign-born households, participation rates in 1996 were higher when the householder was a noncitizen (29 percent) than when the householder was a naturalized citizen (18 percent). This finding is important in that PRWORA imposed new restrictions on access to benefits by noncitizens.

## Research on the Impact of Welfare Reform on Immigrants

Several efforts are under way to measure the effects of the significant policy changes in immigrant eligibility on families and on Federal programs. Some preliminary evidence is already available. Data from the CPS show that between 1994 and 1997, use of public benefits among noncitizens fell more sharply (35 percent) than among citizens (14 percent). Noncitizens accounted for 23 percent of the overall decline in welfare caseloads that occurred between 1994 and 1997, even though they were only 9 percent of the households receiving welfare in 1994.<sup>6</sup> Parallel results were found in an analysis of Los Angeles

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<sup>4</sup> The poverty definition used by the Federal government for statistical purposes is based on a set of money income thresholds that vary by family size and composition and do not take into account non-cash benefits or taxes.

<sup>5</sup> Means-tested programs are those that require the income and/or assets of an individual or family to be below specified thresholds in order to qualify for benefits. These programs provide cash and non-cash assistance to portions of the low-income population. The non-cash programs included here are food stamps, housing assistance, and Medicaid. The cash programs included here are Aid to Families with Dependent Children, General Assistance, and Supplemental Security Income.

<sup>6</sup> Michael Fix and Jeffrey Passel, Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform: 1994-97, The Urban Institute, Washington, DC, March 1999.

County data on Medicaid and TANF applications. Applications in these two programs declined 71 percent among noncitizens although there was no such decline among citizens.

These declines in noncitizen participation occurred prior to full implementation of the PRWORA eligibility changes. It has been suggested that these findings indicate the presence of a “chilling effect” on noncitizen participation independent of the actual implementation of new eligibility restrictions based on immigration status. Much confusion and perhaps erroneous information appears to exist in immigrant communities and among local service providers about who is eligible and for what benefits. Immigrants also have been fearful that individuals who apply for and receive benefits may suffer adverse immigration consequences related to the application by the INS of the “public charge” doctrine. Recent guidance by the INS on “public charge” issues and policies<sup>7</sup> should help to clarify for immigrant families and benefit providers what are or are not the consequences related to receipt of different benefits.

The findings cited above were part of a Federal Government-financed project by the Urban Institute to examine the impact of PRWORA on immigrants, their families and communities (see the more detailed description below). Additional data and analyses from this and other DHHS-funded studies about the effects of PRWORA on immigrants and DHHS programs will become available in the near future.

The Office of the Assistant Secretary for Planning and Evaluation (DHHS)—together with the Administration for Children and Families (DHHS), the Health Care Financing Administration (DHHS), the Department of Agriculture (Economic Research Service and Food and Nutrition Service), and the Immigration and Naturalization Service—has sponsored a study by the Urban Institute to gather information on the health and economic status of immigrants, their families, and their communities. The study took place in New York City and Los Angeles. It consists of several parts: (1) 1,650 household interviews in each city, with in-depth follow-up interviews of 150 households in each city; (2) interviews with community organizations (both governmental and non-governmental); and (3) analyses of data on immigrants from several existing data sets both at the national level (e.g., the CPS, the National Health Interview Survey, etc.) and using local administrative data for the focal cities. Data collection was completed in the summer of 2000. The study will include a profile of immigrants and their communities that can be compared to citizens. The analysis will identify trends and indicators of well-being for immigrants and communities. A final report is expected in 2001, with some interim analyses available sooner. Earlier findings from this study on the utilization of benefits by citizens and immigrants have already been mentioned. More information about the project and copies of the earlier reports in their entirety can be found at the Urban Institute’s web site (<http://www.urban.org>).

## **New Immigrant Eligibility Laws that Impact HHS Programs**

The Department of Health and Human Services (HHS) administers a wide range of health and social service programs for families and individuals residing within the United States. During the period covered by this report [fiscal years (FYs) 1995-1997] major new welfare reform legislation was passed under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193, hereinafter referred to as “PRWORA”). Enacted on August 22, 1996, PRWORA substantially changed the laws governing immigrant<sup>8</sup> eligibility for many HHS-administered services and assistance programs.

The new law makes the rules on immigrant eligibility for major cash, medical, and other safety net assistance programs considerably more complex. For example, a needy immigrant’s eligibility for benefits under major HHS programs -- Temporary Assistance for Needy Families (TANF), Medicaid, and the State

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<sup>7</sup> The INS published in the *Federal Register* a notice of proposed rulemaking (NPRM) on May 26, 1999, clarifying the various issues regarding benefit use and “public charge” determinations. The INS also published in the same *Federal Register* a memo to field personnel implementing immediately the “public charge” policy put forth in the NPRM.

<sup>8</sup> In this section, the term “immigrant” is used as a synonym for “alien,” not as “immigrant” is defined in the Immigration and Nationality Act, unless the context indicates otherwise.

Children’s Health Insurance Program (SCHIP—which began in FY 1998) -- now depends not only on the type of visa held by the individual (e.g., legal permanent resident, refugee, asylee, parolee, etc.), but also the date by which the immigrant entered the country (before or after PRWORA’s date of enactment), and individual State and/or local policy choices regarding immigrant eligibility for these programs.

Most “qualified aliens”<sup>9</sup> arriving on or after August 22, 1996 are banned from receiving “Federal means-tested public benefits” during their first 5 years in the United States.<sup>10</sup> On August 26, 1997, HHS published a notice in the Federal Register interpreting the term “Federal means-tested public benefit” and concluding that among HHS programs, Medicaid (except for emergency services) and TANF benefits meet the definition. Subsequently the State Children’s Health Insurance Program (SCHIP) was created by Congress, and it became a third “Federal means-tested benefit” program administered by HHS.

Although there is a mandatory 5-year ban on assistance under TANF, Medicaid, and SCHIP for non-expected immigrants entering after PRWORA enactment, States were required to provide coverage to qualified aliens who were already receiving such assistance as of August 22, 1996. States were required to cover these qualified aliens until January 1, 1997. After that time, States have had the flexibility to determine whether or not to provide TANF, Medicaid, or SSBG assistance to non-expected legal immigrants who meet the criteria of qualified aliens.<sup>11</sup>

However, as a result of PRWORA, “non-qualified” aliens -- primarily undocumented aliens and non-immigrants (including students and tourists) but also certain lawful immigrants with temporary statuses -- are not eligible for most “Federal public benefits,” and the law requires agencies providing such benefits to implement procedures that verify the citizenship and immigration status of all applicants. Nonprofit entities that provide Federal public benefits are exempt from the verification requirement. On August 4, 1998, HHS published a notice in the Federal Register interpreting the term “Federal public benefit.”<sup>12</sup> The notice listed the 31 HHS programs that deliver Federal public benefits and are required to verify the citizenship and immigration status of applicants in order to avoid providing benefits to non-qualified aliens.

Immigration status-based eligibility is a new requirement for many of these programs. For programs such as the Child Care and Development Fund, the Low Income Home Energy Assistance Program (LIHEAP), SSBG, and the disability programs, program administrators and direct service providers (unless they are nonprofits) must now implement new procedures for verifying citizenship and immigration status in compliance with INS regulations, incurring new administrative costs in the process. HHS is currently reviewing the public comments on this notice.

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<sup>9</sup> “Qualified aliens” include: legal permanent residents; asylees; refugees; aliens paroled into the United States for at least 1 year; aliens whose deportations are being withheld; aliens granted conditional entry (prior to April 1, 1980); battered alien spouses, battered alien children, the alien parents of battered children, and alien children of battered parents who fit certain criteria; and Cuban/Haitian entrants (Section 431 of PRWORA, as amended).

<sup>10</sup> Exceptions to this 5-year ban are made for refugees, asylees, aliens whose deportation is being withheld, Amerasians, Cuban/Haitian entrants, veterans, and members of the military on active duty, their spouses and unmarried dependent children.

<sup>11</sup> At this time, Wyoming is the only State that has chosen to make most qualified aliens ineligible for TANF and Medicaid assistance.

<sup>12</sup> The HHS programs which provide “Federal Public Benefits” according to the August 4, 1998 interpretation are: Adoption Assistance, Administration on Developmental Disabilities (ADD) – State Developmental Disabilities, Councils (direct services only), ADD – Special Projects (direct services only), ADD – University Affiliated Programs (clinical disability assessment services only), Adult Programs/Payment to Territories, Agency for Health Care Policy and Research Dissertation Grants, Child Care and Development Fund, Clinical Training Grant for Faculty Development in Alcohol & Drug Abuse, Foster Care, Health Profession Education and Training Assistance, Independent Living Program, Job Opportunities for Low Income Individuals (JOLI), Low Income Home Energy Assistance Program (LIHEAP), Medicare, Medicaid (except assistance for an emergency medical condition), Mental Health Clinical Training Grants, Native Hawaiian Loan Program, Refugee Cash Assistance, Refugee Medical Assistance, Refugee Preventive Health Services Program, Refugee Social Services Formula and Discretionary Program, Refugee Targeted Assistance Formula and Discretionary Program, Refugee Unaccompanied Minors Program, Refugee Voluntary Agency Matching Grant Program, Repatriation Program, Residential Energy Assistance Challenge Option (REACH), Social Services Block Grant (SSBG), State Child Health Insurance Program (SCHIP), and Temporary Assistance for Needy Families (TANF).

There remains, however, a substantial number of HHS programs that do not condition receipt of services on an individual's citizenship or immigration status. Because the chilling effects of recent policy changes may extend beyond the programs directly affected, it is possible that immigrant participation in other HHS programs may also have declined. However, data that would allow determination of the indirect effect of PRWORA on these HHS-administered programs are not ordinarily collected. For example, community health centers provide preventive and primary health care to persons in need of such services. These centers serve medically underserved and disadvantaged populations that often include immigrants. These centers play a significant role in ensuring the health of immigrant communities, as well as maintaining the overall public health. However, because receipt of center services has never been based on an individual's citizenship or immigration status, the centers do not collect information on the immigration status of the people they serve. Similarly, many other HHS programs which do not base eligibility on citizenship or immigration status do not collect such data from participants or recipients.

The budget impact on most HHS programs of the statutory changes has been minimal at the Federal level. Most HHS programs, with the significant exception of Medicaid, are either discretionary programs with fixed appropriations or mandatory programs with "close-ended" appropriations. Therefore in these programs the number of immigrants that are served would have no effect on Federal spending levels, which are fixed. Use of services by fewer or more immigrants generally would have no budget impact. The new laws restricting Medicaid eligibility for most legal immigrants entering the country on or after August 22, 1996, do have the effect of reducing Federal outlays under that program.

**Four operational components in HHS provide services and benefits that go to citizens and immigrants:** the Administration for Children and Families (ACF), Public Health Service (PHS), Administration on Aging (AoA), and the Health Care Financing Administration (HCFA). Summaries of the major programs administered by these agencies follow. In addition to programs that provide services and benefits, HHS also funds important research and evaluations, some of which address issues related to immigrants and immigration. Key research in these areas funded by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Institute on Child Health and Human Development (NICHD) is also summarized below.

## HHS Research and Evaluation

### Office of the Assistant Secretary for Planning and Evaluation (ASPE)

ASPE conducts research in order to gain a better understanding of broad issues related to immigration policy and the well being of immigrant families. Our current research has particular emphasis on obtaining better information about the impact of immigration policies on HHS benefit programs for the disadvantaged. These efforts are particularly important in light of the policy changes brought about by PRWORA, but also because the usefulness of current program administrative data for evaluating these issues is so limited.

ASPE – together with ACF, HCFA, the Department of Agriculture (the Economic Research Service and the Food and Nutrition Service), and the Immigration and Naturalization Service – has sponsored a study by the Urban Institute to gather information on the health and economic status of immigrants. The study took place in New York City and Los Angeles and gathered information on the effects of welfare reform on immigrants and their communities. The study consists of several parts: (1) 1,650 household interviews in each city, with in-depth follow-ups of 150 households in each city; (2) interviews with community organizations (both governmental and non-governmental); and (3) analyses of data on immigrants from several existing data sets both at the national level (e.g., CPS, National Health Interview Survey, etc.) and using local administrative data for the focal cities. Data collection was completed in the summer of 2000. The study will include a profile of immigrants that can be compared to citizens. The analysis will identify trends and indicators of well-being for immigrants and their communities. A final report is expected in 2001, with some interim analyses available sooner. More information about the project and copies of the earlier reports in their entirety can be found at the Urban Institute's web site (<http://www.urban.org/>).

ASPE has also contracted with the Urban Institute to maintain a micro-simulation computer model used to analyze the effects of government tax, transfer, and health programs on individuals, families, households, and on Federal and State budgets. This Transfer Income Model – or TRIM – can model the effects of policy changes in 12 major tax, transfer, and health programs for the entire noninstitutional population of the United States. TRIM provides a source for detailed information on programs and their changes over time and can be used to address a wide range of policy questions, including estimating effects of possible or actual changes in program and policy rules. Since the enactment of PRWORA, ASPE has provided resources to ensure that new parameters are established in TRIM to permit estimates to be made by citizenship and immigration status.

Finally, ASPE has worked with other agencies, both within and outside HHS, to try to improve information on the citizenship and immigration status of individuals under existing, or planned, surveys. For example, we have been working with the National Center for Health Statistics, which is part of the Centers for Disease Control and Prevention of HHS, to test the feasibility of collecting information on citizenship and immigration status as part of the Department's major survey of health status, the National Health Interview Survey (NHIS). We have also worked with the U.S. Census Bureau to ensure that the new Survey of Program Dynamics (SPD) required under PRWORA includes information on the citizenship and immigration status of individuals, similar to information already collected in the Bureau's CPS and Survey of Income and Program Participation (SIPP).

## National Institute of Child Health and Human Development (NICHD)

The movement and distribution of populations within and across national boundaries affects population growth rates, the diversity of local and national populations, and the pressure of population growth on local environments. Migration also has important influences on the well-being of individuals and families, as well as that of sending and receiving communities. Despite its importance, of the three components of population growth – fertility, mortality, and migration – research on migration has been the least developed within NICHD.

NICHD undertook to redress this disparity in the early 1990's with a series of strategic investments in data on migrants and program initiatives to stimulate research. The initiatives included: research on Hispanic child health, including the social, behavioral and cultural factors related to such health; research on U.S. immigration in general; and identifying population movement as an NICHD Area of High Program Relevance (FYs 1996-1998) and as a Special Emphasis (FY 1999-). As a result, the number of NICHD-supported investigator-initiated research projects on migration has more than tripled since FY 1993.

### Immigration and Immigrants

In the United States, the relatively large flows and wide diversity of immigrants have both short- and long-term impacts on population size, composition, and growth, as well as broad social and economic implications. In fact, immigration will play the dominant role in America's future population growth, through the combined effects of adding new people and maintaining higher fertility levels. By most estimates, the non-Hispanic white population will comprise only 50 percent of the total population by 2050. The number of school-age children will expand rapidly in that time. NICHD-supported research is providing a much richer picture of the health and well-being of immigrant children and families in the United States and is forcing serious reconsideration of conventional wisdom concerning immigrants and immigration.

#### Children and Families of Immigrants

Immigrant children are the fastest growing segment of the U.S. population. One-fifth of U.S. children aged 18 and under are growing up in immigrant families. However, past research on immigrants has focused mostly on adults. The physical and mental health of children in immigrant families is of critical interest, because central features of adult functioning – labor force productivity, quality of parenting, civic participation – will be profoundly affected by whether children in immigrant families experience healthy development and successful adaptation to American life in the 21st century.

With support from NICHD and ASPE, the National Research Council/Institute of Medicine undertook a major synthesis of past research on immigrant children and commissioned new analyses. Their report issued in 1998, *From Generation to Generation: The Health and Well-Being of Children in Immigrant Families*, documents that immigrant children are as healthy or healthier than children of U.S.-born parents, but their health status appears to decline the longer they have been in the United States. Using new data from an NICHD-supported study, the report showed that first generation immigrant youth are healthier physically and are less involved in risky behavior (sexual activity, juvenile delinquency, violent behavior, substance abuse) than are second generation and native youth. For some ethnic groups, family and neighborhood factors such as poverty, single parent households, and unsafe or isolating neighborhoods, reduce the health protection associated with immigrant status. Lack of health insurance coverage was 3 times more likely for non-citizen children, and nearly twice as likely for citizen children in immigrant families, compared to children whose parents were born in the United States. However, immigrant families are optimistic about their children's chances for upward mobility and extremely resilient to the difficulties of their immigrant status.

#### Repudiating Conventional Wisdom about Immigration

Already, a number of findings stemming from NICHD-supported research projects are beginning to repudiate conventional thinking about the changing characteristics of immigrants over time, the process of

immigrant adaptation and assimilation. There is a greater awareness of how important it can be to distinguish between immigrants who are citizens or not, foreign-born or not, and/or legal or not, when describing health or socioeconomic status.

- New immigrants are not really new. In the NIS pilot survey (see discussion below), only about a third of immigrants who obtained their residence papers during July and August of 1996 were actually new to the United States. The majority had between 2 and 7 years of previous experience in this country. In addition, about 20 percent of new legal immigrants in that study entered illegally at either their first or their last trip to the United States. This finding has begun to change how researchers think about “immigrants” and underscores the ambiguities associated with information about “duration of stay,” since it is not clear what is being reported as “year of entry” in the decennial census and major national surveys such as the Current Population Survey.
- Legal immigrants are better schooled, on average, than the native-born population. The skill levels of legal immigrants are much higher than originally thought from analysis of census data. The median years of schooling completed among those aged 25 and above is 13 years, a full year higher than among the native-born. The proportion with postgraduate education, 21 percent, is almost 3 times larger than among the native-born. However, legal immigrants also have a higher proportion with low levels of schooling than the native-born—more than 3 times as many legal immigrants (20 percent) as native-born (6 percent) have completed less than 9 years of schooling.
- The skill level of legal immigrants entering the United States is improving. Data from the 1970-1990 decennial censuses suggest that the labor market skills of recent immigrants are quite low and have been declining significantly relative to skills of the native-born population. However, NICHD-supported research on legal immigrants over the period 1972-1995 paints a much different picture. During most of the last 25 years, the labor market skills of male legal immigrants have been as high or higher than that of male native-born workers. In addition, there has been a steady rise in the skill-level of legal immigrants during the last half of the 1980’s and throughout the 1990’s. The changing skill composition of legal immigrants was influenced by changes in immigration laws and changing economic conditions in sending countries and the United States. Proposals to reduce legal immigrant flows in response to concerns about declining immigrant skill levels could produce the opposite result by reducing the number of highly skilled legal immigrants and encouraging additional illegal immigrant flows into the labor market.
- Legalized immigrants do experience upward mobility. Analysis of the Legalized Population Surveys suggests that immigrants, even while undocumented, were quickly incorporated into the labor force, albeit at the lower end of the occupational scale. With time in the United States and with legalization of their status, however, their jobs improved and, as a group, they experienced upward mobility not unlike that attributed to immigrants who arrived earlier in the 20<sup>th</sup> century. They do not languish at the bottom of the socioeconomic ladder as some research has suggested.

### New Immigrant Survey (NIS)

Many fundamental questions about immigration remain unanswered: the effects of current immigration flows on future immigration entitlements, changes in the skill composition of entry cohorts of immigrants over time, the number and types of immigrants, their return to their home country, the transitions between legal and illegal statuses, the contributions of immigrants to the economy, and patterns of adaptation and assimilation. Despite the importance of the issues, immigration policy is handicapped by the lack of reliable and relevant longitudinal data. To address this major data limitation, the NICHD, the Immigration and Naturalization Service (INS), the National Science Foundation (NSF), and the National Institute on Aging (NIA) cooperatively funded a New Immigrant Survey Pilot Study (NIS-P). The pilot study demonstrated the feasibility of sampling new green card holders from INS administrative records, tested different strategies for locating and retaining the sample, and developed the substantive content of the survey instruments. In addition, the NIS-P has already provided some new information about the behavior of legal immigrants (highlighted above), demonstrating the potential usefulness of a full-scale New Immigrant Survey (NIS), which could provide immediate policy-relevant information on immigrants in the

United States and also serve as the foundation for a sustained effort to track their life-course. A decision to implement a full NIS for an initial 5-year period was made in FY 2000, and planning is under way.

## HHS Programs and Services

### Administration for Children and Families (ACF)

#### Office of Refugee Resettlement

The Federal government, through the Office of Refugee Resettlement (ORR), funds and administers programs for persons who have been admitted into the United States with refugee status, for those who have been granted asylum, for Cuban and Haitian entrants, and certain Amerasians (referred to collectively hereinafter as "refugees"). The primary objective of these programs is to help refugees become self-sufficient as quickly as possible after their arrival in the United States.

#### Agency Summary

Federal resettlement assistance to refugees is provided primarily through a State-administered refugee resettlement program. States are responsible for planning, administering, and coordinating refugee resettlement activities. Services and assistance available to refugees include cash and medical assistance, social services, and care of unaccompanied minors. More detailed information on ORR programs appears in the *Report to the Congress on the Refugee Resettlement Program*, published annually.

#### Cash and Medical Assistance

Many working-age refugees from all parts of the world are able to find employment soon after arrival in their new communities. For those who need services before placement in jobs, short-term financial support may be available through the local resettlement agency. However, when refugees require additional assistance and training beyond short-term support, they may apply for help from the State-administered cash and medical assistance programs, which are supported with Federal funds.

Refugees are eligible to apply for cash assistance benefits under title IV-A of the Social Security Act or Supplemental Security Income (SSI) programs and may participate as long as they continue to meet program eligibility requirements. Refugees who qualify for AFDC or, after 8/22/96, TANF, or SSI also become eligible for Medicaid benefits. Refugees also may be eligible for the Medicaid medically needy program if they have incomes slightly above that required for Medicaid eligibility and incur medical expenses that bring their net income down to the State Medicaid eligibility level.

The Refugee Act of 1980, as codified in the Immigration and Nationality Act, permits ORR to reimburse States for title IV-A payments made to refugees, for Medicaid costs incurred on a refugee's behalf, and for refugee SSI costs in those States which supplement Federal SSI payments. This reimbursement period, originally limited to 36 months, was reduced to 31 months in 1986, 24 months in 1988, and 4 months in 1990. Since 1990, ORR appropriations have not been sufficient to continue reimbursing States for these costs.

Some refugees do not qualify for cash assistance under the title IV-A or SSI programs because they do not meet the categorical eligibility criteria. These refugees may receive special cash assistance called Refugee Cash Assistance (RCA) which is provided at the same level as the former AFDC program. As with the aforementioned programs, the original period of eligibility was limited to 36 months after entry into the United States. The period of eligibility was reduced to 18 months in FY 1982, 12 months in FY 1989, and 8 months in FY 1992. The RCA eligibility period has remained stable at 8 months.

In all States, refugees eligible for RCA are also eligible for Refugee Medical Assistance (RMA) for the same period as RCA. Refugees also may be eligible for RMA alone if they have incomes slightly above

that required for Medicaid eligibility and incur medical expenses that bring their net income down to the Medicaid eligibility level. States are reimbursed for RMA costs.

After the period of eligibility for RCA and RMA has expired, refugees who continue to be ineligible for title IV-A, SSI, or Medicaid may qualify for State- or locally funded General Assistance (GA) programs on the same basis as other residents of the locality in which they reside. Similarly, refugees not eligible for Medicaid or no longer eligible for RMA may be eligible for State- or locally funded General Medical Assistance (GMA) programs. The Federal government previously reimbursed States for their GA and GMA costs for a period of months after entry into the United States, but since 1990, appropriations have not been sufficient to allow ORR to provide such reimbursement.

In FY 1997, the refugee cash and medical assistance expenditures were approximately \$191.6 million.

### Unaccompanied Minors

Resettlement of unaccompanied minor refugees who require foster care upon their arrival in the United States is provided through two national voluntary agencies, the United States Catholic Conference (USCC) and Lutheran Immigration and Refugee Service (LIRS). These agencies place the refugee children in licensed child welfare programs operated by their local affiliates. Unaccompanied minor refugees are eligible for the same general range of child welfare benefits available to non-refugee children in the State. They are placed in home foster care, group care, independent living, or residential treatment facilities. States receive Federal reimbursement for costs incurred on their behalf until the month after their 18th birthdays or such higher age as is permitted under the State's child welfare plan (Title IV-B of the Social Security Act).

### Social Services

Federal funding is available to States for a broad range of social services to refugees. Currently, about 85 percent of the social service funds are allocated directly to States according to their proportion of all refugees who arrived in the United States during the 3 previous fiscal years. States with small refugee populations receive at least \$75,000 in social service funds. States use most of their social service funds for employment-related services, such as English language training, employment counseling, job placement, and vocational training. States may also provide services identified in ORR regulations, such as orientation, translation, social adjustment, transportation, and day care.

### Discretionary Projects

The remaining social services funds are used for a variety of initiatives and individual projects intended to contribute to the effectiveness and efficiency of refugee resettlement service delivery. During FY 1995-1997, major discretionary projects included the following:

- The Citizenship program helps hard-to-reach refugees, such as the elderly, homebound and preliterate, prepare for citizenship. Grants were awarded to voluntary and State refugee agencies and mutual assistance associations.
- The Elderly Refugee program assists older refugees to become citizens and links them to mainstream agencies at the local level for services for aging residents.
- The Community Orientation program provides new arrivals with culturally and linguistically appropriate orientation training in preparation for their new life in the United States.
- The Microenterprise Development Initiative assists refugees in starting or expanding small business through training in business skills, access to credit, and individualized business technical assistance.

- The Preferred Communities program assists national voluntary agencies with placement of newly arriving refugees in communities with good job opportunities.
- The Mental Health program increases access to mental health services for refugees through a program of training and orientation for clinicians who work with refugees and, when needed, through provision of direct clinical services.
- The Unanticipated Arrivals program enables communities to respond to the arrival of new ethnic populations of refugees and entrants, particularly where the existing service systems do not have appropriate bilingual capacity.
- The Ethnic Community program provides new ethnic communities with small amounts of funds to form advisory groups or associations for the purpose of community and grass roots organizing.
- The Community and Family Strengthening program supports services to strengthen communities and families. These grants offer English language training, citizenship services, literacy and parental skills, crime prevention services for refugee youth, services to victims of domestic violence, specialized services for women, the establishment of local community organizations and parent-school relationships.

#### Targeted Assistance

This program provides employment services to refugees and entrants who reside in counties with unusually large concentrations of refugees. The substantial need of these populations for services has necessitated supplementation of local service resources.

In addition to the county targeted assistance program, Florida has received funds to provide health care to eligible Cuban/Haitian entrants and for the Dade County public school system to support education for entrant children.

In FY 1995, ORR awarded \$44.5 million to 42 counties in 20 States. In FY 1996, \$44.3 million was awarded to 39 counties in 21 States. In FY 1997, ORR awarded \$44.5 million to 45 counties in 20 States.

#### Match Grant Program

This program provides an alternative to the Federally funded, State-administered program. In FY 1995-1996, ORR, through the Match Grant program, provided up to \$1,000 per refugee on a dollar-per-dollar matching basis, to voluntary agencies participating in the program. In mid-FY 1997, the Federal match was raised to \$1.40 per dollar raised by the voluntary agencies up to a maximum of \$1,400 per refugee. The goal of this program is to help refugees attain self-sufficiency within 4 months after arrival. Matching grants fund a range of activities, including case management, employment services, maintenance assistance, and support services.

Because of increases in the number of arriving Jewish refugees from the former Soviet Union who are traditionally served by this program, matching grant appropriations have increased in recent years from \$32.6 million in FY 1994 to \$39.3 million in FY 1997.

#### Refugee Preventive Health

The Preventive Health program assists States and localities in providing health screening and preventive services for newly arriving refugees. These funds are intended to give the States the capacity to coordinate preventive health services available through public health programs, Medicaid and the refugee medical assistance (RMA) program. Service provision includes screening of all contagious diseases of public health concern, immunizations, preventive therapy and orientation to the U.S. health care system.

## Impact of Immigration on ORR Programs

Although a person may meet the criteria for admission into the United States as a refugee, the existence of the U.S. refugee admissions program does not automatically entitle that individual to enter. The annual admissions program is a legal mechanism for admitting an applicant who is among those persons for whom the United States has a special concern and who is otherwise eligible. The need for resettlement, not the desire of a refugee to enter the United States, is a governing principle in the management of the U.S. refugee program.

Refugees arrive through a highly regulated process. Crisis events that increase the flow of refugees may be unpredictable, e.g., the circumstances that developed in Iraq in the fall of 1996 resulting in the U.S. government airlifting 6,600 Kurdish and Iraqi evacuees from a temporary safe-haven in Turkey to Guam for asylum processing. More typically, refugees are admitted to the United States through a procedure that balances foreign policy considerations against perceived domestic concerns, such as unemployment and housing shortages. The refugee resettlement process is much more controlled than the arrival of immigrants, who have outnumbered refugee arrivals in recent years by a magnitude of 7 or 8 to 1, since a high proportion of immigrants are immediate relatives of U.S. citizens and not regulated by the immigration preference system.

### Demographic Impact<sup>13</sup>

From FY 1995 to FY 1997, the United States admitted 306,500 refugees, Amerasian immigrants, and Cuban and Haitian entrants, compared with 395,100 in the previous 3-year period (FY 1992 to FY 1994). These persons came from nearly 50 countries, with the largest number arriving from the republics of the former Soviet Union. For the period FY 1983 through FY 1997, the United States admitted a total of 398,600 Soviet refugees. From FY 1995 to FY 1997, 91,500 Soviet refugees arrived (23 percent of the total) compared with 152,400 in the previous 3-year period (38 percent of the total).

Refugee arrivals from Cuba, Iraq, Somalia, and the former Yugoslavia have increased substantially in recent years. For the period FY 1983 through FY 1997, the United States admitted 112,700 Cubans, 31,900 Iraqis, 21,800 Somalis, and 52,600 refugees from the former Yugoslavia. From FY 1995 to FY 1997, the United States admitted 65,900 Cuban refugees and entrants compared with 29,100 in the previous 3-year period; 15,500 Iraqi refugees compared to 12,900 in the previous 3-year period; 13,900 Somali refugees compared to 7,700 in the previous 3-year period; and 43,300 refugees from the former Yugoslavia compared to only 9,300 in the previous 3-year period. Arrivals from these five countries account for 75 percent of all arrivals for the period FY 1995 to FY 1997.

Although Vietnamese refugees and Amerasian immigrants retain the largest share of arrivals, Southeast Asian numbers have declined in recent years. For the period FY 1983 through FY 1997, the United States admitted 430,800 Vietnamese refugees and Amerasian immigrants. From FY 1995 to FY 1997, 57,700 Vietnamese and Amerasian immigrants arrived (13 percent of the total) compared with 123,600 in the previous 3-year period (29 percent of the total). The decline in Laotian refugees is more dramatic. For the period FY 1983 through FY 1997, the United States admitted 113,400. From FY 1995 to FY 1997, 6,800 Laotians arrived (6 percent of the total) compared with 20,400 in the previous 3-year period (18 percent of the total). The last year in which Cambodian refugees arrived in any significant numbers was FY 1990.

### Geographic Impact

Refugees arriving in the United States are placed in all 50 States, the District of Columbia, and several territories. The placement process strives to spread the impact of refugees around the country. Refugees are generally not placed in a location that already has a large refugee population unless they have a close relative residing in the area. Since most recent refugees have been joining relatives who became established earlier, their distribution still does not parallel that of the overall U.S. population. Southeast

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<sup>13</sup>All arrival figures are rounded to the nearest 100.

Asian refugees have settled in every State and one territory. However, some refugee groups are concentrated in a handful of States including Florida, Illinois, and New York.

For the period FY 1983 through FY 1997, the top five resettlement States in order of magnitude were California, New York, Florida, Texas, and Washington. Thirty-six percent of Southeast Asian refugees reside in California, and 22 percent of non-Southeast Asian refugees reside in New York. From FY 1995 to FY 1997, as well as from FY 1992 to FY 1994, the top five resettlement States were the same but not in the same order. From FY 1995 to FY 1997, as well as from FY 1992 to FY 1994, California resettled more Southeast Asian refugees (mostly from Vietnam) than any other State. From FY 1995 to FY 1997, Florida resettled more non-Southeast Asian refugees (mostly from Cuba) than any other State, followed by New York which resettled mostly refugees from the former Soviet Union. From FY 1992 to FY 1994, New York resettled more non-Southeast Asian refugees (mostly from the former Soviet Union) than any other State. Parenthetically, California also resettled the second largest number of refugees from the former Soviet Union during both time periods. From FY 1995 to FY 1997, as well as from FY 1992 to FY 1994, California resettled more Somalis than any other State, followed by Georgia and Virginia. Florida has consistently resettled the vast majority of Cubans. From FY 1995 to FY 1997, Michigan followed by Texas and then by California resettled the greatest number of refugees from Iraq, compared to FY 1992 to FY 1995, when California resettled the greatest number of refugees from Iraq followed by Michigan and Illinois. Finally, Washington resettled significant numbers of refugees from the former Soviet Union, Vietnam, and the former Yugoslavia from FY 1995 to FY 1997 and again significant numbers of refugees from the former Soviet Union and Vietnam from FY 1992 to FY 1994.

### Economic Impact

The economic impact of refugee arrivals depends on many factors: the employment potential of refugees, including their education skills, English language competence, and health; the needs that they have as individuals and members of families for financial resources, whether for food, shelter, or child-rearing; and the economic environment in which they settle, including the availability of jobs, housing, and other local resources.

In the short term, the primary question is whether or not refugees who obtain employment are able to become self-sufficient. To address this question, ORR conducts an annual native-language survey of refugees, Amerasian immigrants, and entrants who have entered the United States during the previous 5 years. The most recently published survey, conducted in the fall of 1997, includes interviews with 1,983 households. Survey results reveal the following:

- Employment increases with residence in the United States  
Results from the 1997 survey indicate that the employment-to-population ratio (EPR) of refugees aged 16 or older who have come to the United States during the 5 previous years was 53.9 percent, compared to an equivalent rate of 63.8 percent for the overall U.S. population. Although lower than that of the U.S. population as a whole, refugee employment appears to increase with each year of residence. While the overall EPR for the 1997 arrivals was only 50 percent, the EPR of refugees who had arrived in 1992 was 58 percent. It should be noted that the survey sample population includes refugees who have been in the country for only a short time and also excludes from the survey sample many refugees who arrived prior to 1992 (who are more likely to be residing in self-sufficient households).
- Use of public assistance varies widely among refugee households  
The 1997 survey indicates that over 55 percent of refugee households were self-supporting. The hourly wage for all working refugees was \$6.82 for 1997 arrivals and \$8.12 for 1992 arrivals, with an overall average of \$7.38. About 21 percent of the households were among the ranks of the working poor, having some earned income, but still qualifying for public assistance. Another 21 percent of the refugee households had no earned income and depended entirely on public assistance. Household receipt of public assistance reflects not only problems finding employment, but also differences in

need and ability. For example, 27 percent of self-supporting households reported they had at least one member fluent in English compared to 9 percent of households that depend entirely on public assistance. Another example involves SSI. Twenty-one percent of refugee households had at least one household member who received SSI. However, utilization varied greatly according to the number of refugees over age 65. Refugees from the former Soviet Union were found to utilize SSI most often. With about 16 percent of their 5-year population aged 65 or over, 37 percent of their households received SSI. By contrast, only 8 percent of refugees from Latin America were aged 65 or older, and 5 percent or less of all remaining refugee groups were 65 or over. The median age for the seven refugee groups (formed from the survey respondents) ranged from a low of 27 years for Africa to 41 years for the former Soviet Union.

## **Office of Community Services**

### **Community Services Block Grant Program**

#### Program Summary

Community Services Block Grants (CSBG) are awarded to States who in turn provide grants and contracts to a network of public and private community based organizations, (including Community Action Agencies and migrant and seasonal farm worker organizations) to provide services and undertake activities to ameliorate the causes and conditions of poverty in local communities. CSBG funds also are made available to Indian Tribes who apply directly to the Office of Community Services (OCS). In FY 1997, \$489.6 million was appropriated to carry out the purposes of the CSBG Program.

Recipients of CSBG funds are required to provide a range of services and activities to address the following needs: employment, education, making better use of available income, housing, nutrition, emergency services, and health. States and Indian Tribes have the flexibility to provide, consistent with the statute, such services and activities that they determine best meet the needs of low-income individuals and families.

#### Impact of Immigration on CSBG Program

Federal data on the extent to which immigrants can and do access CSBG programs are unavailable. There has been no statutory or regulatory requirement to collect such information either on the part of OCS or the states or tribes receiving CSBG funds. Because the CSBG budget is not calculated based on the number of individuals served, there is no impact directly attributable to immigrant or citizen utilization.

### **Discretionary Grants Program**

#### Program Summary

In FY 1997, the CSBG Discretionary Grants Program provided \$24.5 million in assistance to programs of national and regional significance. Assistance is available on a competitive basis to the following entities: private, locally initiated community development corporations that sponsor enterprises providing employment, training, and business development opportunities for low-income residents; public and private non-profit agencies that provide activities benefiting migrants and seasonal farm workers; public and private organizations that carry out programs in rural and community facilities development; and private, non-profit organizations that provide recreational activities for low-income youth.

#### Impact of Immigration on Discretionary Grants Program

Funding is provided for the development of projects to aid low-income individuals in general and does not focus on any particular needy population, such as immigrants or refugees. Eligible organizations representing such groups must compete with all other applicants for funding. Immigrants and refugees probably receive services from projects funded under the discretionary grants program, particularly from projects directed towards serving migrants and seasonal farm workers, but there is no data available

indicating the number and location of such users. There are no restrictions on serving immigrants in projects funded under this program.

## Community Food and Nutrition Program

### Program Summary

The Community Food and Nutrition Program in FY 1997 provided \$4 million in assistance to public and private agencies at the community-based, state, and national levels for the purposes of: coordinating existing food assistance resources; assisting in identifying sponsors of child nutrition programs and initiating new programs in underserved and unserved areas; and developing innovative approaches at the State and local levels to meet the nutritional needs of low-income people. Funding for this program is provided on a competitive basis as well as distributed to States on a formula basis.

### Impact of Immigration on Community Food and Nutrition Program

The impact of immigration on this program is similar to that of the Discretionary Grants program. While there is no data available on the extent to which this program serves immigrants; it is reasonable to assume that immigrants who are served by this program benefit to the same extent as citizens who also are served.

## Low Income Home Energy Assistance Program (LIHEAP)

### Program Summary

The Low Income Home Energy Assistance Program helps low-income people meet their home energy costs. In FY 1997, \$1 billion was appropriated for the regular program, and \$215 million in contingency funds was released. Recipients of funding were the States, the District of Columbia, Indian tribes and tribal organizations, and U.S. territories.

### Impact of Immigration on LIHEAP

There is no Federal information on the extent to which immigrants can and do access LIHEAP. The LIHEAP statute does not specify immigrants as a target group for assistance. LIHEAP grantees and other interested parties were notified on August 6, 1998 that, subject to certain important exceptions, providers of LIHEAP-funded energy assistance (other than nonprofit charitable organizations) were required to verify the immigration and citizenship status of applicants in order to ensure that non-qualified aliens do not receive non-excepted LIHEAP benefits and services. Because the budget for LIHEAP is not determined by the number of persons who access its services, there is no effect on its budgetary total attributable to immigrant access or restriction.

## Social Services Block Grant (SSBG)

### Program Summary

The Social Services Block Grant (Title XX of the Social Security Act) provides formula grants directly to the 50 States, the District of Columbia, and eligible territories and commonwealths. Under SSBG, Federal funds are available without a matching requirement. In FY 1997, States received a total allotment of \$2.5 billion. Within the specific limitations in the law, each State has the flexibility to determine what services will be provided, who is eligible to receive services, and how funds are distributed among the various services offered. State and local Title XX agencies (i.e., county, city and regional offices) may provide these services directly or purchase them from qualified agencies and individuals.

Also, in the Omnibus Budget Reconciliation Act of 1993, Congress amended Title XX of the Social Security Act to provide a one-time set-aside in grant funds totaling \$1 billion for localities designated as Empowerment Zones and Enterprise Communities. These grants are called "EZ/EC SSBG" funds and are

separate and distinct from the regular "Title XX Social Services Block Grant" in both the flexible program uses for the funds and the decision-making authority for determining those uses.

Specifically, Title XX was amended to permit a greatly expanded range of programmatic activities that can be financed with EZ/EC SSBG monies, as opposed to the more limited options for "regular" Social Services Block Grant funds, including economic/community development and infrastructure projects. Furthermore, all decision-making authority for using EZ/EC SSBG funds to finance particular activities is vested in the local EZ/EC lead entity and community-based governance process, as opposed to the State under the "regular" Title XX Social Services Block Grant; in the EZ/EC program, the State primarily functions as a "pass-through" funding conduit for the EZ/EC SSBG award.

EZ/EC SSBG funds were provided to 6 urban and 3 rural empowerment zones and 95 enterprise communities to assist those localities in addressing their specific needs. Among the programs that the EZ/EC's identified as relevant to their communities are: programs to train and employ zone residents in the construction and rehabilitation of public infrastructure and affordable housing; after-school programs to keep schools open during the evenings and on weekends; and drug and alcohol prevention and treatment programs that provide comprehensive services for pregnant women, mothers, and their children.

#### Impact of Immigration on SSBG Programs

Each State must submit a pre-expenditure report to the Secretary of HHS on the intended use of SSBG funds. The only requirement in the statute is that the report include information about the type of activities to be funded and the characteristics of the individuals to be served. While there is no specific information available in these reports on the social services provided to immigrants and refugees, a State has the flexibility to offer services under SSBG to these groups (other than to non-qualified aliens, subject to important exceptions related to the type of service being provided, and the type of organization providing the service). Under PRWORA, States have the option to deny SSBG assistance to non-excepted qualified aliens beginning January 1, 1997, but based on the information submitted in State SSBG plans, no State is currently denying SSBG-funded services to qualified aliens. Because the budgets for SSBG programs are not based on the number of individuals that use their services, immigrant use has no effect on the budget outlays.

Although many of the 104 EZ/EC localities receiving EZ/EC SSBG funds may include immigrant populations, the size and configuration of those designated areas prohibits a valid assessment of that population and the services they currently may be receiving.

### **Head Start**

#### **Program Summary**

Head Start is a national program that provides comprehensive educational, medical, health, nutritional, social and other services to primarily low-income preschool children and their families. In FY 1997, about 794,000 children received Head Start services. Up to 10 percent of Head Start's enrollment may be reserved for children from families above the Federal poverty level (FPL). Also 10 percent of enrollment must be reserved for preschool children with disabilities (currently, about 13 percent of Head Start's national enrollment are children with disabilities). In addition, Head Start funds programs for Indian and migrant children. The 1994 reauthorization of the Head Start Act established a new Early Head Start program for low-income families with infants and toddlers. In FY 1997, \$159 million was used to support 173 projects to provide Early Head Start child development and family support services in all 50 states and in the District of Columbia and Puerto Rico. These projects, plus a number of Parent and Child Centers and Comprehensive Child Development Programs, served 22,000 children under age 3 in FY 1997. In FY 1997, there were 1,456 Head Start grantees and approximately 600 delegate agencies in the 50 states, the District of Columbia, and eligible territories and commonwealths.

## Impact of Immigration on the Head Start Program

There are no data on the number of immigrants being served by the Head Start program. As far as the budget is concerned, since Head Start's budget is not based on the number of children and families served, immigrant access to this program does not affect it.

## Office of Family Assistance

### Aid to Families With Dependent Children (AFDC)

Note: as indicated before, AFDC was replaced by the Temporary Assistance for Needy Families with the enactment of P.L. 104-193 on August 22, 1996.

The Aid to Families with Dependent Children program (Title IV-A of the Social Security Act) was a Federally-funded program administered by States and certain territories. In the AFDC program, States made assistance payments to needy families with dependent children deprived of parental support or care because of a parent's absence, death, incapacity, or the unemployment of a parent who is the principal earner.

In order to become eligible for AFDC payments, the individual had to be a citizen or lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. However, provisions included in the Immigration Reform and Control Act of 1986 (IRCA) disqualified newly legalized immigrants from participation in the AFDC program for a period of 5 years from the date of receipt of their legalized status; the only exceptions to this disqualification were for Cuban and Haitian entrants.

An application from a sponsored alien not otherwise disqualified under IRCA who applied for AFDC within 3 years of his/her entry into the United States was evaluated by having the sponsor's income and resources deemed available to the alien according to a prescribed formula for a period not to exceed 3 years from the alien applicant's date of entry.

In FY 1997, total State and Federal expenditures for the AFDC program were \$5.2 billion.

### Impact of Immigration on AFDC

Table 4-1 shows the AFDC reciprocity rates for legal immigrants (including refugees) from 1993 to 1997, not including recipients of emergency assistance.<sup>14</sup> According to this table, the legal immigrant proportion of all AFDC recipients has remained relatively modest, between 5 and 6 percent of the total AFDC population. There was a decrease of nearly 30 percent in the number of immigrant recipients of AFDC, from a high of 825,126 in FY 1995 to 601,896 in FY 1997. This decrease generally mirrors the overall decrease in total AFDC caseload during this period, and is attributable primarily to welfare reform.

**Table 4-1 — AFDC Reciprocity Rates for Legal Immigrants: FYs 1993-1997**

	1993	1994	1995	1996	1997
Number of Legal Immigrant Recipients	722,814	823,318	825,126	744,654	601,896
Number of All AFDC Recipients	14,045,207	14,246,450	13,752,095	12,621,250	11,356,535
Percent of Legal Immigrant AFDC Recipients	5.1	5.8	6.0	5.9	5.3

<sup>14</sup> These figures are based on the AFDC Quality Control (QC) File, a sample of State administrative data that were used to study the trends in immigrant usage of AFDC. Quality Control data were drawn from monthly samples provided by each State and were used to determine errors in payments to recipients. Some potential problems with the AFDC QC data included an insufficient number of sample immigrant cases in some states and problems relating to the proper coding of citizenship status in some States.

## Emergency Assistance (EA)

### Program Summary

Emergency Assistance was a State-administered optional program that provided temporary financial assistance and services to needy families with children to prevent destitution and provide shelter. The Federal Government shared 50 percent of the costs of these benefits with the States. If a State elected to operate an EA program, it provided assistance to any family member, otherwise eligible for AFDC, including one who is a citizen or an alien lawfully admitted for permanent residence or otherwise residing in the United States under color of law. A State also had the option to provide EA to undocumented immigrants.

States had flexibility in defining what constituted an emergency and the type and amount of assistance that they would provide. Assistance could have been in the form of cash, services, or items a family needs, such as food, clothing, and furniture. Federal matching funds were available only for emergency assistance that the State authorized during one 30-day period in any 12 consecutive months. Funds could be available to meet needs that arose before the 30-day period or that extended beyond the 30-day period.

In FY 1997, total Federal/State expenditures for the EA program were approximately \$679 million.

### Impact of Immigration on EA Program

No Federal information is available on the impact of immigration on the EA program.

## Temporary Assistance for Needy Families (TANF) Program

### Program Summary

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 eliminated the AFDC, Emergency Assistance, and Jobs Opportunities and Basic Skills Training (JOBS) programs and created the TANF program. The TANF program is a block grant program. TANF block grants to States total \$16.5 billion annually through FY 2002. States had until July 1, 1997 to implement their TANF programs. The TANF program also has a cost-sharing requirement, known as maintenance-of-effort (MOE), to ensure that States continue to contribute their own money toward meeting the needs of eligible families. Under the maintenance-of-effort requirement, States must maintain their own spending at 80 percent of their FY 1994 spending level (or 75 percent if they meet the required work participation rates). The MOE funds may be used in the TANF program either by commingling them with Federal TANF funds or by segregating them, and they may also be used in separate State programs outside TANF. The MOE requirement at the 80 percent level totals \$11.1 billion annually and \$10.4 billion at the 75 percent level. Essentially, States must use their TANF and MOE funds consistent with the purposes of the new law, which focuses on reducing welfare dependency and helping families become self-sufficient. The new law also contains strong work requirements and places a time limit on most assistance. States have broad flexibility in the design and operation of their welfare programs.

### Basic Policy on Non-Citizens

PRWORA imposed restrictions on the ability of some non-citizens to receive Federal or State and local public benefits. The TANF program, using Federal TANF funds or State funds commingled with Federal TANF funds, generally provides a Federal public benefit, which means only qualified aliens may receive Federally funded TANF benefits (subject to important exceptions related to the type of service being provided and the type of organization providing the service). Non-exempt qualified aliens entering the country on or after August 22, 1996 are banned from receiving Federal TANF benefits for 5 years. Thereafter, States may choose whether or not to provide Federal TANF benefits to otherwise eligible qualified aliens.

States may also use their own funds to assist qualified aliens as well as certain non-qualified aliens. Specifically, States may use segregated State funds in TANF or funds in separate State programs to provide TANF or other State or local public benefits to qualified aliens not eligible for TANF under the 5-year bar, nonimmigrants under the Immigration and Nationality Act or aliens paroled into this country under section 212(d)(5) of such Act for less than 1 year. States may also use MOE funds to provide State TANF or other State or local benefits to illegal aliens if the State enacts a law after August 22, 1996 that affirmatively provides that illegal aliens are eligible to receive (all or particular) State or local public benefits. If a State determines that a particular State-funded benefit or service available in the State is not a public benefit, then the State may provide that benefit to any eligible alien family member.

## **Office of Child Support Enforcement**

### **Program Summary**

Established in 1975, the Child Support Enforcement (CSE) program is a joint Federal and State effort (Title IV-D of the Social Security Act). Its goals are to ensure that children are supported financially by their parents, to foster family responsibility, and to reduce welfare costs.

### **Impact of Immigration on CSE Program**

Data on immigrants' use of CSE services are not available. CSE cases fall into four categories: TANF, non-TANF, Medicaid only, and Foster Care. There are no restrictions or limitations on use of services by immigrants.

## **Administration on Developmental Disabilities (ADD)**

### **Program Summary**

The Administration on Developmental Disabilities administers the programs authorized under the Developmental Disabilities Assistance and Bill of Rights Act, as amended. The goal of these programs is to assure that individuals with developmental disabilities and their families participate in the design of, and access to, culturally competent services, supports, and other assistance and opportunities that promote independence, productivity and integration and inclusion into the community. The Developmental Disabilities programs work in partnership with individuals with developmental disabilities and their families, State governments, local communities, and the private sector to address such issues as prevention; diagnosis; early intervention; therapy; education; training; employment; leisure opportunities; community and institutional living.

Many services supported by ADD and provided by States and local communities are available to immigrants and refugees with disabilities and their families. The Developmental Disabilities programs are comprised of the following four programs:

- State Developmental Disabilities Councils, which promote capacity building and advocacy, the development of consumer and family centered comprehensive system, and a coordinated array of supports, and other assistance designed to help people with developmental disabilities.
- The Protection and Advocacy (P&A) Program, which provides for the protection and advocacy of legal and human rights through formula grants to States.
- University Affiliated Programs (UAP), which provide interdisciplinary training, exemplary service, technical assistance, and information dissemination activities.
- Projects of National Significance (PNS) are awards to innovative public or private non-profit institutions that seek to enhance the independence, productivity, integration and inclusion into the community of people with developmental disabilities. Monies also support the development of national and State policy.

## Impact of Immigration on the ADD

The impact of immigration on local ADD-supported programs is unknown and difficult to assess, as eligibility for ADD-related programs was not based on immigration status prior to the enactment of PRWORA. Direct services provided by many of the ADD programs are considered to be Federal public benefits and are therefore only available to qualified aliens. However, since many of the ADD grantees are non-profit organizations, verification of citizenship and immigration status is not required. It should also be noted that because the budgets for ADD's programs are not calculated based on the number of individuals served, immigrant use has no effect on the total budget.

## Public Health Service

### Substance Abuse and Mental Health Services Administration (SAMHSA)

#### Agency Summary

SAMHSA conducts several programs that might be affected by immigration into the United States: the Refugee Mental Health Program; two SAMHSA-administered block grants; a program providing assistance to homeless individuals with serious mental illness; a program providing comprehensive community-based services for children with serious emotional disturbance; a program providing protection and advocacy for individuals with serious mental illness; a program that provides assistance to communities in developing resources to prevent substance abuse; and several demonstration programs. Descriptions of these programs are included in Appendix A.

#### Refugee Mental Health Program (RMHP)

##### Program Summary

The RMHP originated in ADAMHA in 1980 in response to the arrival of nearly 125,000 Cubans on the South Florida shores. The basic mission of the RMHP was to provide mental health assessment, treatment and consultation. In 1992, in conjunction with the reorganization of ADAMHA, the activities of the RMHP were transferred to the Refugee Mental Health Branch, Center for Mental Health Services, SAMHSA. At that time, consultative activities were expanded to other Federal agencies, most notably, the Office of Refugee Resettlement (ORR), Administration for Children and Families, DHHS. In 1995, the original Cuban/Haitian activities of the RMHP were transferred to the Department of Justice. At the same time, the consultative activities were transferred to the Special Programs Development Branch, CMHS, SAMHSA.

Since 1995, the Special Programs Branch of RMHP, through an interagency agreement with the ORR, provides mental health consultation and technical assistance to Federal, State, local agencies, and ORR-funded programs. These activities include on-site and telephone consultation, community assessments, development and dissemination of technical assistance documents, and development and provision of workshops and training programs to resettlement staff and mental health personnel. RMHP staff may also be assigned to special missions. For example, RMHP staff were involved in the planning for Operation Provide Refuge in 1999 and served on the Director's staff overseeing all health/mental health planning and services for Kosovar Albanians processed at Fort Dix, N.J. Later, in 1999, RMHP staff participated in a Presidential Delegation to Kosovo, which was tasked with conducting a comprehensive psychosocial needs assessment of returning refugees.

##### Impact of Immigration on the Refugee Mental Health Program

For the Refugee Mental Health Program, policies which potentially affect mass migrations or repatriations have a significant impact on program activities.

## Block Grants

### Program Summaries

- **Community Mental Health Services Block Grant.**  
The Community Mental Health Services Block Grant provides funds to the States and Territories to enable them to carry out the States' plans for providing comprehensive community mental health services to adults with serious mental illness and to children with a serious emotional disturbance; evaluate programs and services carried out under the plan; and conduct planning, administration, and educational activities related to providing services under the plan.
- **Substance Abuse Prevention and Treatment (SAPT) Block Grant.**  
The SAPT Block Grant provides funds directly to States to provide substance abuse prevention and treatment services based upon State Needs Assessments and State Plans.

### Impact of Immigration on Block Grant Programs

For the SAMHSA block grants, because these funding mechanisms are primarily based on population-driven formulas for determining State allotments, a significant increase in a State's population caused by immigration would require an increase in the State's allotment. Allotments to other States would decrease correspondingly. However, receipt of services from these programs has not been dependent on citizenship or immigrant status, and there is no information regarding immigrant utilization of services.

## Assistance to Homeless Individuals with Mental Illness

### Program Summary

SAMHSA supports a program to assist homeless persons with severe mental illness, initially through the Mental Health Services to the Homeless (MHSH) block grant, and then through the Projects for Assistance in Transition from Homelessness (PATH) formula grant program. Both the MHSH block grant and the PATH program have provided outreach and mental health treatment programs to homeless persons with serious mental illness and, under the PATH program, to those individuals at risk of homelessness.

### Impact of Immigration on Assistance to Homeless Individuals with Mental Illness Program

Eligibility for this program has not been dependent on citizenship or immigrant status. Therefore, no information regarding utilization of services by immigrants is available.

## Comprehensive Community Mental Health Services for Children and their Families Program

### Program Summary

The Comprehensive Community Mental Health Services for Children and Their Families Program was authorized in 1992 in the ADAMHA Reorganization Act to provide grants to States, political subdivisions, Indian tribes, and tribal organizations for provision of an array of community-based services organized into a system of care for children with serious emotional, behavioral, or mental disorders, and their families.

### Impact of Immigration on Comprehensive Community Mental Health Services for Children and Their Families Program

This program does not condition eligibility for its services on immigrant status. No information is available regarding immigrant utilization of services.

## Protection and Advocacy for Individuals with Mental Illness (PAIMI)

### Program Summary

The PAIMI Act of 1986 authorizes formula grant allotments to be awarded to Protection and Advocacy (P&A) systems that have been designated by the Governor in each State (and the District of Columbia and certain territories) to protect the rights of and advocate for individuals with disabilities. The allotments are to be used to pursue administrative, legal, and other appropriate remedies to redress complaints of abuse, neglect, and rights violations and to protect and advocate the rights of individuals with mental illness through activities to ensure the enforcement of the Constitution, and Federal and State statutes.

### Impact of Immigration on PAIMI

Receipt of services from this program has not been dependent on citizenship or immigrant status, and information regarding immigrant utilization of services is not available.

## Discretionary Grant Programs

### Program Summaries

SAMHSA offers discretionary grant funding primarily through the Knowledge Development and Application (KD&A) program. The goal of this program is to develop new knowledge about ways to improve the prevention and treatment of substance abuse and mental illness, and to work with State and local governments as well as providers, families, and consumers to apply that knowledge effectively in everyday practice. These programs have included Targeted Capacity Expansion, Target Cities, HIV/AIDS Outreach, State Incentive Grants, Pregnant and Postpartum Women and Infants programs, Community Action grants, and Children of Substance Abusing Parents.

### Impact of Immigration on Discretionary Programs

SAMHSA's discretionary programs have not conditioned eligibility for services on citizenship or immigrant status. Consequently, there is no information regarding immigrant utilization of services available. However, since the programs' budgets are not determined by the number of persons accessing their services, immigrant access would not affect the total budget.

## **Centers for Disease Control and Prevention (CDC)**

### Agency Summary

The mission of the Centers for Disease Control and Prevention is to prevent unnecessary illness and premature death. CDC strives to achieve national prevention objectives by:

- conducting surveillance, epidemiologic investigation, and laboratory research;
- serving as national and international reference laboratories;
- providing assistance, including grants, to State and local health departments; and
- disseminating findings through partners in academic institutions, medical care settings, and business and labor groups.

Services funded by CDC and provided by State and local health departments are available to immigrants and refugees. For example, CDC's Preventive Health and Health Services Block Grant is designed to give states flexibility to fund priority prevention programs tailored to specific needs. This Block Grant funds a wide variety of preventive health services. CDC also funds state-level activities in immunization, tuberculosis control, sexually-transmitted disease prevention and control, HIV/AIDS prevention and

education, health education and health promotion. In addition, CDC manages a national program for control of infectious diseases.

CDC's Division of Quarantine has the regulatory responsibility to prevent the introduction of communicable diseases into the United States. This mission is accomplished by monitoring the overseas medical examination of immigrants and refugees applying for permanent U.S. residency. The Division of Quarantine writes and disseminates the guidelines for this medical examination and informs State and local health departments of the arrival of all refugees and immigrants with diseases of public health significance.

#### Impact of Immigration on CDC Programs

The impact of immigration on local preventive health services supported by CDC grant funds is unknown and difficult to assess. Eligibility for CDC-supported services is not based on immigration status, and national data on the immigration status of recipients is not maintained. However, it is reasonable to assume that immigrants benefit from CDC services. Therefore, changes in immigration and program eligibility could impact the local operation of CDC programs substantially, particularly in communities with high concentrations of immigrants. As for the budgets of these programs, immigrant use has no effect on the budget totals since they are not based on the number of individuals served.

### **Health Resources and Services Administration (HRSA)**

#### Agency Summary

The Health Resources and Services Administration, through the programs that it funds and administers, seeks to improve the health of the Nation by assuring quality health care to underserved, vulnerable, and special-need populations and by promoting appropriate health professions workforce capacity and practice, particularly in primary care and public health. In FY 1997, HRSA provided \$3.4 billion to 80 programs. Together, HRSA's programs operate with the goal of improving access to care for millions of Americans.

#### Impact of Immigration on HRSA Programs

HRSA administers preventive and primary health care programs that address the needs of disadvantaged and underserved populations. These programs seek to minimize infant mortality, eliminate racial disparities in health, and to bring down cultural and linguistic barriers that limit access to care.

Since HRSA-funded programs are located in areas most accessible to underserved and disadvantaged populations, it can be assumed that these programs serve immigrants. However, since the eligibility for these programs is not dependent on citizenship or immigration status, no information regarding utilization of services by immigrants is available.

The service delivery programs funded by HRSA include:

- Community and Migrant Health Centers, Health Care for the Homeless, Health Services for Residents of Public Housing, and Healthy Schools, Healthy Communities;
- Maternal and Child Health Title V block grant, Special Projects of Regional and National Significance, Community Integrated Service Systems, and pediatric emergency medical services;
- Ryan White grants to States, metropolitan areas and local service providers for the provision of primary and support services for persons living with HIV/AIDS.

Program descriptions are in Appendix B.

## **Administration On Aging (AoA)**

### **Agency Summary**

In the United States, 45 million people are 60 years of age or older. Some of these older individuals are at risk of losing their independence, including 4 million people over age 85, those living alone without a care giver, members of minority groups, older persons with physical or mental impairments, low-income older persons, and those who are abused, neglected, or exploited.

The Administration on Aging (AoA) was established by the Older Americans Act of 1965 (OAA) to meet the diverse needs of the increasing number of older individuals. The AoA is the Federal focal point and advocacy agency for older persons. It works closely with its nationwide network of State Agencies on Aging, Area Agencies on Aging, and Tribal Organizations to plan, coordinate, and develop community-based systems of services designed to meet the unique needs of older persons and their care givers. It funds in-home and community-based supportive and nutrition services including: Access services (e.g., information and assistance, transportation, and case management); In-home services (e.g., home repair, home-delivered meals, personal care, and homemaker-home health aide); Community-based services (e.g., senior centers, congregate meals, day care, nursing home ombudsmen, health promotion, etc.); and Care giver services (e.g., respite, counseling, and education).

### **Impact of Immigration on the AoA**

The effect of immigration on local OAA supported services is unknown and difficult to assess, because OAA programs do not collect information on immigration status. However, it is reasonable to assume that immigrants benefit from OAA programs and services, particularly in communities with high concentrations of older immigrants. As for the budget, immigrant use of OAA programs would not affect the total budget since it is not calculated based on the number of individuals accessing those programs.

## **Health Care Financing Administration (HCFA)**

### **Medicaid**

#### **Program Summary**

The Medicaid program is a State-administered, Federally assisted program providing medical assistance to individuals and families who meet certain eligibility requirements. Medicaid Stateplans provide assistance to certain low-income families, children, pregnant women, and to certain low-income individuals who are aged, blind or disabled. In FY 1997, 34.9 million individuals received medical assistance. Medicaid benefits totaled \$161 billion, of which \$91 billion was the Federal share.

Table 4-2 shows the total number of Medicaid recipients and the percentage of recipients in each of the following categories for FY 1997.

Table 4-2 — Medicaid Enrollees by Program, FY 1997

Program	Persons enrolled (millions)	Percent
Total	34.9	100.0
Aged/Blind/Disabled	10.1	28.9
AFDC-Children	15.3	43.8
AFDC-Adults	6.8	19.5
Other	2.7	7.7

#### Impact of Immigration on the Medicaid Program

Prior to enactment of PRWORA (P.L. 104-193) on August 22, 1996, title XIX of the Social Security Act permitted full Medicaid eligibility to otherwise eligible non-citizens who were lawful permanent residents or persons permanently residing in the United States under color of law (PRUCOL). Such non-citizens who were members of a group covered by the State Plan and met all other eligibility requirements (e.g., related to income) could receive Medicaid. In addition, non-citizens in an immigration status not described above could, if they otherwise met Medicaid eligibility criteria, receive Medicaid for the treatment of an emergency medical condition.

Passage of PRWORA greatly changed the eligibility of non-citizens. The new eligibility criteria limit full Medicaid eligibility to so-called “qualified aliens.” This classification incorporates lawful permanent residents and the following formerly PRUCOL categories: asylees, refugees, parolees for more than 1 year, conditional entrants, Cuban/Haitian entrants, aliens whose deportation is being withheld under the INA, and battered alien spouses, battered alien children, the alien parents of battered children, and alien children of battered parents who fit certain criteria.

Welfare reform also imposed additional requirements and limitations on the Medicaid eligibility of qualified aliens based on whether their date of entry into the United States was before, or on or after, August 22, 1996. It established a 5-year bar to eligibility for non-emergency services applicable to qualified aliens who enter the United States on or after August 22, 1996. However, this bar does not apply to those qualified aliens who are exempt from it by law. For example, refugees, asylees, and individuals with status as an active duty member of the United States armed forces or as a veteran are exempt from the 5-year bar applicable to other qualified aliens. In addition, lawful permanent residents who entered the United States before August 22, 1996, and who possess 40 quarters of work in the United States without use of means-tested benefits are exempt from the limitation on eligibility contained in welfare reform.

Some PRUCOL aliens who prior to welfare reform were eligible for full Medicaid are now considered non-qualified aliens. However, otherwise eligible aliens, whether qualified aliens or not, are eligible to have payments made for treatment of emergency medical conditions. Emergency medical condition is defined to mean that an individual, after sudden onset, has acute symptoms of sufficient severity such that the absence of immediate treatment could cause serious jeopardy to any bodily organ or part (paraphrase of 1903(v) of the Social Security Act).

Passage of the Balanced Budget Act of 1997 eased the limitations on qualified aliens’ eligibility for Medicaid. These changes consist of:

- Extending from 5 to 7 years the exemption from the limits imposed by welfare available to refugees, asylees, active duty military and veterans.
- Adding Amerasians to the exempt groups above.
- Including Cuban/Haitian entrants as refugees.

- Permitting qualified aliens who were receiving SSI on the day PRWORA was enacted to continue to receive SSI and any Medicaid for which they were eligible, and permitting qualified aliens who were living in the United States on the date welfare reform was enacted, who were not receiving SSI but who are or become disabled, to receive SSI and Medicaid.
- Providing that aliens who were receiving SSI on the date PRWORA was enacted, based on an application filed before January 1, 1979, for whom SSA lacks evidence that they are not qualified aliens will be considered to be qualified aliens for the purpose of SSI and Medicaid eligibility.
- Clarifying that American Indians born outside the United States will be recognized as qualified aliens (lawful permanent residents) and exempt from the 40 quarters requirement.

In 1998, Congress passed legislation which further protected the benefits of SSI recipients. Those non-qualified aliens, formerly PRUCOL aliens, who were receiving SSI on the date welfare reform was enacted would continue to be eligible to receive both SSI and Medicaid. Thus, all aliens who were receiving SSI on August 22, 1996, remain eligible for those benefits and for Medicaid to the extent Medicaid is provided to individuals in a State receiving SSI.

## **Medicare**

### **Program Summary**

The Medicare program is a Federal health insurance program for most people age 65 or older and certain people with disabilities. The Medicare program has two parts; Hospital Insurance (Part A) and Supplemental Medical Insurance (Part B). Generally, most people age 65 and older have access to Medicare Part A benefits, based on their own or their spouse's employment, without having to pay a premium. Medicare Part A is "premium-free" for individuals who meet the age requirement and for whom any of these three statements is true:

- They receive benefits under the Social Security or Railroad Retirement system.
- They could receive benefits under the Social Security or Railroad Retirement system but have not filed for them.
- The individual or their spouse had Medicare-covered government employment.

Individuals under 65 years of age also can get premium-free Medicare Part A benefits if they have been a disabled beneficiary under Social Security or the Railroad Retirement Board for more than 24 months.

Part B benefits are available to almost all resident citizens 65 years of age or over; to certain aliens 65 years of age or over, even those who are not entitled to Part A; and to disabled beneficiaries entitled to Medicare Part A. Most Medicare Part B enrollees are eligible for Part B because they are eligible for premium-free Medicare Part A benefits based on the work described previously. All Medicare Part B enrollees pay premiums. The premiums differ in amount based on the how the enrollees became eligible for Medicare Part B (e.g., previous employment, buy-in option, etc.).

Table 4-3 shows the number of individuals enrolled in Medicare in calendar year 1997 and benefit payments made during 1997.

**Table 4-3 — Medicare Enrollees and Benefit Payments, 1997**

	<b>Medicare Enrollees (millions)</b>	<b>Benefit Payments (billions)</b>
<b>Hospital Insurance (Part A)</b>	<b>38.0</b>	<b>\$137.8</b>
Aged	33.2	121.8
Disabled	4.8	16.0
<b>Supplemental Medical Insurance (Part B)</b>	<b>36.4</b>	<b>72.8</b>
Aged	32.1	62.4
Disabled	4.3	10.4

#### Impact of Immigration on the Medicare Program

Legal immigrants and citizens who are not otherwise eligible may opt to buy-in to the Medicare program, if they meet certain eligibility criteria. Immigrants must be over age 65 and must meet a 5-year U.S. residency requirement before becoming eligible to purchase Medicare, Part B. Individuals age 65 or older not otherwise entitled to Part A may purchase Part A coverage if they are enrolled in Part B. Legal immigrants must have resided in the United States continuously for 5 years prior to the month in which they apply for Part A. Purchasers of Part A must be enrolled in Part B, thus all immigrants who exercise this purchasing option are required to meet the 5-year residency requirement for both Parts A and B. In 1997, the number of individuals paying Hospital Insurance (Part A) Premiums totaled 352,000, which is less than 1 percent of the total number of Medicare Part A enrollees in that year. In 1994, the number of individuals opting to buy-in to Medicare Part A was 301,000. Because of the way this data was gathered and maintained, it is not possible to determine the number or percentage of immigrants included in these totals.

Other than this residency requirement, Medicare does not have any special eligibility requirements for non-citizens or non-residents. Any individual residing in the United States may enroll in Medicare if s/he meets the enrollment requirements related primarily to age and contributions (managed by the Social Security Administration), or may purchase it if contributions are not sufficient. In addition, since immigrants are younger than the general population and generally attached to the workforce, new immigrants represent a positive contribution to the Medicare Trust Funds and help support the system.

## Appendix A: Additional Information on SAMHSA Programs

### Federal Refugee Mental Health Program

The Office of Refugee Resettlement (ORR), Administration for Children and Families (ACF), has an intra-agency agreement (IAG) with the Refugee Mental Health Program (RMHP), Special Programs Development Branch (SPDB), Division of Program Development, Special Populations, Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA). The purpose of the IAG is to provide refugee mental health consultation, advice, and guidance to the refugee resettlement network and to serve as the focal point in the Federal government on mental health issues and services for refugees and torture survivors. RMHP activities include:

- Providing technical assistance and consultation on mental health and social adjustment issues to resettlement agencies and community-based organizations that are trying to establish and/or expand mental health services or collaborate with local professionals to respond to mental health needs of refugees;
- Providing consultation to ORR staff on refugee mental health program development, with particular emphasis on new program initiatives;
- Educating and providing consultation to public and private mental health clinics and programs about mental health needs and social adjustment issues of refugees, identification and management of severe mental illness in refugees, and variables involved in prevention of various behavioral problems or psychiatric disorders;
- Conducting regional workgroup meetings, conferences, and symposia on special refugee populations, including newly arrived refugee groups, or special mental health and social adjustment issues, including but not limited to issues of violence, torture, and trauma;
- Identifying refugee mental health materials, programs and expertise available nationally and maintaining an up-to-date, retrievable collection of these resources;
- Providing technical assistance and consultation in the area of refugee mental health to scientists and health professionals within SAMHSA and on behalf of SAMHSA to other agencies; and
- Responding to refugee emergencies or special initiatives during national crises (upon the special request of other Federal programs or agencies).

### Substance Abuse Prevention and Treatment (SAPT) Block Grant (Formula Grant)

The SAPT Block Grant provides financial assistance to States and Territories to support projects for the development and implementation of prevention activities and treatment services directed to the diseases of alcohol abuse, alcoholism, drug abuse, and drug addiction. Funds may be used at the discretion of the Single State Authority for substance abuse prevention and treatment to achieve the statutory objectives, including the fulfillment of certain requirements. Not less than 20 percent of the funds shall be spent for programs for individuals who do not require treatment for substance abuse, to educate and counsel such individuals and to provide for activities to reduce the risk of abuse by developing community-based strategies for prevention of such abuse, including the use of alcoholic beverages and tobacco products by individuals to whom it is unlawful to sell or distribute such beverages or products. In FY 1993, States were required to expend not less than 5 percent of the grant to increase (relative to FY 1992) the availability of treatment services designed for pregnant women and women with dependent children (either by establishing new programs or expanding the capacity of existing programs). A similar requirement existed for FY 1994 relative to FY 1993 levels. For FY 1995 and subsequent fiscal years, States are required to expend an amount equal to the amount expended for FY 1994 (See 42 U.S.C. 300x-22(c)). States must require programs of treatment for intravenous drug abuse to admit individuals into treatment within 14 days after they make such a request, or 120 days of a request, if interim services are made available within 48 hours. States must require any entity receiving block grant funds to routinely make available, directly or

through arrangements with other public or nonprofit entities, tuberculosis services such as counseling, testing, treatment, and States with an AIDS case rate of 10 or more such cases per 100,000 individuals (“designated States”) must carry out 1 or more projects to make available early intervention services for substance abusers at risk for the human immunodeficiency virus (HIV) disease (See 42 U.S.C. 300x-24(b)). Other statutory requirements also apply. The formula grant accounts for approximately 47 percent of all public funds made available by States and territories to more than 7,000 subrecipients, e.g., managed behavioral healthcare organizations, regional and county authorities, local governments, and community based organizations, to support the delivery of treatment services to individuals and families impacted by substance abuse. It provides the majority of funding in 26 states and 5 other jurisdictions. Additional information regarding the SAPT Block Grant program is available on CSAT’s Treatment Improvement Exchange (TIE) web site (<http://www.treatment.org>) or via the SAMHSA home page (<http://www.samhsa.gov/csat>).

### **Community Mental Health Services Block Grant**

The Community Mental Health Services Block Grant provides financial assistance to States and Territories to enable them to carry out the State's plan for providing comprehensive community-based mental health services to adults with a serious mental illness and to children with a serious emotional disturbance; to evaluate programs and services carried out under the plan; and to conduct planning, administration and educational activities related to providing services under the plan.

The States in developing their mental health plans, which are an integral component of the application process, must address the 12 criteria of community mental health systems that are required in the law. States are given considerable flexibility in the use of the funds; however, the funds should be used to implement activities described in the mental health plan and may not be used to provide inpatient services; to make cash payments to intended recipients of health services; to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment; to satisfy any requirement for the expenditure of nonfederal funds as a condition for the receipt of Federal funds; or to provide financial assistance to any entity other than a public or nonprofit private entity. States are permitted to use up to 5 percent of grant funds for administrative costs related to administering the funds.

In order to ensure that Federal funds are not supplanted, States must demonstrate that they are maintaining their State expenditures for community based mental health services at the same level as the average for the previous 2 years and must maintain State expenditures for the integrated services system for children with serious emotional disturbances at not less than the FY 1994 base amount. In general, any amount paid to a State under the program shall be available for obligation until the end of the fiscal year for which the amounts were paid, and if obligated by the end of such year, shall remain available for expenditure until the end of the succeeding fiscal year.

Community involvement in the State’s planning process is another significant component of the Mental Health Block Grant. The law requires that each State have a mental health planning council that is made up of State residents that are interested in or involved in the mental health system including providers, advocates, consumers of services, or family members of consumers. The mental health planning council duties include reviewing and commenting on each State’s plan for mental health services, advocating for persons with serious mental illness and serious emotional disturbance, and monitoring and evaluating the adequacy of mental health services in the State.

## **Comprehensive Community Mental Health Services for Children and their Families Program**

The Comprehensive Community Mental Health Services for Children and Their Families Program was authorized in 1992 in the ADAMHA Reorganization Act to provide grants to States, political subdivisions of States, Indian tribes, and tribal organizations for the provision of an array of community-based services organized into a system of care for children with serious emotional, behavioral, or mental disorders and their families. Funded initially at a level of \$4.9 million in FY 1993, the appropriation was increased in FY 1994 to \$35 million and to \$60 million in FY 1995 and FY 1996, \$70 million in FY 1997, \$73 million in FY 1998, \$78 million in FY 1999, and has been increased to \$83 million in FY 2000. The purpose of the program is to plan, develop, and implement systems of care that are comprehensive, community-based, coordinated, family-focused, and culturally competent.

The individuals served by these systems of care are persons from birth to age 21, who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within DSM-IV, that resulted in a functional disturbance. Approximately 14 to 20 percent (8 to 13 million) of all American children experience mental and emotional disturbances. Included in this group are approximately 3.5 million youngsters (5 percent of the child and adolescent population) who have serious emotional disturbances.

The Comprehensive Community Mental Health Services for Children and Their Families Program has funded 65 grants since 1993. Twenty-two grants have completed their 5-year funding cycle, and 43 currently funded grants are in the early or middle stages of development. An ongoing comprehensive evaluation of the program indicates that over 42,000 children and their families have been served. Outcome findings show notable improvements for children after 1 year in services such as: (1) ***Law Enforcement Contacts Reduced*** -- No law enforcement contacts were reported for 43 percent of the children who had one or more contacts in the 12 months before entering services; (2) ***School Grades Improved*** -- The percentage of children with average or above average school grades increased by 20 percent; (3) ***Fewer School Absences*** -- The percentage of children attending school very infrequently (1-25 percent of the time) decreased by 38 percent; and (4) ***Mental Health Improved*** -- A reliable positive change in behaviors as assessed by clinicians was observed among 36 percent of the children.

## **Protection and Advocacy for Individuals with Mental Illness (PAIMI) Program**

The Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act of 1986 (42 U.S.C. 10801 et seq.) authorized formula grant awards to protection and advocacy (P&A) systems designated by the Governors of each State and five Territories, and the Mayor of the District of Columbia. The awards are used by the State P&A systems to protect and advocate on behalf of individuals with mental illness who are abused and/or neglected, or at risk for abuse/neglect or other civil rights violations while in care or in treatment at a public or private residential facility. To ensure enforcement of the Constitutional and statutory rights (Federal and State) of individuals with mental illness, State P&A systems are empowered to pursue a variety of intervention strategies, such as administrative, systemic, legal, etc., to redress complaints of abuse, neglect, and rights violations and to protect and advocate the rights of individuals with mental illness.

Under the PAIMI Act, State P&A systems are authorized to (1) investigate suspected incidents of abuse or neglect or other violations of rights of individuals with mental illness; (2) gain access to the records of individuals with mental illness; and (3) access public and private facilities that provide care or treatment to these individuals when investigating allegations of abuse or neglect. The systems may also address issues that arise when the individual with mental illness is transported to, admitted to, or discharged from (90 days post-discharge limitation) a residential care or treatment facility. The eligibility criteria for PAIMI program services are as follows: an individual who has a significant mental illness or emotional impairment, as determined by a mental health professional qualified under the laws and regulations of the State; and who is an inpatient or resident in a facility rendering care or treatment; who is being admitted to/transported from a facility; or who is involuntarily confined in a municipal detention center for reasons other than serving a sentence from conviction for a criminal offense. Pursuant to the PAIMI Act, facilities may be public or

private, include hospitals, nursing homes, group or foster home, semi-independent or supervised housing, juvenile detention centers, homeless shelters, jails and prisons.

Each State P&A system is administered by either a multi-member governing authority or a board of directors comprising members who broadly represent and are knowledgeable of State mental health consumer needs and issues. The PAIMI Act mandates that each State P&A system establish an advisory council, comprised of at least 60 percent recipients or former recipients of mental health services or their family members, to advise the governing authority/board on policies and priorities to be carried out in protecting and advocating the rights of individuals with mental illness.

### **Knowledge Development and Application Program (Discretionary)**

In FY 1996, the Center for Substance Abuse Treatment (CSAT) amended its discretionary grant portfolio and implemented the Knowledge Development and Application (KD&A) Program. The KD&A Program is designed to increase efficiency and effectiveness of substance abuse treatment services throughout the nation. The Knowledge Development (KD) programs, e.g., the Marijuana Treatment Program and the Wrap Around Services Impact Study (WASIS), utilize the findings of the health services research projects funded by the National Institutes of Health (NIAAA, NIDA) to replicate the interventions introduced in a controlled environment and determine if such interventions can produce similar results in a variety of clinical settings. The Knowledge Application (KA) programs, e.g., the Addiction Technology Transfer Center (<http://www.nattc.org>), the National Leadership Institute (<http://www.nli4cbos.org>), and the Knowledge Application Program, facilitate the exchange of exemplary practice information and prepare treatment providers to adopt exemplary practices that have been replicated in the field. Additional information regarding the SAMHSA/CSAT Knowledge Development and Application Programs, e.g., copies of the Guidance for Applicants and the Knowledge Development (KD) grantees is available on the SAMHSA home page (<http://www.samhsa.gov>).

### **KD&A Program Summary (FY 1996 and FY 1997)**

Cooperative Agreement for a Multisite Study of the Effectiveness of Brief Treatment for Cannabis (Marijuana) Dependency TI 96-02 (Short title: Cannabis Dependence Treatment). The Marijuana Treatment Project (MTP) is comparing two experimental groups (Brief Treatment Group vs. Extended Treatment Group) and a control group (Delayed Treatment Control Group). The MTP recruited 450 participants (68 percent male, 32 percent female, mean age 36 years) and conducted follow-up evaluations at 4-, 9-, and 15-months post-treatment. Post-treatment follow-up rates among participants were greater than 80 percent at the three post-treatment intervals. The MTP preliminary data indicate that chronic marijuana smokers will participate in marijuana-specific treatment and will respond to treatment—the study found significant reductions in days of use after treatment.

Cooperative Agreement for Wrap-Around Services for Clients in Non-Residential Substance Abuse Treatment Programs; Evaluating Utility and Cost-Effectiveness in the Context of Changes in Health Care Financing TI 96-03 (Short title: Wrap-Around Service). The Wrap-Around Services Impact Study (WASIS) is examining the impact of treatment retention and outcome when substance abuse treatment services are augmented with an array of wrap-around services, e.g., transportation, childcare, housing, medical care, advisory legal services, educational/vocational opportunities, etc. The study involves 11 Single County Authorities, 41 service delivery units, and more than 2,000 service recipients in rural and western Pennsylvania. Preliminary WASIS findings confirm that an enriched treatment experience (Table 1-E Model for Comprehensive Alcohol and Other Drug Treatment, CSAT Technical Assistance Publication No. 11, *Treatment for Alcohol and Other Drug Abuse: Opportunities for Coordination*) contributes to retention in treatment and a reduction in substance use among services recipients. For example, the provision of child care, transportation, educational opportunities, and housing contribute independently to retention in treatment ( $p < .03$ ), and the provision of basic needs (e.g., food, clothing) and transportation contributes independently to reduced substance use.

Cooperative Agreements for Managed Care and Adolescents TI 97-001 (Short Title: Adolescent Managed Care). This is a re-issuance of a previous Guidance for Applicants (GFA) TI 96-01 that focused on managed care for adults who are substance abusers, individuals with severe mental illness, and categorically-eligible women and children. The previous GFA, Cooperative Agreements for Managed Care and Vulnerable Populations, was co-sponsored by the three SAMHSA Centers (CSAT, the Center for Mental Health Services, and the Center for Substance Abuse Prevention). This announcement is sponsored by CSAT only and includes adolescent substance abusers who, in addition, may be involved with the juvenile justice system and/or may be receiving services in the mental health system.

The previous GFA funded 15 Study Sites and a Coordinating Center. Applications for this GFA shall be for Study Sites and a Coordinating Center. The existing Coordinating Center, Human Services Research Institute (HSRI) in Cambridge, Massachusetts, has been selected to apply for a single-source award as the Coordinating Center for this Adolescent Managed Care Knowledge Development and Application (KDA) study. Since HSRI is the Coordinating Center for the existing managed care Study Site cooperative agreements, they are in a unique position to integrate these new adolescent cooperative agreements into the ongoing initiative.

In this GFA, a collaborative, multi-site study approach will be used to evaluate the effects of different models of managed care on publicly-funded adolescents with substance abuse problems. The cooperative agreement mechanism is being used because the complexity of the program requires substantial programmatic involvement of CSAT staff to facilitate communication and coordination across projects.

Cooperative Agreements for a Multi-Site Study of the Effectiveness of Treatment for Cannabis (Marijuana) Dependent Youth TI 97-002 (Short Title: Cannabis Youth Treatments). The purpose of this program is to compare the effectiveness of a variety of interventions and treatments for adolescents (ages 12-18) meeting the criteria for cannabis dependence as currently defined by DSM-IV. It is likely that while some young people will seek treatment on their own, others will do so only under pressure from parents, schools or other agencies (e.g., juvenile justice agencies). The purpose of this program is twofold: (1) to test the relative effectiveness and cost effectiveness of a variety of interventions targeted at reducing/eliminating marijuana abuse and dependency in adolescents; and (2) to provide validated models of these interventions to the treatment field.

CSAT's Cannabis Youth Treatment (CYT) project (<http://www.chestnut.org/li/cyt>) is the largest randomized experiment ever undertaken of adolescent treatment. The CYT project has already made significant advances by developing five treatment manuals for use in clinical practice. The project has screened 1,000 adolescents, and 606 adolescents (61 percent) met the inclusion criteria. Of the 606 adolescents who met the inclusion criteria, 500 adolescents (83 percent of the screened eligibles) were recruited and randomized, and more than 70 percent of the adolescents met the criteria for completing treatment. Post-treatment client and collateral follow-up, as reported by clients and confirmed by client urinalysis and collateral interviews, is being conducted at 3-, 6-, 9-, and 12 months. The project will make comparisons of five promising approaches as well as cost and cost-effectiveness estimates for the five treatment interventions. The CYT project is being conducted by Chestnut Health Systems, Inc., Bloomington, Illinois; Operation PAR, Inc., St. Petersburg, Florida; Child Guidance Center, Children's Hospital of Philadelphia, Pennsylvania; and the University of Connecticut Health Center, Farmington, Connecticut. During the past 3 years, CSAT has funded more adolescent treatment studies than were found in the entire research literature prior to 1997.

Cooperative Agreements on Criminal Justice Diversion Interventions for Individuals with Co-occurring Mental Illness and Substance Abuse Disorders SM 97-006 (Short Title: Criminal Justice Diversion Program). This program addresses a services priority: diversion of individuals with co-occurring severe mental illness and substance abuse disorders from the criminal justice system to community treatment alternatives. It seeks to provide an empirical basis for understanding the effectiveness of pre-booking and post-booking models of criminal justice diversion in improving selected outcomes for individuals with co-occurring disorders who are alleged to have been involved in criminal activity. The primary outcomes to

be assessed include but are not limited to: criminal recidivism, time incarcerated, psychiatric hospitalization, psychiatric status, functional status, continuity of participation in treatment, homelessness, emergency treatment utilization, and frequency of substance abuse.

Grantees participating in the program, upon approval of the final evaluation plan, will study the differences in these outcomes for individuals with criminal justice encounters adjudicated without diversion and those diverted to community treatment programs in lieu of jail. In addition, a coordinated, multi-site evaluation will be used to test the relative effectiveness of different diversion models and to synthesize the intervention results at the Federal program level. In this way, the study addresses both intra-site effectiveness at the individual client level and relative effectiveness across program models. Because of the complexity of the program, requiring substantial programmatic involvement of Federal staff to facilitate communication and coordination across projects, the cooperative agreement mechanism was used.

## Appendix B: Additional Information on HRSA Programs

### Primary Health Care Programs

- **Community and Migrant Health Centers**

Community and Migrant Health Centers (C/MHCs) provide culturally sensitive, family-oriented preventive and primary health care services. They also provide essential ancillary services such as dental, laboratory test, X-ray, and pharmacy services. In addition, many centers provide other health and community services such as transportation, translation, nutrition, and health education. Health center services are tailored to meet the specific needs of the communities they serve, including the needs of special population groups, such as migrant farmworkers and individuals who are homeless.

- **Health Care for the Homeless**

The Health Care for the Homeless (HCH) Program emphasizes a multi-disciplinary approach to delivering care to homeless persons, combining aggressive street outreach with integrated systems of primary care, mental health and substance abuse services, case management, and client advocacy. Emphasis is placed on coordinating efforts with other community health providers and social service agencies.

- **Health Services for Residents of Public Housing**

The mission of the Public Housing Primary Care (PHPC) Program is to provide residents of public housing with increased access to comprehensive primary health care services through the direct provision of health promotion and disease prevention activities and primary health care services on the premises of public housing developments, or at least other locations immediately accessible to residents of public housing.

- **Healthy Schools, Healthy Communities Program**

The Healthy Schools, Healthy Communities (HSHC) Program provides comprehensive primary care and preventive health care services including ancillary and enabling services. These services are culturally sensitive, appropriate, family-oriented and tailored to meet the specific needs of the community and youth served.

- **National Hansen's Disease Program**

The National Hansen's Disease Program (NHDP) offers health care to Hansen's Disease (HD) patients at Carville, Louisiana, at other contract supported locations in the Baton Rouge area, and in grant supported outpatient regional clinics. The NHDP also coordinates with local health agencies, Medicare and Medicaid agencies to assure care for HD patients.

Approximately 700 center grantees with over 3,000 sites across the United States and its territories provide primary health care for 8.3 million underserved persons. For FY 1997, the Community Health Center program, which includes funding for Migrant Health Centers, Health Care for the Homeless, Health Services for Residents of Public Housing programs, and Healthy Schools, Healthy Communities, was appropriated \$802 million.

Of the \$802 million appropriated in FY 1997, the MHC program was appropriated \$68.6 million and provided services to over 550,000 migrant and seasonal farmworkers and their families. The HCH program (which includes funding for the HSHC Program) was appropriated \$69.3 million and provided services to nearly 438,000 clients. The PHPC Program was appropriated \$9.8 million and served more than 44,000 clients. The NHDP was appropriated \$17.1 million in FY 1997 and provided services to 125 residents and over 3,000 ambulatory patients.

## **Maternal and Child Health Block Grant**

The Maternal and Child Health (MCH) Block Grant program is a Federal/State partnership program designed to improve the health of mothers, children and adolescents. The populations served by these grants are primarily low income, uninsured, disadvantaged mothers and infant children. States use block grant funds to provide preventive and primary health care to pregnant and postpartum women and to infants, children, and adolescents, as well as specialized services to children with special health care needs. States also use the funds to support initiatives that address State- and community-specific needs, public health screening, assessment, health education, and disease prevention.

In FY 1995, the program provided health services for approximately 16,973,487 women, infants, children, children with special health care needs, and others (Maternal and Child Health Bureau Report, 1994-1995, p. A-16). Additionally, the figures for FY 1996 and FY 1997 show that 18,768,852 and 24,014,719 people, respectively, were served by the MCH Block Grant Program (MCHB Report, 1996, p. A-10, and the Title V Information System, respectively).

A special set-aside of the Block Grant funds special projects of regional and national significance (SPRANS) by providing support for research in such areas as genetic diseases and hemophilia and training for providers of such services. In FY 1995, the MCH Block Grant Program was appropriated \$683.9 million, and of this amount, \$101 million was set aside for SPRANS projects. Respectively, the MCH Block Grant appropriations were \$678.2 million and \$681.0 million for FYs 1996 and 1997.

The Community Integrated Service Systems grants made through the MCH Block Grant help to build healthy homes for mothers and children. Rooted in the communities they serve, integrated service systems reach out to families in need and provide a range of services in ways that accommodate their clients' culture and living circumstances.

The Traumatic Brain Injury (TBI) program, also funded with MCH Block Grant set-aside funds, supports activities by States that implement Statewide systems that ensure access to comprehensive and coordinated TBI services.

During FYs 1995-97, the Healthy Start Program supported interventions aimed at decreasing contributing factors to infant mortality rates in more than 22 communities with infant mortality rates at least 1.5 times the national average. Each Healthy Start site creates its own menu of services, but most include outreach to women and families at high risk for premature birth and premature death, coordination and case-by-case management of services to women and their infants, family education, and services for fathers. The Healthy Start Program was appropriated \$104.2 million for FY 1995, \$92.8 million for FY 1996, and \$95.9 million for FY 1997.

The Emergency Medical Services for Children program aims to enhance and expand delivery of emergency medical services to acutely ill and seriously injured children. The goal of the program is to reduce child and youth mortality and morbidity sustained as a result of severe acute illness or trauma. The EMSC Program was appropriated \$9.9 million for FY 1995, \$10.8 million for FY 1996, and \$12.5 million for FY 1997.

## **Ryan White Comprehensive AIDS Resources Emergency (CARE) Act Programs**

Part A (Title I) of the CARE Act authorizes grants for outpatient and ambulatory health and support services to Eligible Metropolitan Areas (EMAs) with a cumulative total of more than 2,000 cases of AIDS for the most recent 5-year period. These grants fund systems of community-based care composed of approximately 25 categories of medical and other health and social support services for individuals with HIV in EMAs. These services are intended primarily for low income/underinsured people living with HIV/AIDS.

Part B of the CARE Act provides grants to States and territories for the provision of more than 25 types of medical and other health and social support services delivered primarily through regional HIV service delivery consortia for individuals with HIV, the provision of home and community-based case, support for State AIDS Drug Assistance Programs and for Health Insurance Continuation Programs for low-income persons with HIV disease.

Part C of the CARE Act provides funding to outpatient, primary care service providers for HIV early intervention services that are not otherwise reimbursable. Early intervention services aimed at preventing and/or reducing HIV-related morbidity are emphasized by these programs as part of the program of comprehensive care. Early intervention consists of the medical, educational, and psychological services designed to prevent the further spread of HIV, forestall the onset of illness, facilitate access to services, and to provide psychosocial support to HIV-infected individuals and their families.

The purpose of Part D of the CARE Act is to improve and expand the primary care and support services for children, youth, women and families in order to increase access to comprehensive, coordinated, community-based family-centered systems of care.

In FY 1995, \$356.5 million was appropriated for the Title I program; \$198.1 million for Title II, \$52.3 million for Title III; and \$26 million for Title IV.

In FY 1996, \$391.7 million was appropriated for the Title I program; \$260.8 million for Title II, \$56.9 million for Title III; and \$29 million for Title IV.

In FY 1997, \$449.9 million was appropriated for the Title I program; \$416.9 million for Title II, \$69.6 million for Title III; and \$36 million for Title IV.

## Social Security Retirement, Survivors, and Disability Insurance (RSDI)

### Program Summary

The RSDI program is designed to partially replace the income that is lost by a worker and/or his or her family when the worker retires in old age, becomes severely disabled before retirement age, or dies. About 97 percent of the jobs in paid employment and all self-employment are covered under Social Security.

### Impact of Immigration on RSDI Program

The RSDI program generally treats aliens the same as U.S. citizens. There are two exceptions, as follows:

- Under the alien nonpayment provision, a beneficiary who is not a citizen or national of the United States and has been outside the United States for 6 consecutive calendar months may not be paid benefits beginning with the seventh month of absence. Benefits resume when the beneficiary returns to the United States and remains for 1 full calendar month. Certain exceptions in the law to this general rule allow many aliens to receive their benefits outside the United States without interruption. These exceptions are based, for the most part, on the citizenship of the individual.
- Entitled aliens who are deported for certain reasons under the INA may not be paid benefits. Benefits may again be payable if the deported alien is subsequently admitted for permanent residence by the INS.

**Table 4-4 — Aliens Not Paid RSDI Benefits Under Nonpayment Provisions, By Selected Month**

Month	Nonpayment After 6-Month Absence	Nonpayment Due to Deportation
March 1992	13,103	762
March 1995	16,689	951
March 1998	18,613	950
March 1999	18,581	956
August 1999	18,943	960

Note: Figures are not available for 1993 or 1994.

Some aliens enter the United States illegally. Others enter legally but lose their status because they remain in the United States beyond the period of their authorized stay. Many of these aliens work in the United States long enough to become insured for RSDI benefits.

For claims filed before December 1, 1996, individuals in the United States meeting RSDI eligibility requirements are paid benefits without regard to citizenship or alien status. However, effective with applications filed December 1, 1996, or later, an alien must be lawfully present in the United States, as defined by the Attorney General, to receive RSDI benefits in the United States.

**Table 4-5 — Number of Aliens Affected by the Lawful Presence Provisions,  
By Selected Month**

<b>Category of Aliens Affected by Lawful Presence Provision</b>	<b>August 1997</b>	<b>November 1998</b>	<b>October 1999</b>
LAPR aliens and other aliens not needing reverification of lawful presence	13,654	27,584	37,475
Aliens needing reverification of lawful presence in the United States	1,060	2,187	3,356
<b>Subtotal: Lawfully present aliens</b>	<b>14,714</b>	<b>29,771</b>	<b>40,831</b>
Aliens in the United States who are not lawfully present and whose benefits are suspended	732	782	1,146
Aliens who have failed to cooperate in providing evidence of lawful presence in the United States and whose benefits are suspended	908	711	928
<b>Subtotal: Aliens suspended due to failure to meet lawful presence requirements</b>	<b>1,640</b>	<b>1,493</b>	<b>2,074</b>

**Enumeration Process (Issuing Social Security Numbers)**

**Program Summary**

The nine-digit Social Security number (SSN) was originally intended only to keep track of the earnings of people who worked in jobs covered under the Social Security program. By the early 1970's the use of the number expanded as the government and private sector increasingly used it as a multipurpose identifier. Because of the risk of fraud and widespread use of the SSN and the SSN card, Congress enacted legislation requiring all applicants for SSNs to provide evidence to establish age, identity, and citizenship or alien status.

An individual, whether citizen or alien, needs an SSN to obtain a job, pay taxes, or receive benefits under many government benefit programs. SSA issues SSN cards to those aliens admitted for permanent residence and to some admitted on a temporary basis, with or without work authorization.

Aliens, like all applicants, must meet certain requirements to obtain SSNs. In addition to providing evidence of age, identity, and alien status, applicants age 18 and older applying for original SSN cards must appear for a personal interview. Lawful aliens who want SSN cards for work purposes must prove they are authorized to work, usually by showing their INS documents. SSA issues unrestricted SSN cards to permanent resident aliens and refugees. In September 1992, SSA began issuing SSN cards with the legend "VALID FOR WORK ONLY WITH INS AUTHORIZATION" to aliens lawfully admitted to the United States with temporary work authorization. SSA issues SSN cards with the legend "NOT VALID FOR EMPLOYMENT" to lawful aliens not authorized to work who need an SSN for non-work purposes (for example, to obtain a driver's license in a State that requires an SSN for that purpose). In February 1996, SSA began defining a valid non-work reason as a Federal, State, or local statute or regulation that requires the individual to provide an SSN to obtain the benefit or service. SSA issues SSN cards to illegal aliens only when they will be paid benefits under a program financed in whole or in part from Federal funds. They receive cards annotated "NOT VALID FOR EMPLOYMENT."

### Impact of Immigration on SSN Issuance

Each year, SSA issues millions of original and replacement SSN cards. About one-fourth of the original cards and about 7 percent of the replacement cards are issued to aliens. The majority of the cards go to aliens who are authorized to work, as described above. The totals for FYs 1992 through 1996 are shown in Table 4-6.

Table 4-6 — Original and Replacement SSN Cards Issued: FYs 1992-1996

Year	Total Issued	Total Issued to Aliens	Percent of Total Cards Issued Which Were Issued to Aliens	Percent of Cards Issued to Aliens Who Were Work Authorized
<b>Original SSN Cards</b>				
1992	7 million	1.6 million	23	74
1993	6.2 million	1.5 million	24	73
1994	6 million	1.4 million	23	62
1995	6 million	1.5 million	25	63
1996	5.7 million	1.3 million	23	76
<b>Replacement SSN Cards</b>				
1992	10.7 million	0.765 million	7	91
1993	10.7 million	0.800 million	7	92
1994	10.4 million	0.790 million	8	93
1995	11.2 million	0.795 million	7	91
1996	10.9 million	0.774 million	7	95

### Supplemental Security Income (SSI)

#### Program Summary

The SSI program provides cash assistance directly to aged, blind, and disabled persons to help bring their income up to a Federally established minimum level. SSA administers SSI payments nationwide. Eligibility has been limited to individuals (and their eligible spouses) who are age 65 and over, blind, or disabled; are U.S. citizens or certain aliens; and whose countable income and resources fall below Federally established levels.

SSI operates as a program of last resort. Applicants are required to apply for all other benefits for which they may be eligible before evaluation for SSI eligibility. The SSI program then provides monthly payments to make up the difference between countable income and the minimum income floor established by statute. The minimum income in calendar year 1998 was \$494 a month for individuals and \$741 a month for individuals with an eligible spouse.

There is a close relationship between the SSI program and the Medicaid Program. In all but 18 States, the application for SSI is also an application for Medicaid. Seven States and the Commonwealth of the Northern Mariana Islands use the SSI eligibility criteria to determine Medicaid eligibility but require a separate application for Medicaid. Finally, 11 States use at least 1 Medicaid eligibility criterion that is more restrictive than the SSI program.

#### Eligibility of Various Categories of Aliens in the SSI Program

Prior to August 22, 1996, to be eligible for SSI benefits, an individual had to be a U.S. citizen or national, an alien lawfully admitted for permanent residence, or an alien who was a permanent resident under color of law (PRUCOL).

Legislation enacted on August 22, 1996 (and subsequently amended), eliminated the PRUCOL category for almost all aliens. Under current law, to be SSI-eligible an alien must be in a “qualified” status and meet one of the exceptions to the general bar on eligibility that applies to qualified aliens.

Qualified aliens include: Lawfully admitted permanent residents (LAPRs); refugees admitted to the United States pursuant to section 207 of the INA; asylees pursuant to section 208 of the INA; parolees under section 212(d)(5) of the INA for a period of at least 1 year; an alien whose deportation has been withheld under section 243(h) of the INA as in effect prior to April 1, 1997, or whose removal has been withheld under section 241(b)(3); an alien granted conditional entry pursuant to section 203(a)(7) of the INA as in effect prior to April 1, 1980; Cuban and Haitian entrants as defined in section 501(e) of the Refugee Education and Assistance Act of 1980; and certain aliens who have been battered or subjected to extreme cruelty or whose children or parents have been so treated.

Exceptions that permit qualified aliens to receive SSI include (but are not limited to): LAPRs who can be credited with 40 qualifying quarters of work, qualified aliens with U.S. military active duty or veteran status, and qualified aliens who were lawfully residing in the United States on August 22, 1996, and are blind or disabled. In addition, nonqualified aliens who were receiving SSI on August 22, 1996, may remain eligible as long as the PRUCOL status and all other SSI eligibility criteria are met.

### Program Size

Table 4-7 shows the Federal funds for 1992-1998; the total number of recipients (citizens and aliens) of SSI program benefits in December of each year; and, in addition to Federal funds, State supplementation paid to SSI recipients.

**Table 4-7 — Size of Total SSI Program, 1992-1998**

Month	Persons Served (millions)		
December 1992	5.6		
December 1993	6.0		
December 1994	6.3		
December 1995	6.5		
December 1996	6.6		
December 1997	6.5		
December 1998	6.6		
		Other Resources Available to Program (billions)	
Calendar Year	Federal Funds (thousands)	Federally Administered	State Administered
1992	\$18,246,934	\$3.4	\$0.6
1993	\$20,721,613	\$3.3	\$0.6
1994	\$22,175,233	\$3.1	\$0.6
1995	\$23,919,430	\$3.1	\$0.5
1996	\$25,264,878	\$3.0	\$0.6
1997	\$25,457,387	\$2.9	\$0.8
1998	\$26,404,793	\$3.0	\$0.8

Note: Program data cover all U.S. citizens and aliens. The figures for 1992 through 1994 have been revised in light of new data from files produced in past years.

### **Number of Aliens in the SSI Population**

The number of aliens in the SSI population in December of each year from 1992 through 1998 is shown in Table 4-8.

**Table 4-8 — Aliens in the SSI Population, 1992-1998**

<b>Month</b>	<b>Aliens Receiving SSI Benefits</b>
December 1992	601,430
December 1993	683,150
December 1994	738,140
December 1995	785,410
December 1996	724,990
December 1997	650,830
December 1998	669,630

Note: The figures for 1992 through 1994 have been revised in light of new data from files produced in past years.

### **Impact of Immigration on the SSI Program**

Aliens made up 10 percent of the SSI recipients in December 1998.

## Alien Participation in the Food Stamp Program

### Abstract

The U.S. Department of Agriculture, through its Food and Nutrition Service (FNS), administers 15 domestic nutrition assistance programs. The Food Stamp Program (FSP) is the largest nutrition program, with explicit Federal statutory restrictions on the eligibility and participation of aliens. The National School Lunch and School Breakfast Programs condition eligibility for benefits on eligibility for a free public education.

Until the enactment and implementation of welfare reform, most immigrants admitted legally into the country were eligible to receive food stamps, provided that they met the other criteria for eligibility. Aliens eligible for benefits included legal permanent residents, refugees, asylees, and persons granted withholding of deportation. Aliens applying for food stamps had to provide acceptable documentation to verify that they were eligible aliens. Undocumented aliens have never been eligible to receive food stamp benefits.

P.L. 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), restricted the eligibility of aliens for food stamp benefits. Refugees, asylees, and persons granted withholding of deportation continued to be eligible for benefits for the first 5 years after arrival in the United States. However, legal permanent residents, the largest group of aliens who were eligible for food stamps, lost their eligibility immediately if they were not current participants in the Food Stamp Program or at their next re-certification unless they:

- were members of the armed services, veterans, or the spouse or dependent of a member of the armed services or a veteran;
- could demonstrate that they paid Social Security taxes for 40 quarters; or
- became U.S. citizens.

Even legal permanent resident aliens who met one of the exemption criteria were barred from participation in the Food Stamp Program for the first 5 years after arrival, unless they were originally admitted as refugees and later converted status.

P.L. 105-18, the Supplemental Appropriations Act for FY 1997, included authority for States to purchase food stamps from the Federal government to use for a State-funded food assistance program for legal immigrants.

P.L. 105-85, the Agricultural Research, Extension and Education Reform Act of 1998, was enacted in June 1998. This law restored eligibility to permanent resident aliens who were legally living in the United States at the time that PRWORA was enacted and who were either disabled, under age 18, or over 65 as of August 1996, when PRWORA was enacted. Additionally, the new law extended the exemption permitting food stamp eligibility of refugees, asylees, and persons granted withholding of deportation from 5 to 7 years.

On May 25, 1999, the Vice President announced new Immigration and Naturalization Service (INS) policy which clarified that receipt of nutrition assistance benefits provided by FNS does *not* make an immigrant a “public charge” – that immigrants would not be subject to deportation, denied entry into the United States, denied permanent residency, or denied citizenship because of receipt of food stamps, WIC benefits, free and reduced price school lunches, or other nutrition assistance provided by FNS.

In FY 1998, the most recent year of data on the citizenship status of FSP recipients, an estimated 1.03 million FSP recipients (5.3 percent of the caseload) were foreign-born, and of that, 616,000 were aliens (3.1 percent of the caseload). Immigrants (all foreign-born, including naturalized citizens and aliens) received 5 percent of FSP benefits; 3 percent of benefits were received by aliens.

U.S. Department of Agriculture  
Food and Nutrition Service  
Office of Analysis, Nutrition and Evaluation  
3101 Park Center Drive  
Alexandria, VA 22302

## Introduction

The U.S. Department of Agriculture (USDA) through its Food and Nutrition Service (FNS) administers 15 domestic nutrition assistance programs (Table 4-9). Four programs (the Food Stamp Program, the Nutrition Assistance Program for Puerto Rico, Pacific Island Assistance, and Food Distribution on Indian Reservations) help meet the basic needs of low-income families and individuals. The remaining programs provide supplemental benefits to groups with special needs, especially those at different developmental stages: infants, children, child-bearing women, and the elderly.

**Table 4-9 — Domestic Food Assistance Programs**

The Food Stamp Program
The Nutrition Assistance Program for Puerto Rico
The Food Distribution Program on Indian Reservations
The National School Lunch Program
The School Breakfast Program
The Summer Food Service Program
The Child and Adult Care Food Program
The Special Milk Program
Special Supplemental Food Program for Women, Infants and Children
Farmers Market Nutrition Program
Commodity Supplemental Food Program
The Emergency Food Assistance Program
Pacific Island Assistance
Commodities to Charitable Institutions and Summer Camps
Nutrition Program for the Elderly

The Food Stamp Program (FSP) is the cornerstone of domestic nutrition assistance, accounting for more than half of all dollars spent in FY 1998. It provides a monthly benefit to households and individuals with low income and few assets in the 50 States, the District of Columbia, Guam, and the Virgin Islands. The Nutrition Assistance Program for Puerto Rico, Pacific Island Assistance, and the Food Distribution Program on Indian Reservations serve a similar function in Puerto Rico, on the Trust Territories, and on Indian reservations, respectively. In FY 1998, food stamp recipients received \$16.9 billion in benefits. In an average month, 19.8 million people received food stamps.

The National School Lunch Program serves children in schools and residential institutions. It is available to 98 percent of public school children and more than 90 percent of all school children. The School Breakfast Program serves the same group but is less widely available. It is most frequently found in schools serving high proportions of lower income students. The Special Milk Program primarily serves children in schools not participating in other child nutrition programs. The Child and Adult Care Food Program serves children and functionally impaired or elderly adults cared for in day care centers, family day care homes, and adult day care programs. The Summer Food Service Program provides meals to school children in needy areas during school vacations.

The Special Supplemental Food Program for Women, Infants and Children, popularly known as the WIC Program, serves low-income infants, children and child-bearing women who are found to be at nutritional risk. WIC provides nutritious supplementary food, nutrition education, and referrals to health care services. The Commodity Supplemental Food Program serves essentially the same group, and in addition provides benefits to the elderly in certain areas.

The Emergency Food Assistance Program provides commodities for home consumption through food banks and other charitable institutions. Commodities for Charitable Institutions provides commodities to

soup kitchens and similar organizations to support meal service to needy recipients. The Nutrition Program for the Elderly supplements other programs for the elderly with cash and commodities for meals in senior citizen centers and similar settings.

Four programs (the Food Stamp Program; the National School Lunch Program; the Special Supplemental Food Program for Women, Infants and Children; and the Nutrition Assistance Program for Puerto Rico) paid out nearly \$30 billion in benefits to program participants in FY 1998, 89 percent of all food assistance benefits. FSP alone provided \$16.9 billion in benefits to participants, 56 percent of all food assistance benefits in FY 1998.

Among the domestic food assistance programs administered by USDA, FSP is by far the largest with explicit Federal statutory restrictions on the eligibility and participation of aliens. (The National School Lunch Program and the School Breakfast Program condition eligibility for benefits on eligibility for a free public education.) Moreover, FSP is the only program for which any data exist on participation by immigrants. Consequently, this discussion focuses exclusively on the extent of participation by aliens in FSP.

What follows is a brief description of FSP, eligible alien categories, a system for verifying eligible alien status, and the most recent data available on alien participation in FSP.

## **The Food Stamp Program**

### **Program Description**

FSP is a nationwide program which helps low-income families and individuals buy the food they need to maintain a nutritious diet. In an average month in FY 1998, about 19.8 million people received food stamp benefits at an annual cost of \$16.9 billion.

The Food Stamp Act of 1977, as amended, defines the group of people who comprise a household for food stamp purposes and sets uniform criteria for their eligibility. These include a gross and net income limit, a resource limit, and a variety of non-financial criteria.

To be eligible for food stamps, the gross monthly income of most households must be at or below 130 percent of the Federal poverty guidelines (\$21,720 annually for a family of four effective October 1, 1999) and net income – after allowable deductions – must be at or below 100 percent of the guidelines. Households with an elderly or disabled member are subject only to the net income test. Gross income includes all cash payments to the household with a few exceptions that include non-recurring lump sum payments and reimbursement of certain expenses. Deductions subtracted from the household's gross monthly income to determine its net income include: a standard deduction, an earned income deduction, a dependent care deduction, an excess shelter expense deduction, a special medical deduction (for elderly or disabled persons), and a child support deduction for court-ordered payments to another household.

The value of a household's assets (excluding a home, personal belongings, and certain vehicles) is also accounted for in determining program eligibility. Most households are permitted up to \$2,000 in countable resources. Households with at least one person age 60 years or older are allowed up to \$3,000.

People can qualify for benefits only as part of a "food stamp household." In general, a food stamp household may consist of an individual who lives alone or who lives with others but usually purchases and prepares food separately; or groups of individuals who live, purchase food, and prepare meals together.

FSP includes several provisions to encourage able-bodied participants to seek and hold jobs. With certain exceptions, physically and mentally fit food stamp participants must register for and accept suitable employment. Able-bodied participants without dependents must work at least half time or participate in a qualifying work training activity to be eligible for more than 3 months in a 3-year period.

The maximum amount of food stamps a household can receive is set according to 100 percent of the June cost of the Thrifty Food Plan (TFP) for a reference family of four, adjusted for household size. (TFP is the least costly food plan developed by the Center for Nutrition Policy and Promotion at USDA, which suggests the amounts of food that could be consumed by males and females of different ages to meet dietary standards.) The maximum allotments are revised periodically to reflect changes in the cost of foods included in the TFP. The food stamp benefit issued to each household is based on the number of people in the household and the amount of net income available after subtracting allowable deductions. Monthly benefits are equal to the maximum allotment for that household less 30 percent of its net income.

### **Eligibility of Aliens in the Food Stamp Program**

Under current regulations, an individual applying for food stamps who is not a citizen of the United States must provide acceptable documentation which verifies that he or she is an eligible alien (the exception is for those applying for disaster assistance benefits).

Prior to the enactment of P.L. 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), the following groups of aliens were considered "eligible aliens":

- those with the status of lawful permanent resident;
- those admitted as refugees;
- those granted asylum; and
- those for whom the Attorney General had withheld deportation.

PRWORA dramatically altered the eligibility of aliens for Federal means-tested programs, including the Food Stamp Program. Aliens legally in the United States became ineligible for food stamps unless they belonged to one of the groups described below:

- those admitted as refugees or asylees, or those who have had their deportation withheld within the last 5 years;
- active-duty military personnel, honorably discharged veterans, and their spouses and dependent children; or
- those with 40 or more quarters of earnings and no public assistance receipt.

Even legal permanent resident aliens who met one of the exemption criteria were barred from participation in the Food Stamp Program for the first 5 years after arrival, unless they were originally admitted as a refugee and later converted status.

PRWORA provided that those aliens receiving benefits as of August 22, 1996, were allowed to continue receiving benefits until the first of either their re-certification date or August 22, 1997. For new applicants, the alien restrictions generally became effective October 1, 1996. Section 510 of P.L. 104-208, the Department of Defense Appropriations Act of 1997, allowed aliens currently receiving benefits to continue on the caseload until the first re-certification after April 1, 1997 or until August 22, 1997.

These restrictions were modified somewhat by P.L. 105-185, the Agricultural Research, Extension, and Education Reform Act of 1998. This law restored eligibility to permanent resident aliens who were legally residing in the United States at the time that PRWORA was enacted and who are either disabled, under age 18, or over 65 as of August 1996, when PRWORA was enacted.

P.L. 105-18, the Supplemental Appropriations Act for FY 1997, included authority for States to purchase food stamps from the Federal Government to use for a State-funded food assistance program for legal immigrants.

On May 25, 1999, the Vice President announced new INS policy which clarified that receipt of nutrition assistance benefits provided by FNS does *not* make an immigrant a “public charge” – that immigrant would not be subject to deportation, denied entry into the United States, denied permanent residency, or denied citizenship because of receipt of food stamps, WIC benefits, free and reduced price school lunches, or other nutrition assistance provided by FNS.

### **Alien Verification in the Food Stamp Program**

The Immigration Reform and Control Act of 1986 (IRCA) established the Systematic Alien Verification for Entitlements (SAVE) program, a two-level verification system developed and maintained by the Immigration and Naturalization Service (INS). Between October 1, 1988, and August 22, 1996, agencies administering FSP were required to validate the documentation of an alien applicant's status by accessing the INS database or by submitting manual verification requests to INS. However, PRWORA made use of SAVE optional.

### **Alien Participation in the Food Stamp Program**

The most recent data available on the extent of participation by lawful aliens in FSP is based on data from the food stamp quality control system. The quality control system is an ongoing review of a sample of food stamp households to determine if they are eligible to participate and receive the correct benefit. FNS uses this sample -- consisting of approximately 51,000 participating households during the year -- to provide detailed information on the characteristics of participants, including alien status. Aliens are defined as all recipients who are not United States citizens; however, since undocumented aliens are not permitted to receive food stamps, almost all aliens are legal permanent residents, refugees, asylees, or those who have been granted withholding of deportation.

As shown in Table 4-10, aliens make up a relatively small proportion of the total food stamp caseload and receive a small fraction of the total benefits. In FY 1998, the most recent year that we have data on the citizenship status of participants, 616,000 aliens living in 351,000 households received food stamps. Non-citizens represented 3.1 percent of all food stamp recipients. They received 3.0 percent of all food stamp benefits in that year. The overwhelming majority of alien recipients were lawful permanent residents; other aliens represented only one-third of the alien caseload and only 1 percent of all food stamp recipients.

In 1998, for the first time, the number of naturalized citizen participants exceeded the number of permanent resident alien participants (409,000 versus 405,000). The total number of foreign-born persons receiving food stamps was 1 million, representing 5 percent of the caseload and 5 percent of benefits received.

In the general population, resident aliens predominately live in a small number of States (California, Texas, New York, and Florida). Consistent with this pattern, the quality control sample data suggest that alien participation in FSP is highly localized. In 1998, 157,000 alien recipients lived in California, 66,000 lived in Texas, 60,000 lived in New York, and 28,000 lived in Florida. These 4 States accounted for over 75 percent of all aliens receiving food stamps, and no other State had as many as 10,000 permanent resident aliens receiving food stamps. However, because the sample size used to estimate alien participation is relatively small, these estimates should be interpreted with care.

**Table 4-10— Citizenship Status of Food Stamp Recipients:  
FYs 1995-1998**

<b>Citizenship Type</b>	<b>FY 1995</b>	<b>FY 1996</b>	<b>FY 1997</b>	<b>FY 1998</b>
Native Born Citizen	24,508,000	23,428,000	21,158,000	18,704,000
Naturalized Citizen	244,000	277,000	367,000	409,000
Permanent Resident	1,451,000	1,463,000	1,023,000	405,000
Refugee	384,000	377,000	265,000	198,000
Other Alien	9,000	8,000	10,000	13,000
<b>Alien Subtotal</b>	<b>1,844,000</b>	<b>1,848,000</b>	<b>1,298,000</b>	<b>616,000</b>
<b>Foreign-born Subtotal</b>	<b>2,088,000</b>	<b>2,125,000</b>	<b>1,665,000</b>	<b>1,025,000</b>
<b>Total Caseload</b>	<b>26,955,000</b>	<b>25,926,000</b>	<b>23,117,000</b>	<b>19,969,000</b>

Notes: Figures are based on the Food Stamp Program Quality Control System (QC) full-year data for FYs 1995 through 1998. Because the QC data are based on a sample and are weighted by household size, the individual aggregate participation numbers may vary somewhat from administrative data on Food Stamp Program participation.

Because the citizenship status is unknown for some participants, numbers will not sum to their total.

Permanent residents include those coded as having obtained legal status through the Immigration Reform and Control Act's amnesty provisions.

Refugees include those granted asylum.

Other aliens may include aliens granted withholding of deportation, non-immigrants admitted for a specified period, Mexican citizens with border-crossing cards, undocumented aliens, and non-citizens whose exact status is unknown.

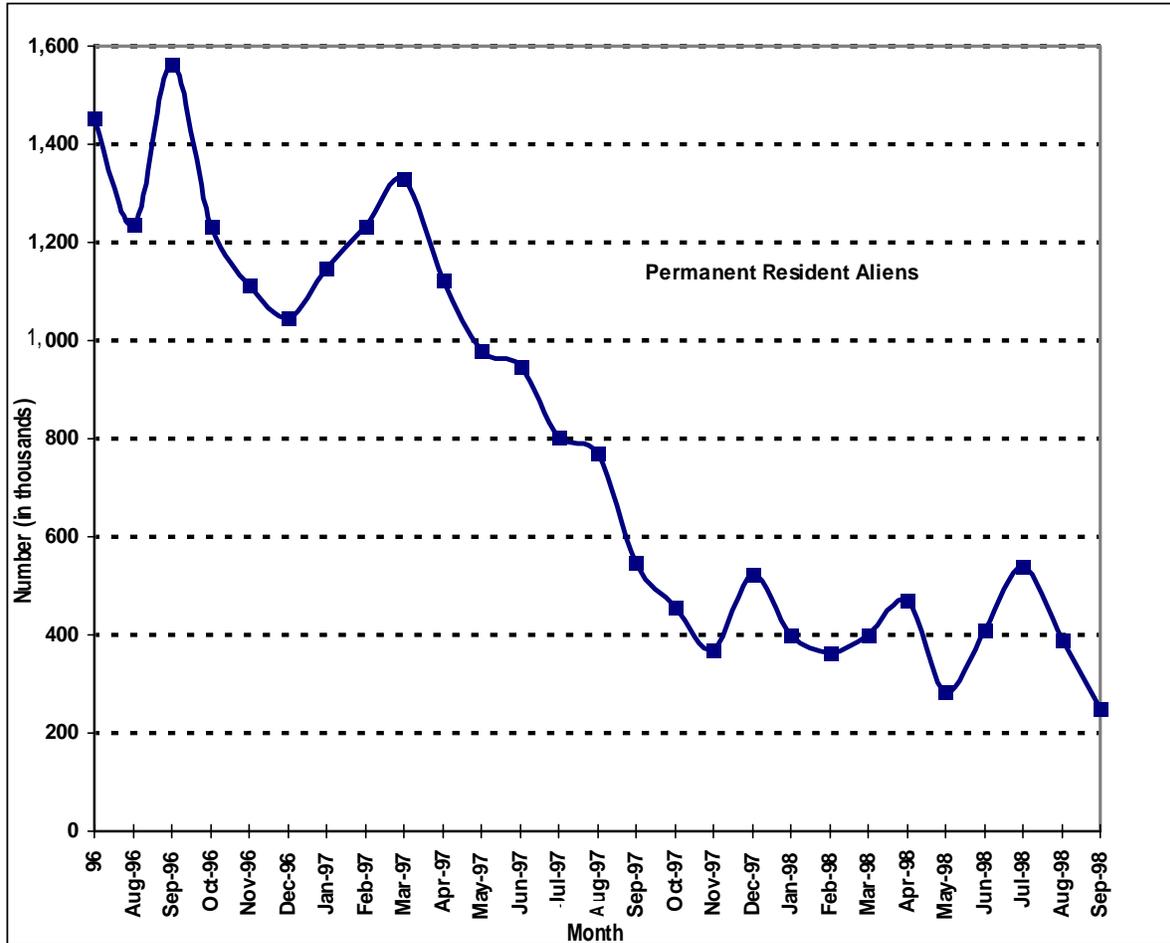
### **Recent Trends in Food Stamp Participation among Immigrants and Their Families**

The number of people receiving food stamps fell by 8 million between 1994 and 1998, a decline of nearly 30 percent. However, while declines were steep among many subgroups of participants, declines were especially sharp among legal immigrants.

In 1994, nearly 1.5 million legal immigrants received food stamps. This number dropped sharply after welfare reform was enacted. The number of legal immigrants receiving food stamps declined steadily throughout late 1996 and most of 1997 (Chart 4-1) and stayed level in 1998. The decline was gradual throughout FY 1997. This indicates that as current immigrants left the program, they were not replaced by new immigrant participants.

Restrictions on participation by legal immigrants appear to have deterred participation by their children, many of whom retained their eligibility for food stamps. Participation among U.S.-born children living with their legal immigrant parents fell faster than participation among children living with native-born parents (Table 4-11). The number of participating children living with legal immigrants fell by 60 percent, versus 12 percent for children living with native-born parents.

Chart 4-1 — Legal Immigrant Participants in the Food Stamp Program:  
July 1996 through September 1998



**Table 4-11 — Number of Children Participating in the Food Stamp Program by Citizenship Status of Parents:  
FY 1996 and FY 1998 (Thousands)**

	<b>Participants: 1996</b>	<b>Participants: 1998</b>	<b>Participation Change</b>	<b>Percent Change</b>
Children Living with Legal Immigrants	1,176	333	-843	-72 %
Children Not Living with Legal Immigrants	11,486	10,070	-1,416	-12 %

Although those admitted as refugees (and asylees and those granted withholding of deportation) remained eligible for benefits if they had arrived in the United States within the past 5 years (now 7 after enactment of the Agricultural Research, Extension and Education Reform Act), the number of refugees receiving food stamps fell by nearly half. Many of those coded as “refugees” in the data may have, in fact, arrived more than 5 years ago. Another reason for the participation decline may be confusion among refugees about their eligibility, particularly if they had converted to legal permanent resident status, as many do after a year in this country.

The number of naturalized citizens receiving food stamps rose by 162,000 between 1994 and 1998, an increase of 66 percent (Table 4-12). The number of households rose by 62 percent. This increase reflects the surge in naturalizations starting in 1993.

**Table 4-12 — Number of Legal Immigrants Receiving Food Stamps by Immigration Status:  
1994 and 1998 (Thousands)**

	<b>Participants: 1996</b>	<b>Participants: 1998</b>	<b>Participation Change</b>	<b>Percent Change</b>
Permanent Resident Aliens	1,453	243	-1,210	- 83 %
Refugees	379	360	-19	- 5 %
Naturalized Citizens	247	409	+162	+ 66 %
<b>All Legal Immigrants</b>	<b>2,079</b>	<b>1,012</b>	<b>-1,067</b>	<b>- 51 %</b>

### **State-Funded Food Assistance Program for Immigrants**

In June 1997, the President signed into law legislation that provided authority for States to purchase food stamps from the Federal government to use in a State-funded food assistance program for legal immigrants.

The first State to implement this provision was Nebraska, which in August 1997 began providing benefits to all legal immigrants made ineligible as a result of welfare reform. Other States soon followed suit, and by September 1998, 12 States provided 175,000 legal immigrants with State-funded food stamps (either in the form of coupons or Electronic Benefit Transfer payments). Some States provided benefits to subgroups: California provided benefits to children and the elderly; New York, Illinois, and New Jersey provided benefits to children, the elderly, and the disabled; Florida provided benefits to the elderly only; Maryland provided benefits to children; and Ohio provided benefits to SSI recipients. Maine, Nebraska, Rhode Island, Washington, and Wisconsin provided benefits to all legal immigrants made ineligible.

A handful of States ran food assistance programs for legal immigrants independently of the Federal government. These included Connecticut, Massachusetts, and Minnesota, which provided benefits to all legal immigrants made ineligible; and Texas, which provided benefits to the elderly and to disabled SSI recipients.

The Agricultural Research, Extension and Education Reform Act, which was implemented in November 1999, restored eligibility to many of the groups targeted by State food assistance programs. A few States discontinued their food assistance programs, while others changed the target population. By August 1999, nine States provided State-funded food stamp benefits to legal immigrants, while four other States provided independent food assistance programs for legal immigrants. The State-funded programs provided benefits to 105,000 legal immigrants. Table 4-13 shows the State-by-State participation in these programs.

**Table 4-13 — State-Funded Food Programs for Legal Immigrants: August 1999**

State	Starting Date	Targeted Population	Persons Served (Monthly Estimate)*	Issuance (Monthly Estimate)*
<b>State Funded Food Stamp Programs (Benefits Purchased from the Federal Government)</b>				
California	09-01-97	Most legal immigrants otherwise eligible in the U.S. before 8/22/96 and certain immigrants arriving on or after 8/22/96	Coupons -- 83,973 EBT -- 9,220	Coupons -- \$4,164,802 EBT -- \$495,183
Illinois	01-01-98	Parents of FS eligible children and 60-64 yr. olds; must have been in the U.S. on 8/22/96	EBT -- 606	EBT -- \$31,550
Maine	09-01-98	Legal immigrants otherwise eligible	Coupons -- 398	Coupons -- \$19,720
Maryland	10-01-97	Children under 18 arriving in the U.S. after 8/22/96	EBT -- 360	EBT -- \$30,000
Nebraska	08-01-97	Legal immigrants otherwise eligible	Coupons -- 790	Coupons -- \$62,674
New York	09-01-97	Elderly (60-67 yr. olds) living in the same county since 8/22/96	Coupons -- 3,790 EBT -- 361	Coupons -- \$377,209 EBT -- \$30,376
Ohio (Phasing out program)	04-01-98	SSI recipients who resided in Ohio as of 8/22/96	Coupons -- 4 EBT -- 7	Coupons -- \$163 EBT -- \$483
Washington	09-01-97	Legal immigrants otherwise eligible	Coupons -- 5,073	Coupons -- \$401,695
Wisconsin	08-01-98	Legal immigrants otherwise eligible	Coupons -- 766	Coupons -- \$34,082
<b>Total</b>			<b>Coupons-94,794 EBT--10,554 105,348</b>	<b>Coupons -- 5,060,345 EBT -- \$587,592 \$5,647,937</b>

<b>Independent State-Funded Food Assistance Programs</b>				
Connecticut	04-01-98 State EBT	Legal immigrants otherwise eligible	Unknown	Unknown
Massachusetts	10-01-97 State EBT	Legal immigrants otherwise eligible	Unknown	Unknown
New Jersey	03-10-99 State EBT	Parents of FS eligible children complying with work requirements; elderly (65 or older) arriving after 8/22/96; GA unemployables	Unknown	Unknown
Rhode Island	10-01-98 State EBT	Legal immigrants otherwise eligible	Unknown	Unknown

\* Estimates are based on information reported by States to USDA and are an average of the prior 3 months. "EBT" refers to "Electronic Benefit Transfer" payments.