

# **Immigrant Access to Health Benefits**

A RESOURCE MANUAL



Prepared for  
The Access Project

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**The Access Project** is a program of the Center for Community Health Research and Action of the Heller School for Social Policy and Management at Brandeis University. It has served as a resource center for local communities working to improve health and healthcare access since 1998. The project receives its funding from a variety of public and private sources.

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# Introduction

There is little question that passage of the Personal Responsibility and Work Opportunities Reconciliation Act of 1996 (PRWORA) dramatically weakened the nation's safety net for immigrants. Under the law's harsh restrictions, even legally present, long-time residents found themselves facing the prospect of losing cash assistance and health benefits that they had received for years. While PRWORA affects immigrants' access to all federal, state, and local public benefits, its impact on health care has been particularly harsh. Loss of benefit eligibility has swelled the ranks of the uninsured in immigrant communities and has created additional demands on safety net providers such as clinics and public hospitals. Fear of reporting and public charge determinations have driven many immigrants and their children out of the public health care system, even when they are eligible for benefits.

Fortunately, Congress was not oblivious to the hardships reported after the law went into effect. In the two years following enactment, organized efforts to allay PRWORA's damage have resulted in important benefit restorations. In addition, new federal policy on public charge, the safety net for immigrants is a nearly incomprehensible patchwork of rules and restrictions that confuse even the most seasoned expert. Significant restrictions on benefit eligibility remain, especially for immigrants who enter the United States after August 22, 1996, the date PRWORA was enacted. Immigrants still face significant barriers to access. Many of these barriers are not new. Benefit granting agencies and programs often fail to provide appropriate linguistic services. Immigrants encounter prejudice and discrimination, and many still fear that contact with public programs may result in unwanted and unfavorable scrutiny by the Immigration and Naturalization Service.

Increasing immigrants' access to health care in the wake of welfare reform will not be easy. Quick fixes that comprehensively address the health care needs of our communities are likely to be elusive for many years to come. But we can begin by becoming knowledgeable, not only about the law's restrictions, but also about the opportunities that may be presented for advocacy at the state and local level to fill gaps created by the federal law.

This manual was written for use as a resource in conjunction with an intensive training program developed by The Access Project and the National Health Law Program. It is essentially a primer on health access for immigrants. It details and explains basic eligibility requirements for key federal and state programs and identifies issues that can be significant barriers to access for immigrants and their families.

Recommendations are included in each chapter and are intended to stimulate discussion and activity to improve immigrants' access to health care.



## Medicaid and State Children's Health Insurance Program (SCHIP) for Immigrants

### I. Medicaid Basics

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#### A. What is Medicaid?

The Medicaid program was established by the federal government in 1965 as part of the Social Security Act to provide health care and services to certain groups of low-income people. Medicaid is the largest and most important public health insurance program in the country. In 1998, the Medicaid program covered 40.6 million people. Over half of all Medicaid enrollees are children under age 21.<sup>1</sup>

Although children are the largest group of beneficiaries, the Medicaid program is a critical source of health insurance for people who are elderly and who have disabilities. Medicaid pays for over half of all nursing home care. Medicaid dollars account for nearly 50 percent of all public funding for mental health and substance abuse treatment and 68 percent of dollars spent by state developmental disability service systems. Medicaid is also the primary payer of medical care for more than half of all adults living with HIV/AIDS and for 90 percent of all children with HIV/AIDS.<sup>2</sup>

The Medicaid program is operated jointly by the federal government and state governments. The federal government shares the cost of the program with the states and sets the basic rules concerning eligibility, scope of coverage, quality, and administration. However, within this framework, states have a great deal of flexibility to individualize their Medicaid programs and, under certain circumstances, can obtain waivers from some of the federal

<sup>1</sup> For more information about the Medicaid program generally, see *Medicaid: A Primer*, Kaiser Commission on Medicaid and the Uninsured, August 1999, posted at [www.kff.org](http://www.kff.org).

<sup>2</sup> *Medicaid's Role for People with Aids, Fact Sheet*, The Henry J. Kaiser Family Foundation, December 1996.

requirements.<sup>3</sup> Thus, state Medicaid programs vary greatly in terms of who can get Medicaid, what services are provided, and how the services are paid.<sup>4</sup>

The federal share of cost is called federal financial participation (FFP). FFP ranges from 50 to 83 percent, depending on poverty levels within the state. States pay providers for medical services and then submit claims to the federal government to obtain reimbursement of the federal share of costs.

At the federal level, the agency responsible for administration of the Medicaid program is the Centers for Medicare and Medicaid Services (CMS) [formerly the Health Care Financing Administration (HCFA)]. CMS is headquartered in Baltimore and there are ten regional offices throughout the United States.

At the state level, the Medicaid program must be administered by a single state agency, usually the state human services agency or health department. Often, the welfare agency will also play an important role in making eligibility determinations.

## B. Who can get Medicaid?

1. *Anyone has the right to apply for Medicaid, but not everyone can get it.* There are two major requirements:

**a. The person must be poor or low-income.** As a general rule, a successful applicant for Medicaid must demonstrate that his/her income and resources fall below levels set by the state. The amount of income and resources that an applicant can have will depend on the specific limits set by the state, and the limits may vary between the different eligibility groups offered by the state.

**b. The person must fit into a group that is covered by Medicaid.** It is not enough to be poor; you must also fit into the profile of one of the groups that Medicaid covers. Millions of poor men and women are ineligible for Medicaid because they do not fit the profile of any of the covered groups.<sup>5</sup>

2. *States must cover certain specified groups.* These groups are referred to as “mandatory categorically needy.” They include:

**a. Families with dependent children under Section 1931 of the Social Security Act.** These are primarily single parent families with incomes and resources that do not exceed eligibility standards established under

<sup>3</sup> Medicaid’s federal requirements are found at 42 U.S.C. §1396a et seq. Federal regulations implementing the Medicaid program are found at 42 C.F.R. §430 et seq.

<sup>4</sup> Every state must file a state plan with the federal government that describes the state’s Medicaid program. Information about a state’s Medicaid program should be available from the agency within the state responsible for its administration.

<sup>5</sup> Childless, nondisabled adults under age 65 generally are not eligible for Medicaid.

the state's old Aid to Families with Dependent Children (AFDC) program that was in effect on July 16, 1996. Families with dependent children who meet the income and resource guidelines do not have to be on welfare to get Medicaid.

- b. Families with dependent children moving from welfare to work.** If a family with at least one dependent child loses welfare or their Medicaid coverage under the Section 1931 standards because they obtained employment and had increased earned income, and if the family had been receiving 1931 Medicaid coverage in at least three of the six months immediately before they became ineligible, the state must provide six months of transitional Medicaid. Transitional Medicaid is sometimes called Transitional Medical Assistance or TMA. The state must provide an additional six months of transitional Medicaid provided the family complies with certain income reporting requirements and the family's income does not exceed 185 percent of the federal poverty level (FPL).<sup>6</sup>
- c. Families with dependent children with increased child support.** If a family loses welfare or Medicaid coverage under Section 1931 because of increased child support or spousal support, the state must provide Medicaid for an additional four months.
- d. Children who receive federal adoption assistance or foster care maintenance payments.**
- e. Pregnant women.** Pregnant women are eligible for Medicaid if their income is less than 133 percent of the federal poverty level (FPL). Women who applied for and received Medicaid while they were pregnant remain eligible for Medicaid for all pregnancy and postpartum services during the 60-day period beginning on the last day of the pregnancy.<sup>7</sup>
- f. Children.** Children age five or younger are eligible if their family income is less than 133 percent of the federal poverty level. Children born after September 30, 1983 (who are less than 19 years old) are eligible if their family income is less than 100 percent of the federal poverty level. By September 30, 2003, states must cover children who are age six through 19 with family income up to 100 percent of the federal poverty level. (States have the option to cover these children immediately.)

<sup>6</sup> Federal poverty levels for 2001 are reproduced in Appendix A.

<sup>7</sup> It is clear that Medicaid has taken particular steps to ensure that needy pregnant women and children are covered through the program. As a result, a first-time pregnant woman can now qualify for Medicaid even if she has no other dependent children in the house, and a child may qualify for Medicaid although her/his parent does not.

- g. Infants.** Infants born to women who are eligible for and receiving Medicaid on the date of the child's birth are automatically eligible for Medicaid for one year from birth as long as the mother remains eligible.
  - h. People who are aged, blind, and disabled.** In most states, all aged, blind, and disabled poor who receive Supplemental Security Income (SSI) get Medicaid.<sup>8</sup> In a few states, such persons are not automatically eligible. They must meet a "spend down" requirement. (See explanation of *medically needy* on the following page.)
  - i. People receiving mandatory state supplements.** Medicaid must cover persons receiving mandatory state supplements.
  - j. People with disabilities.** Under limited circumstances, states must provide Medicaid to people with disabilities who work, certain disabled adult children, and disabled widows or widowers.<sup>9</sup>
  - k. "Pickle" people.** States must provide Medicaid to people who lose SSI because they have received a cost-of-living increase in their Social Security checks.
  - l. Low-income Medicare beneficiaries.** States must provide Medicaid coverage to pay for Medicare Part A and Part B premiums, deductibles, and coinsurance for Medicare beneficiaries who have incomes at or below 100 percent of the federal poverty level and have resources that do not exceed twice the SSI resource eligibility standard.
3. *States have the option to provide Medicaid to other groups.* These are called the "optional categorically needy."<sup>10</sup> For example, states can decide to cover:
- a. People who are eligible for SSI but have not applied for it.**
  - b. Children under state adoption assistance programs.** Most states cover this category of children.

<sup>8</sup> As of January 1998, the states where SSI recipients do not automatically get Medicaid are: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.

<sup>9</sup> There are two programs for the working disabled: (1) "qualified severely impaired individuals" who work and (a) were eligible and received SSI benefits on the basis of blindness or disability in the previous month, and were eligible for Medicaid, (b) continue to be blind or have the disabling condition, (c) except for their earnings, would be eligible for SSI, (d) not receiving Medicaid benefits would seriously inhibit their ability to continue or obtain employment, and (e) have insufficient earnings to make up for the loss of SSI, Medicaid, and attendant care services; and (2) "qualified disabled and working individuals" who have exhausted their extended Medicare coverage and would otherwise be entitled to purchase extended Medicare Part A benefits, and (a) have incomes at or below 200% of the FPL, (b) have resources at or below twice the SSI standard, and (c) are not otherwise eligible for Medicaid.

<sup>10</sup> For the most part, if the state elects to provide Medicaid coverage, it must follow the eligibility criteria of the most closely related cash-assistance program; i.e., for families and children, it would be Section 1931, and for the aged, blind, and disabled, it would be SSI.

- c. **Optional targeted low-income children.** These are children who are eligible for Medicaid under the State Children’s Health Insurance Program (SCHIP). (See discussion at Section III.)
  - d. **Pregnant women and infants with incomes up to 185 percent of the federal poverty level.** The state gets to decide the exact percentage of poverty that it will cover.
  - e. **Persons who are age 65 or older or disabled with incomes up to the federal poverty level.** Again, the state gets to determine the exact percentage of poverty it will cover. Only a few states have chosen to cover this group of the aged and disabled.
4. *States have the option to provide Medicaid to people who are “medically needy.”* The medically needy are people who would qualify for Medicaid except that their incomes are too high. The medically needy are able to meet the costs of daily living—food, shelter, and clothing—but if a medical crisis occurs or if they have ongoing chronic medical problems, they cannot afford the care they need. To qualify for Medicaid, these individuals must spend their excess income on medical expenses during a specified period before they qualify for Medicaid. This is usually called “spend down” or “share of cost.” States choosing to cover the medically needy must at least cover pregnant and postpartum women and children under age 18.<sup>11</sup>

### C. What does Medicaid cover?

States must cover a basic package of health care services including hospital care, nursing home care, physician services, laboratory and x-ray services, family planning services, health center and rural health center services, nurse midwife, and nurse practitioner services. Medicaid also provides a comprehensive children’s health benefit package known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). EPSDT covers a wide range of screening, diagnostic, and treatment services for children under age 21.

States have the option to provide additional services under Medicaid, including prescription drugs, institutional care for people with mental retardation, home and community-based care for the elderly, case management services, personal care and other services for individuals with disabilities, and adult dental and vision care.

<sup>11</sup> The following states cover the medically needy: California, Connecticut, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin, as well as the District of Columbia.

## D. Applying for Medicaid benefits

1. *Place of application.* Applicants for Medicaid ordinarily apply through the state or local welfare agency. States must also accept and process Medicaid applications for pregnant women and children at locations other than welfare offices. These locations must include public hospitals, community and migrant health clinics, and other facilities serving large numbers of poor pregnant women and children.
2. *Form of application.* States have considerable flexibility to design their Medicaid applications. Many states are moving to simplify and shorten their forms and are reducing the amount of information that applicants must provide during the application process. Many states have also developed joint application forms for their SCHIP and Medicaid programs and are using mail-in applications.
3. *State of residence.* States must provide Medicaid to eligible residents of the state, including residents who are absent from the state. State residency requirements are:
  - a. **As a general rule, the state of residence is where the individual is living with the intention to remain there permanently or for an indefinite period of time.<sup>12</sup>**
  - b. **States are prohibited from denying Medicaid to an otherwise qualified resident of the state because:**
    - The individual's residence is not maintained permanently or at a fixed address.
    - Of a durational residence requirement.
    - Of a temporary absence from the state.
  - c. **There are special rules for migrant and other transient workers.** An individual involved in work of a transient nature or who goes to another state seeking employment has two choices:
    - The individual can establish residence in the state in which he/she is employed or is seeking employment.
    - The individual may wish to claim one particular state as his/her domicile or state of residence.

<sup>12</sup> Residency can be proven by showing a driver's license, pay stubs, rent receipts, bills, or proof that the applicant's children are enrolled in school. It may be difficult for people with border crossing cards and for nonimmigrants such as tourists, students, and temporary workers to prove state residency because their status as nonimmigrants implies that they do not intend to stay in the United States; however, it is not impossible. In California, a recent case held that the Department of Health Services could not automatically conclude that people who possess border crossing cards or temporary visas are not California residents. They could use other forms of identification, such as those listed above, and residency determinations should be made only after all the evidence is considered. Latino Coalition for a Healthy California, San Francisco Superior Court Case No. 987374 (injunction issued August 11, 1998). It is advisable to see an immigration counselor for additional information.

**NOTE**

It is unclear whether states will still be allowed to accept a child applicant’s self-declaration of citizenship status after new regulations implementing the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) go into effect. These new rules give states the option to accept third-party declaration, but do not authorize states to accept self-declaration.

4. *Use of Social Security Numbers.* All applicants for and recipients of Medicaid benefits must supply the state agency with a Social Security Number (SSN). However, non-applicant household members (such as a parent applying for benefits on behalf of a minor child) are not required to supply Social Security Numbers. States have no legal basis for denying an application based upon the failure of a nonapplicant to supply his or her SSN.<sup>13</sup>
5. *Declaration of citizenship or satisfactory immigration status.* Applicants for Medicaid must sign a declaration under penalty of perjury and provide documentation that the applicant is a citizen or national of the United States or has satisfactory immigration status (is a qualified immigrant).<sup>14</sup>

For children only, current federal policy permits states to accept self-declaration of citizenship status without further verification. States, however, may require further documentation and verification as a condition of eligibility.

Applicants must be given a reasonable amount of time to provide the required documentation.

<sup>13</sup> On September 21, 2000, the U.S. Dept. of Health and Human Services (HHS) and the U.S. Dept. of Agriculture issued a policy guidance to state officials clarifying when states may and may not request information about citizenship, immigration status, and Social Security Numbers for federal benefits, including Medicaid. The guidance was issued because many states have developed joint applications for a number of programs to make it easier for individuals to receive the services they need. The federal government recognized that in many situations, this has resulted in the inclusion of improper questions regarding citizenship, immigration status, and SSN of persons who are living in the applicant’s household but who are not applying for benefits. These inquiries may have had the effect of discouraging some families from applying for and receiving benefits to which they or their children are entitled. The guidance also recommended that states review their application forms and eligibility determination processes and make any necessary changes to conform with the guidance.

Therefore, although states may require Medicaid applicants provide their SSNs, states may violate the Privacy Act of 1974 when they require non-applicants living in the household or family unit to provide their SSNs. Moreover, state and local agencies must assist individuals in applying for a SSN and may not delay, deny, or discontinue assistance pending the issuance of SSN. States may also request individuals to voluntarily provide their SSNs as long as states make clear that disclosure is voluntary and explain what will be done with the disclosed SSNs. *Policy Guidance Regarding Inquiries into Citizenship, Immigration Status and Social Security Numbers in State Applications for Medicaid, State Children’s Health Insurance Program (SCHIP), Temporary Assistance for Needy Families (TANF), and Food Stamp Benefits*, September 21, 2000, at: [www.hhs.gov/ocr/immigration/triagency.html](http://www.hhs.gov/ocr/immigration/triagency.html); see also *Questions and Answers to Policy Guidance* at: [www.hhs.gov/ocr/immigration/finalqa.html](http://www.hhs.gov/ocr/immigration/finalqa.html).

<sup>14</sup> *Id.* The policy guidance cited in the prior footnote also clarifies that only the immigration status of the applicant for benefits is relevant and application forms should not inquire about the immigration status of other household or family members who are not seeking benefits. For example, if a child is applying for Medicaid or SCHIP, the state may not require the disclosure of the citizenship or immigration status of non-applicant parents or other household or family members.

States must verify immigration status through the Systematic Alien Verification for Entitlements (SAVE). However, states must provide Medicaid eligibility pending verification of immigration status, if the applicant meets all nonimmigration Medicaid eligibility requirements. For more information about verification requirements, see Chapter 5.

6. *Income verification.* Federal rules only require that states verify income after the initial eligibility determination has been made. States must have an income and eligibility verification system for this purpose. To the extent possible, states verify income by using an applicant's Social Security Number to request information from other federal and state agencies. The applicant must be told in writing, at the time of application, that the agency will be requesting this information.
7. *Presumptive eligibility.* Certain categories of applicants may be able to receive Medicaid on a temporary basis without waiting for the state to make an eligibility determination. This is called presumptive eligibility. They include:
  - a. **Pregnant women.** At state option, pregnant women may be determined presumptively eligible for Medicaid if their gross family income does not exceed the highest income standard under which they may be eligible. Only "qualified" providers can make determinations of presumptive eligibility and the period of eligibility lasts only a short time. If a pregnant woman fails to apply for Medicaid before the last day of the month following the month in which she was determined presumptively eligible for Medicaid, her Medicaid benefits will end. Entities that are qualified to make presumptive eligibility determinations for pregnant women include community health centers, hospital clinics, and other specified Medicaid providers determined by the state to be capable of making the necessary income determinations.
  - b. **Children.** In 1997, Congress amended the Medicaid statute to give states the option to provide presumptive eligibility for children under age 19. A period of presumptive eligibility begins on the date when a "qualified entity" determines that a child's family income is not greater than allowed and would end on the date the child's Medicaid eligibility was finally determined or, if no Medicaid application was filed, the last day of the next month, whichever came first. Entities that are qualified to make presumptive eligibility determinations for children include Medicaid providers and entities which are authorized to determine a child's eligibility for services under the Head Start Act, the Child Care and Development Block Grant, and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and those which have been determined by the state to be capable of making the necessary income determinations.



## E. Recipients’ rights (see Appendix B)

Federal laws and regulations provide protections for those applying for and receiving Medicaid benefits. These include:

1. *The right to apply for Medicaid on the day that assistance is sought.*
2. *The right to bring someone with you to help you with the application.*
3. *The right to translation services and translated written materials.*
4. *The right to have a decision made about your application within 45 days, or if the application is based on disability, within 90 days of applying.*
5. *The right (in most states) to receive coverage beginning with the third month prior to the date of application. This is called retroactive Medicaid.*
6. *The right to receive medically necessary treatment and services.* While a state has some authority to limit the amount, duration, and scope of coverage, the state may not restrict the amount, duration, or scope of coverage based solely on the individual’s diagnosis, type of illness, or condition.
7. *The right to receive treatment and services without discrimination based on national origin, race, color, sex, or disability.*
8. *The right to free choice of providers, unless the state has obtained a waiver that requires beneficiaries to obtain their services through a managed care organization.*
9. *The right to continue to receive Medicaid until ineligible to receive Medicaid.*
10. *The right to prior notice and to a fair hearing to contest any decision by the Medicaid agency to deny, terminate, or reduce benefits.*

## II. Immigrant Eligibility for Medicaid

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Prior to enactment of PRWORA, states were required to provide Medicaid to all legally present immigrants who met Medicaid eligibility requirements. PRWORA fundamentally changed immigrants’ access and eligibility in several significant ways:

- States can choose to provide Medicaid coverage (or not) to all qualified immigrants who were legally present in the United States on or before August 22, 1996, the date PRWORA was enacted.<sup>15</sup>
- Certain groups of legally present immigrants who previously were eligible for Medicaid, such as Persons Residing Under the Color of Law (PRUCOL), are no longer eligible for Medicaid.
- Many new immigrants are barred from receiving Medicaid and other federal means-tested public benefits for their first five years in the United States.

<sup>15</sup> **Note:** All states but Wyoming have opted to provide Medicaid to pre-enactment immigrants.

- States can establish eligibility rules for post–August 22, 1996, entrants who are no longer subject to the five-year bar.<sup>16</sup>
- New sponsor-deeming of income rules and enforceable affidavits of support create additional barriers to access. (See Chapter 4.)

### A. Basic rules: pre-enactment immigrants

To be eligible for Medicaid, a noncitizen who established residency in the United States prior to August 22, 1996 must:

1. Meet the eligibility requirements of the Medicaid program, and
2. Meet the PRWORA definition of a “qualified immigrant.”

### B. Qualified immigrant defined

To be qualified, an immigrant must have one of the following immigration statuses:

1. *Legal Permanent Resident (LPR)*. A person who has been granted legal permanent residence status (a green card holder) and thus is entitled to remain in the United States indefinitely.
2. *Refugee*. A person who flees his or her country due to persecution or a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group and who obtains the status while abroad.
3. *Asylee*. A person who has been determined to meet the same requirements as a refugee, but who was already present in the United States at the time he/she obtained asylum.
4. *Immigrant who has had deportation withheld*.<sup>17</sup> A person who establishes that he/she would be likely to face persecution if returned to his/her home country.
5. *Immigrant granted parole for at least one year*. The Department of Justice has discretionary authority to permit certain persons or groups to enter the United States in an emergency or because it serves an overriding public interest. Parole may be granted for humanitarian, legal, or medical reasons.
6. *Immigrant granted conditional entry*. A person who immigrated based upon a marriage that occurred within two years of obtaining permanent residence.
7. *Battered immigrant and her child/children*. This status requires a pending or approved visa petition filed by a U.S. citizen or LPR spouse/parent, a

<sup>16</sup> Virginia, Oregon, Ohio, Idaho, Mississippi, and Wyoming report they will not provide Medicaid to post-enactment immigrants following the five-year bar. These decisions, however, are subject to change because the provision is not effective until August 2001.

<sup>17</sup> Withholding of removal was formerly known as withholding of deportation.

self-petition pursuant to the Violence Against Women Act (VAWA), or an application for cancellation of a removal/suspension of deportation under VAWA, and whose need for benefits has a substantial connection to the battery or cruelty. It also applies to the parent of a battered child and the child of a battered spouse.

8. *Immigrants born in Canada who possess at least 50 percent blood of the American Indian race, or who are members of certain Indian tribes.*
9. *Immigrant who is Cuban or Haitian entrant* (as defined in section 501(e) of the Refugee Education Assistance Act of 1980).

### C. “Not qualified” immigrants

Not qualified immigrants are not eligible for Medicaid, except in emergencies, and include all other noncitizens, such as:

1. *Persons Residing Under Color of Law (PRUCOL)*<sup>18</sup> including:
  - a. **Immigrants granted indefinite voluntary departure.**
  - b. **Immigrants residing in the United States under orders of supervision.**
  - c. **Immigrants who have lived in the United States continuously since January 1, 1972.**
  - d. **Immigrants granted stays or suspension of deportation.**
  - e. **Applicants for asylum and family unity.**
  - f. **Applicants for adjustment of status.**
  - g. **Other immigrants whose departure the INS does not contemplate enforcing.**
2. *Undocumented immigrants.*
3. *Nonimmigrants such as students and foreign visitors.*

### D. Special rules for SSI-linked Medicaid recipients

1. *Any individual who is receiving SSI is automatically eligible for Medicaid.* However, under PRWORA, an immigrant can only receive SSI (and therefore Medicaid) if he or she was receiving SSI on August 22, 1996.
2. *An immigrant who was not receiving SSI on August 22, 1996, can establish eligibility for SSI (and therefore Medicaid) if he or she:*
  - a. **Is a qualified immigrant.**
  - b. **Was legally residing on August 22, 1996.**
  - c. **Meets the SSI disability standard at the time of application.**
3. *Elderly immigrants (age 65 or over) who are qualified immigrants and meet the SSI income and resource standards but who are not disabled are not eligible for SSI.* However, depending on income and resources, an elderly qualified immigrant may qualify for Medicaid under an optional Medicaid eligibility category.

<sup>18</sup> This category generally means that INS is aware of the person’s presence but has no intent to deport him/her. However, PRUCOL is defined differently in different jurisdictions and for different programs.

### **E. New entrants—special rules for immigrants who arrive in the United States after the PRWORA**

1. *Qualified immigrants who arrive in the United States on or after August 22, 1996, are barred from receiving Medicaid and other federal means-tested public benefits for the first five years after they enter the country with a qualified status.*
2. *After five years, although qualified immigrants are no longer barred from receiving Medicaid and other federal means-tested public benefits, many likely will remain ineligible. This is because the states chose not to provide benefits and/or because of the new rules on sponsor-to-immigrant deeming of income. (See Chapter 4.)*

### **F. Mandatory coverage of certain qualified immigrants**

States must provide Medicaid for certain groups of qualified immigrants regardless of their date of entry. Except as noted below, these immigrants are not subject to the five-year bar that applies to immigrants who arrive on or after August 22, 1996. Specifically:

1. *Refugees are eligible for their first seven years in the United States.*
2. *Asylees are eligible for the first seven years after asylum is granted.*
3. *Immigrants whose deportation has been withheld are eligible for the first seven years from the date withholding is granted.*
4. *Cuban and Haitian entrants are eligible for the first seven years in the United States.*
5. *Amerasian immigrants are eligible for the first five years in the United States.*
6. *Honorably discharged U.S. military, active duty military personnel and their spouses, and unmarried dependent children (regardless of date of entry) are eligible.*
7. *Legal Permanent Residents whose residency was established prior to August 22, 1996, must be covered if they have 40 credited quarters of Social Security coverage.*
8. *Legal Permanent Residents who enter the country after August 22, 1996, are subject to the five-year bar. However, once they have been in the country for five years and have 40 credited quarters of coverage under the Social Security Act, they too must be covered, provided they received no federal means-tested public benefits in any such qualifying quarter for any period beginning after December 31, 1996. Generally, these are people who have a ten-year work history.*

## **III. The State Children’s Health Insurance Program**

### **A. Basic program features**

The State Children’s Health Insurance Program was established by Congress in 1997 as part of the Balanced Budget Act. The program provides nearly \$40 billion over a ten-year period to enable states to provide health insurance to uninsured, targeted low-income children. Targeted low-income children are children under the age of 19 whose family incomes meet state-specified guidelines and who are not eligible for Medicaid or any other health insurance.

States have the option to structure their SCHIP program as a separate state health insurance program or to expand their Medicaid programs. States choosing to establish a separate state child health insurance program have considerable flexibility to decide how to structure their programs. States can decide who is eligible, what the benefit package will be, and how much families must pay in premiums, co-payments, and deductibles. If the state chooses to implement SCHIP by expanding its Medicaid program, then all Medicaid rules apply.

States must have screening procedures to ensure that only targeted low-income children are provided coverage using the new funds. In addition, if a Medicaid-eligible child is identified through the screening, he/she is to be enrolled in the Medicaid program and not in the separate state child health insurance program if the state has established one.

All 50 states, the District of Columbia, and all U.S. territories have developed SCHIP programs that have been approved by the federal government. Each program is unique and many have unusual or catchy names such as Badgercare, Healthy Families, ChildcarePlus, and HuskyCare.

On November 8, 1999, CMS proposed new regulations to implement SCHIP that include many important consumer protections for separate SCHIP programs. As of the date that this manual was published, CMS published an interim final rule effective August 24, 2001. This rule is subject to change pending CMS' consideration of public comment.

## B. SCHIP and immigrants

### 1. *Eligible children include:*

- a. **Children born in the United States.** U.S.-born children are U.S. citizens, even if their parents are not legally present. These children are eligible for SCHIP subject to the same eligibility requirements that apply to any other U.S. citizen child.
- b. **All qualified legal immigrant children who were in the United States before August 22, 1996.**
- c. **Refugees, asylees, and certain Cuban, Haitian, and Amerasian immigrants to the same extent that they are eligible for Medicaid.**
- d. **Unmarried, dependent children of honorably discharged veterans and active duty service members of the Armed Forces, regardless of the date of entry.**
- e. **Battered children or children of battered spouses.<sup>19</sup>**

<sup>19</sup> Similar to the requirement for a qualified immigrant under Medicaid, this also requires a pending or approved visa petition filed by a U.S. citizen or LPR spouse/parent, a self-petition pursuant to the Violence Against Women Act, or an application for cancellation of a removal/suspension of deportation under VAWA, and a child or children whose need for benefits is substantially connected to the battery or cruelty. This also includes the parent of a battered child and the child of a battered spouse, 8 U.S.C. §1641(c).

2. *Ineligible children:*

**a. Like Medicaid, the SCHIP program is a federal means-tested public “benefit.”**

Therefore, the PRWORA restrictions on immigrant eligibility also apply to SCHIP. As a general rule, children who are “not qualified” are ineligible for SCHIP. Qualified immigrant children who enter the country on or after August 22, 1996, also are not eligible for SCHIP for the first five years after entry unless they are exempted from the five-year bar.

### C. Applying for benefits

1. *The SCHIP statute does not require applicants to provide Social Security Numbers when applying for benefits.* Yet CMS’ interim final rule would allow states to require Social Security Numbers of applicants under a new interpretation of the federal Privacy Act. (The legality of this interpretation is questionable. Advocates have requested reconsideration of this interpretation when it evaluates submitted public comments.)
2. *States must verify citizenship and immigration status in accordance with procedures discussed in Chapter 5.*

### D. SCHIP funding for services to immigrant communities

Under the SCHIP program, states can receive federal matching funds to pay for specialized types of expenditures, but only to the extent that the expenditures do not exceed 10 percent of the state’s total expenditures on SCHIP benefits. The types of specialized expenditures subject to the 10 percent cap include:

1. *Outreach.* In order to facilitate the enrollment of eligible children, many states are using these federal matching funds for outreach to low-income communities. Outreach strategies can be targeted to immigrant communities to identify and enroll children living in immigrant families who are uninsured and eligible for federal public benefits.
2. *Other child health assistance.* Other child health assistance refers to health benefits coverage that is in addition to the basic benefit package that the state is providing.
3. *Administrative costs.*
4. *Health services initiatives.* Health services initiatives are activities that protect the public health, protect the health of individuals, or improve or promote a state’s capacity to deliver public health services and/or strengthen resources needed to meet public health goals.

#### NOTE

Proposed federal rules implementing the SCHIP program would prohibit states from requiring an applicant to provide a Social Security Number.

### E. Obtaining a variance of the 10 percent cap

#### NOTE

All immigrant children, regardless of their status or date of entry, can participate in, and benefit from, health services initiatives. Health services initiatives such as health education activities, school health programs, and direct services such as newborn screening and lead testing can be targeted to low-income, immigrant communities including temporary communities of migrant or seasonal farm workers.

Under certain circumstances, states can obtain a variance from the 10 percent cap. Getting a variance allows a state to spend more money on health services initiatives and other specialized SCHIP expenses. A state that obtains a variance is no longer subject to the 10 percent cap limitation. While a state can receive additional amounts of federal matching funds for specialized SCHIP expenditures, the amount will be limited because of the need to preserve cost-effectiveness.

To obtain a variance, a state must:

1. *Provide coverage to some portion of SCHIP enrollees through a community-based delivery system.* A community-based delivery system is a network of providers that must have a contract with the state to provide care under the SCHIP program.
2. *Provide cost-effective coverage.* This means that the amount paid to the community-based delivery system on a federal fiscal year, per child basis, must not be greater than the amount that would otherwise have been paid for that child to receive coverage under Title XXI.

## IV. Maximizing Medicaid and SCHIP Eligibility for Immigrants

The complexities of Medicaid and SCHIP eligibility rules are daunting. Even highly trained attorneys have difficulty wading through the impenetrable text. Yet, buried within this oftentimes-baffling array of rules and regulations are many opportunities to maximize the potential of the Medicaid and SCHIP programs to cover more low-income families including immigrants. Here are some suggestions:

1. *Eligibility rules.* States have many choices and considerable flexibility to liberalize eligibility rules to provide expanded Medicaid access. The first step is finding out whom your state covers and whether the state has exercised any of the various options to expand coverage. Has the state opted to provide Medicaid coverage to all pre-enactment and post-enactment qualified immigrants? Has the state opted to use more generous financial methodologies and standards under Section 1931 to reach single- and two-parent families with more income than Medicaid traditionally covers? Has the state opted to implement presumptive eligibility for pregnant women and for children? Does the state cover any of the optional categories of beneficiaries? Has the state considered a health services initiative under SCHIP?
2. *Application forms.* Review application forms to determine whether they contain information or request information that might deter immigrants or members of their families from seeking benefits. Is the form simple and easy to understand? CMS's Model SCHIP/Medicaid Joint Application

Form for Children is available at [www.hcfa.gov](http://www.hcfa.gov). Advocates should obtain a copy of the Medicaid and/or SCHIP application currently used to determine whether they comply with the September 21, 2000, policy guidance issued by HHS.<sup>20</sup>

3. *Process.* Applying for benefits can be difficult. Families may be compelled to spend long hours waiting to submit paperwork or talk to caseworkers, who may be unfriendly, and even hostile. Offices and office hours may not be convenient for those who work or who rely on public transportation. Applicants may be asked to return to the welfare office multiple times and to produce multiple copies or forms of verification. Much of this is unnecessary and only serves to deter people from following through and filing their applications. Applicants who do not speak or read English well or appear to be foreign born often face additional barriers and receive little help or encouragement. Find out and document what an applicant seeking Medicaid or SCHIP benefits confronts, then work to improve the process.
4. *Language and cultural access.* For immigrants, lack of translation services and translated, understandable written materials create additional barriers to access. The extent to which the Medicaid and SCHIP eligibility processes comply with Title VI of the Civil Rights Act of 1964, must be thoroughly assessed. Complaints may be forwarded to the U.S. Department of Health and Human Services (HHS), Office for Civil Rights. (See Chapter 7.)
5. *Outreach to families with children.* States are engaged in a variety of outreach strategies primarily directed at enrolling more children in Medicaid and SCHIP. These activities should be assessed to ensure that outreach strategies are targeted to immigrant communities.
6. *Outreach to the elderly.* Immigrants who are 65 or older and have lived in the United States since before August 22, 1996, can establish eligibility for SSI if they are found to be disabled. However, the Social Security Administration has found that many older adults applying for SSI fail to allege common health problems associated with aging that may establish their eligibility. Outreach and education about the eligibility process and standards can help older immigrants obtain needed benefits.
7. *Recipient education.* There is no substitute for educating the community about the Medicaid and SCHIP programs and providing them with the information they need to navigate the system on their own. A number of states and communities have employed effective strategies for consumer involvement. The National Health Law Program has several publications addressing how to involve and empower consumers in the Medicaid program.

<sup>20</sup> See HHS Model Notice (Model notice to provide guidance to persons applying for benefits about reporting citizenship and immigration status of people in their households) at: [www.hhs.gov/ocr/immigration/notice.html](http://www.hhs.gov/ocr/immigration/notice.html).



# CHAPTER TWO

## Health Benefit Programs Available to All Noncitizens Regardless of Status

Since enactment of PRWORA, the perception in many communities is that noncitizens are no longer entitled to any federal or state public health benefits. In reality, noncitizens remain eligible to receive a wide range of publicly funded health benefits. Moreover, as discussed below, some of these benefits are available to all noncitizens, regardless of their immigration status or when they entered the country.

The following health benefit programs and services are available to all noncitizens, regardless of their immigration status or when they entered the country.

### **I. Emergency Medicaid**

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#### **A. General rule**

As a general rule, states are prohibited from providing Medicaid to immigrants, unless they are Legal Permanent Residents or have a special immigration status that qualifies them to receive benefits.<sup>21</sup> An exception to this general rule is Emergency Medicaid—a form of Medicaid that only pays for treatment of an emergency medical condition.

#### **B. What is an emergency medical condition?**

An emergency medical condition is defined as:

The sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe

<sup>21</sup> 42 U.S.C. §1396b(v)(1).

pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1. *Placing the patient's health in serious jeopardy, or*
2. *Serious impairment to bodily functions, or*
3. *Serious dysfunction of any bodily organ or part.*<sup>22</sup>

### C. Qualifying for Emergency Medicaid

To qualify for Emergency Medicaid, the immigrant must:

1. *Otherwise qualify for Medicaid.* This means that the immigrant must satisfy all Medicaid financial and categorical eligibility requirements, and
2. *Meet state residency requirements.* (See Chapter 1.)

### D. Applying for Emergency Medicaid

Hospitals generally can assist an immigrant to complete an application for Emergency Medicaid. Because immigration status is not relevant to the eligibility decision, the immigrant should not be required to:

1. *Sign a written declaration (under penalty of perjury) that he or she is a citizen, national, or qualified alien.*
2. *Provide documentation of citizenship or alien status.*
3. *Provide a Social Security Number.*

#### EXAMPLES

Jane was pregnant when she came to visit her family in the United States on a tourist visa. She decided to stay in the United States. Her visa expired and a week later, she went into early labor. Is she eligible to receive Emergency Medicaid to deliver her child? Yes, if she intends to live and stay in the state and she meets financial and categorical eligibility requirements of the Medicaid program.

Isabelle is a single mother and has two children, ages two and four. She has high blood pressure and difficulty breathing. Her children are U.S. citizens, but she has no papers. She arrives in the emergency room complaining that she has felt dizzy and short of breath for the past two weeks. She is not in acute distress. Is she eligible to receive Emergency Medicaid? If Isabelle meets the financial eligibility criteria for Medicaid and is a state resident, she could be eligible for Emergency Medicaid. However, based on the facts, it is not clear that her condition meets the definition of an emergency medical condition.

<sup>22</sup> 42 U.S.C. §1396b(v)(3); 42 C.F.R. §440.255.

Marco is 28 years old and has been working as a migrant laborer. Recently, however, he has had no work and no income. He has been sleeping in a homeless shelter. One night, another shelter resident beat him up. He suffered a swollen lip, lost a couple of teeth, and cracked two ribs. He went to the emergency room for treatment. Is Marco eligible for Emergency Medicaid? Probably not. Although Marco meets the financial eligibility requirements, as a single person with no dependents he does not fit into a category that Medicaid covers.

## II. Access to Emergency Care Under EMTALA<sup>23</sup>

### A. General rules

EMTALA of 1986—the Emergency Medical Treatment and Active Labor Act—is a federal law designed to prevent hospital emergency rooms from refusing to treat people who need emergency medical assistance but have no health insurance or other means to pay the bill. It is sometimes called the federal “antidumping” statute.

Under EMTALA, any hospital that participates in Medicare and has an emergency room must:

1. *Examine every patient who comes to the emergency room to determine whether they have an emergency medical condition, or are in active labor.* If they do, the hospital must provide stabilizing treatment within the capacity of the facility.
2. *Not transfer a patient prior to stabilization unless the physician on duty (or another qualified medical person with the doctor’s permission) certifies in writing that the medical benefits of transfer outweigh the increased risks to the individual or unborn child, because proper medical treatment is unavailable there.*

### B. When is a transfer to another hospital or health care facility appropriate?

A transfer is appropriate only when:

1. *It is made to a facility that has space and qualified personnel to treat the patient and has agreed to accept the transfer and to provide appropriate treatment;*
2. *The transferring hospital provides all medical records relating to the emergency medical condition available at the time of the transfer;*

<sup>23</sup> 42 U.S.C. §1395dd. For further discussion of EMTALA, see *Access to Emergency Medical Care: Patients’ Rights and Remedies*, National Health Law Program, October 1991.

3. *The transfer is effected through qualified personnel and by suitable transportation equipment; and*
4. *Reasonable steps have been taken to obtain a written consent from individuals who refuse treatment or transfer.*

### C. Other important provisions of EMTALA

1. *Nondiscrimination.* Hospitals with specialized capabilities or facilities, such as burn units or neonatal intensive care, cannot refuse to accept an appropriate transfer of a patient who requires the specialized care if the hospital has the capability of treating the patient.
2. *No delay in examination of treatment.* Hospitals may not delay the screening or treatment of a patient to inquire about the individual's health insurance status or proposed method of payment.
3. *No retaliation.* Hospitals may not take adverse action against or penalize a physician or other qualified medical person who refuses to authorize the transfer of an individual with an unstabilized emergency medical condition, or any hospital employee because the employee reports a violation of the statute.
4. *Compliance.* Hospitals must have and enforce policies to ensure compliance with the law.
5. *Notice.* Hospitals must post signs in emergency rooms alerting individuals, including women in labor, of their right to examination and stabilizing treatment. They must also post information indicating whether the hospital participates in Medicare.
6. *Penalties.* Hospitals and physicians that fail to comply with EMTALA can be fined up to \$50,000 by the U.S. Department of Health and Human Services for each violation. Hospitals can also lose the right to participate in Medicare and can be sued by individuals for damages for personal injury or to obtain a court order to require the hospital to comply with the law.

#### NOTE

If the hospital serves patients who do not speak English, the hospital is required to translate notices and to provide translation services. See Chapter 7 for further discussion of language access requirements.

## III. Hill-Burton Obligations

The Hill-Burton Act<sup>24</sup> is a federal law that provided hospitals and nursing homes with construction and renovation grant funds. In return, the facilities accepted two distinct obligations: the uncompensated care obligation and the community service obligation.

<sup>24</sup> 42 U.S.C. §291c.

### A. The uncompensated care obligation

**NOTE**

When determining financial eligibility for uncompensated care, a facility may require a 3-month residency to establish a base period for determining family income in the United States. This residency period is not related to immigration status or citizenship.

Facilities receiving Hill-Burton funds agree to provide a reasonable volume of services to persons unable to pay. The annual amount of free care provided must be worth 10 percent of all grants received or 3 percent of their annual operating costs. The obligation lasts only for 20 years after the date of the grant, so many facilities are no longer bound by it, but many are. To obtain a current list of facilities with an uncompensated care obligation go to [www.hrsa.gov/osp/dfcr/obtain/hbstates.htm](http://www.hrsa.gov/osp/dfcr/obtain/hbstates.htm). Facilities with uncompensated care obligations are supposed to post notices about their program in the facility. These notices must be easy to read and printed in languages other than English if a significant part of the community has limited English proficiency.

### B. The community service obligation

Unlike the uncompensated care obligation, the community service obligation never ends. It prohibits Hill-Burton facilities from discriminating on any ground unrelated to an individual's need for services or the availability of the needed services in the facility. Hill-Burton facilities are obligated to accept all persons able to pay for their care, either directly or through insurance coverage including Medicaid, Medicare, and state or local government programs. The facility also has a duty to take reasonable steps to ensure that the facility and its services are available to public assistance beneficiaries and to notify patients of any governmental programs for which they may be eligible. Notably, Hill-Burton hospitals must maintain an open emergency room for everyone in the service area, even those unable to pay.

### C. Enforcing Hill-Burton

The uncompensated care obligation is administered by the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS) office. HHS's Office for Civil Rights is responsible for investigating complaints of hospitals that refuse to honor their community service obligation. Hill-Burton obligations may also be enforced by filing an action in court after administrative remedies have been exhausted.

## IV. Federally Qualified Health Centers

### A. General rules

Federally Qualified Health Centers (FQHCs)<sup>25</sup> receive grants from the federal government to provide health services to underserved populations without regard to a person's ability to pay.

<sup>25</sup> 42 U.S.C. §254b et seq.

## B. Populations served

Underserved populations include migratory and seasonal agricultural workers, the homeless, public housing residents, and people who face barriers in accessing health services because they have difficulty paying for services, because they have language or cultural differences, or because there is an insufficient number of health professionals/resources available in their community.

## C. Services that must be provided

All FQHCs must provide:

1. *Basic health services.* Basic health services include primary care; diagnostic, laboratory, and radiology services; cancer and other disease screening; well child services; immunizations against vaccine-preventable diseases; screening for elevated blood lead levels, communicable diseases, and cholesterol; eye, ear, and dental screenings for children; family planning services; preventive dental services; emergency medical and dental services; and pharmaceutical services as appropriate to a particular health center.
2. *Services that help ensure access to basic health and social services.* Such services include case management; referrals to other medical and health-related providers; outreach, transportation, and interpretive services; health education; and help applying for benefits, including Medicaid.

## V. Migrant Health Clinics

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The U.S. Department of Health and Human Services also makes grants to public and private nonprofit health clinics that agree to provide services to migratory agricultural workers, seasonal agricultural workers, and their families.<sup>26</sup> The required services and obligations are almost identical to those of community health clinics except that migrant health clinic funds can only be used to serve migrants. Funding for this program is inadequate; the program serves only about 15 percent of the estimated farm worker population in need.

## VI. Rural Health Clinics<sup>27</sup>

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The Centers for Medicare and Medicaid Services designate certain clinics in rural areas to receive grant assistance. Services at these clinics include physician, nurse practitioner, and physician assistant services. Many of the services and payment rules that apply to community health clinics also apply to rural clinics.

<sup>26</sup> 42 U.S.C. §254b.

<sup>27</sup> 42 U.S.C. §1395x(aa).

## VII. Short-Term, Non-Cash, In-Kind Emergency Disaster Relief

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Immigrants, regardless of immigration status or date of entry, are eligible to receive short-term, non-cash, emergency disaster relief<sup>28</sup> such as emergency shelter, food, and clothing.

## VIII. Non-Medicaid Funded Public Health Services

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Immigrants, regardless of immigration status or date of entry, are eligible to receive non-Medicaid funded public health assistance<sup>29</sup> including:

- Immunizations for children and adolescents.
- HIV/AIDS-related care and treatment including services funded under the Ryan White Care Act.
- Tuberculosis screening, diagnosis, and treatment.
- Sexually transmitted disease screening, diagnosis, and treatment.
- Testing and treatment of symptoms of other communicable diseases even if the communicable origin is ruled out.

## IX. Community-Based Programs Necessary to Protect Life and Safety

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### A. General Rule

PRWORA authorized the U.S. Attorney General, in his sole and unreviewable discretion, to designate other community programs, services, and assistance for which all immigrants, regardless of immigration status, will continue to be eligible.<sup>30</sup>

### B. Requirements for designation

To be eligible for designation, the program, services, or assistance must meet three criteria:

1. *Be delivered in-kind at the community level, including through public or private non-profit agencies.*
2. *Not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the individual recipient's income or resources.*
3. *Be necessary for the protection of life and safety.*

<sup>28</sup> 8 U.S.C. §1611(b)(1)(B).

<sup>29</sup> 8 U.S.C. §1611(b)(1)(C).

<sup>30</sup> 8 U.S.C. §1611(b)(1)(D).

### C. Designated programs

Programs, services, and assistance designated by the attorney general include:

1. *Police, fire, ambulance, transportation, sanitation, and other regular, widely available services.*
2. *Crisis counseling and intervention programs, such as services and assistance relating to child protection, adult protective services, violence and abuse prevention, including victims of domestic violence or other criminal activity, or treatment of mental illness or substance abuse.*
3. *Short-term shelter or housing assistance for the homeless, for victims of domestic violence, or for runaway, abused, or abandoned children.*
4. *Programs, services, or assistance to help individuals during periods of adverse weather conditions.*
5. *Soup kitchens, community food banks, senior nutrition programs such as meals on wheels, and other such community nutritional services for persons requiring special assistance.*
6. *Medical and public health services (including treatment and prevention of diseases and injuries) and mental health, disability, or substance abuse assistance necessary to protect life and safety.*
7. *Activities designed to protect life and safety of workers, children, and youths or community residents.*
8. *Any other programs, services, or assistance necessary for the protection of life and safety.*

## X. Health Services Initiatives Under SCHIP

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Immigrant children, regardless of status or date of entry, may be eligible for services under a Health Services Initiative. Health Services Initiatives are special programs funded with money from the State Children's Health Insurance Program.<sup>31</sup>

## XI. Additional State and County Programs

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Be sure to check your local and state statutes to see if nonqualified immigrants have access to other programs beyond those mandated by federal law. Different states and counties vary in their provision of additional health programs for immigrants and their children regardless of their immigration status.<sup>32</sup> Also, most counties provide health care services to low-income persons at county facilities and clinics, regardless of immigration status.

<sup>31</sup> 42 U.S.C. §1397aa et seq. See Chapter 1 for additional information about Health Services Initiatives.

<sup>32</sup> See Chapter 3 for further discussion of state and local programs.



## **XII. Maximizing Access to Services Available to All Immigrants Regardless of Status and Date of Entry—Recommendations**

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Despite immigrant eligibility for Emergency Medicaid and other non-Medicaid funded services, obtaining care and coverage can be problematic.

- There may be little public awareness of the availability of these programs for nonqualified immigrants.
- Some states control access to Emergency Medicaid through restrictive—and arguably illegal—policies.
- Even if eligible for benefits, immigrants may be turned away or treated differently than other individuals in need of emergency and public health treatment because of discrimination.<sup>33</sup>
- Many immigrants have been discouraged from applying for any public benefits based on their fear of being identified as a “public charge” or being deported by Immigration and Naturalization Service for applying and/or receiving any such public benefits.

Here are some ideas to improve immigrant access to Emergency Medicaid:

- Review state policies and application forms to determine whether the policies and forms hinder or facilitate access to Emergency Medicaid. Do the forms require applicants to provide a Social Security Number? Do they ask questions about immigration status, which are not relevant to the eligibility determination? Do they ask questions about the immigration status of family members? Do they require unnecessary documentation?
- Survey public and private hospitals to determine whether they are complying with EMTALA, making Emergency Medicaid available, and providing appropriate translation and interpreter services. Collect stories from immigrants about their experiences in hospital emergency rooms.
- Advocate for precertification of eligibility for Emergency Medicaid. At least two states, California and Massachusetts, have procedures in place that allow nonqualified immigrants to pre-qualify for Emergency Medicaid. Immigrants found eligible for Emergency Medicaid are issued a Medicaid card that entitles them to emergency care only. Notably, utilization of emergency care by immigrants in California far surpasses utilization in all other states. According to the Urban Institute, for example, undocumented immigrants in California are ten times more likely to receive Emergency Medicaid than undocumented immigrants in the other 49 states. Although more research is

<sup>33</sup> Such discrimination may be actionable pursuant to Title VI, EMTALA, and the Hill-Burton Act.

needed to account for the wide discrepancy in utilization rates, pre-certification appears to have a positive impact on public and provider awareness of Emergency Medicaid coverage. Pre-certification of Medicaid eligibility for emergency care also gives providers assurance that they will get paid for services they provide and therefore probably helps to increase provider participation.

- Educate the immigrant community about their eligibility for Emergency Medicaid, EMTALA protections, public health services, and community-based services necessary to protect life and safety. Reassure immigrants that they cannot be denied a green card or be deported solely for seeking and receiving Medicaid or any other health care services for which they qualify.
- Identify gaps in coverage (e.g., post-stabilization treatment, preventative care for nonqualified immigrants, and immigrants who arrived after August 22, 1996), identify allies, and work together to develop and fund projects to fill the gaps.

## State and Local Programs<sup>34</sup>

Before welfare reform, state and local governments funded programs to provide health care to low-income immigrants who did not qualify for federally funded programs such as Medicaid. Now, if states want to provide state and local benefits to undocumented immigrants, the PRWORA requires states to affirmatively pass legislation to provide for such eligibility. PRWORA also allows states to impose new restrictions on qualified immigrants' access to state and local public benefits.

Fortunately, many states that had programs in place prior to PRWORA continued to fund them, and some have committed new funds to cover additional initiatives. Still, immigrant health access remains a patchwork. Although an exhaustive discussion of state and local programs is beyond the scope of this manual, this chapter summarizes characteristics of state-funded programs that address immigrant health needs.

### I. Limited Coverage

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Most state-funded initiatives provide limited coverage. Coverage may be limited to particular populations such as children or immigrants who are living in nursing homes. Some states limit coverage by types of service such as prenatal care. Many limit coverage to those who were receiving benefits when PRWORA was enacted or some other date—in effect “grandfathering” coverage and avoiding having to cut people off who otherwise would have lost their benefits.

<sup>34</sup> For an excellent discussion of how states have responded to immigrants' assistance needs after welfare reform, see W. Zimmerman and K. Tumlin, *Patchwork Policies: State Assistance for Immigrants Under Welfare Reform*, The Urban Institute, May 1999. See also Appendix C.

## II. Restricting Access

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States have applied sponsor-deeming rules, residency requirements, and other restrictions that limit immigrants' eligibility for coverage.

## III. Examples of State Programs

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There is tremendous variation in state-funded programs and the extent to which immigrants are covered. States with the most extensive coverage include California, Washington, Hawaii, Connecticut, Massachusetts, Rhode Island, Minnesota, New Jersey, New York, Pennsylvania, and Wisconsin.<sup>35</sup> However, no state has come close to replacing the health benefits lost when PRWORA was enacted or filled in all the gaps that predate the law. For example:

### A. Covering Persons Residing Under Color of Law

Nine states are continuing to provide the equivalent of Medicaid coverage to PRUCOL immigrants. These states are: California, Michigan, Pennsylvania, Connecticut, Missouri, Rhode Island, Delaware, Maine, and New York. (Under a recent decision from New York's highest court, *Aliessa v. Novello*, the court ruled that the state law restricting access to its Medicaid program for PRUCOL immigrants entering the U.S. after September 22, 1996, was unconstitutional because it discriminated between groups of immigrants.) Another ten states are providing coverage to PRUCOL immigrants, but coverage is limited to particular populations or types of care. In Washington, post-enactment PRUCOL immigrants are subject to a one-year residency requirement.

### B. Prenatal care

Twenty-one states provide coverage for prenatal care to legally present immigrants. Ohio limits coverage only to immigrants who were legally present prior to August 22, 1996. Seventeen states provide coverage for prenatal care for undocumented immigrants.

### C. Long-term care and other special populations

Twenty-three states provide some long-term care coverage for legally present immigrants. Most states only cover people who were already receiving benefits.

- In Texas, only PRUCOL immigrants who were receiving benefits as of August 22, 1996, remain eligible.

<sup>35</sup> See Zimmerman and Tumlin, Table 18, Appendix C.

- Ohio and Alaska only cover PRUCOL immigrants who were present prior to enactment of PRWORA.
- California and Minnesota provide long-term care to undocumented immigrants.

#### **D. Health insurance for the elderly and people with disabilities**

Nineteen states have state-funded health insurance programs that provide some coverage to immigrants. In most states, however, coverage is less than that provided under Medicaid. For example:

- New Jersey has two state-funded health insurance programs for uninsured people who are elderly or disabled. The Charity Care program covers all uninsured individuals with incomes up to 200 percent of the Federal Poverty Level. There is a sliding-fee scale for individuals with incomes between 200 percent and 300 percent of FPL. There is no verification requirement for Charity Care and both post- and pre-enactment qualified immigrants are eligible. The GA-Medical program covers elderly and disabled residents who qualify for the state's General Assistance program. However, only pre-enactment qualified immigrants are eligible. The program is also time limited. Noncitizens who are eligible to naturalize are limited to six months of assistance.
- Washington has three programs that provide health care to uninsured elderly and disabled residents: GA-Unemployable, the Medically Indigent program, and the Basic Health Plan. All three programs are open to qualified immigrants, regardless of when they entered the country; however, sponsor-deeming applies (although it has not yet been implemented).
- Connecticut has a state-funded General Assistance Medical program. Noncitizens must live in the state for six months to qualify for these services.
- Wyoming has a state-funded prescription program that covers three prescriptions per month as well as oxygen. Qualified immigrants are eligible.

#### **E. Health insurance coverage for families with children**

Twenty states have some form of health insurance coverage for families with children. All provide coverage to pre-enactment qualified immigrants; three restrict the access of post-enactment qualified immigrants. For example:

- In California, counties are mandated to provide General Relief, including medical assistance to needy persons who do not qualify for federally funded assistance. The program eligibility rules and services vary by county. Some counties impose time limits.
- Several states such as Massachusetts and Colorado have programs that provide coverage for children, but not their parents.

### F. Coverage for new entrants

Only four states have opted to provide state-funded Medicaid coverage for immigrants arriving on or after August 22, 1996, the date PRWORA was enacted. These states—Illinois, Maryland, Virginia, and Rhode Island—all limit coverage to immigrant children and pregnant women.<sup>36</sup>

## IV. Maximizing State and Local Benefit Programs

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Advocacy is key to securing and maintaining funding at the state and local levels for programs that provide health care to immigrants. States with the strongest safety nets are also the states with organized coalitions that work to influence political leadership. Clearly, much can be done at the state and local level to direct resources to fill the gaps and serve the health needs of immigrant communities. Here are some suggestions:

- Identify the programs currently funded by state and local dollars. Find out about how they operate and who they cover. Are there eligibility rules or restrictions that make immigrant access difficult or unlikely? If so, work to eliminate those barriers.
- Explore how well these programs are utilized by immigrants. If utilization is low, find out why. Create an outreach campaign to let communities know about the programs that exist.
- Identify the community's needs. There are many gaps to fill so you will need to prioritize. Find out what other states and communities have done. Create an action plan and then work collaboratively with others to build support to expand coverage.
- Institutional health care providers such as hospitals can be powerful allies in these efforts.

<sup>36</sup> Congress is currently considering several proposals to give states the option to restore Medicaid benefits to some new entrants.

# CHAPTER FOUR

## New Responsibilities for Sponsors: Affidavits of Support, Sponsor Liability and Sponsor-Deeming of Income

As part of the immigration process, many, but not all, immigrants will need to have a sponsor. A sponsor is someone who is willing to sign an agreement to provide financial support to the immigrant. The agreement is called an “affidavit of support.”

Prior to the enactment of PRWORA and the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) in 1996, INS and consular officials could require that a sponsor sign an affidavit of support to provide assurances that the immigrant would not become a “public charge.” Once signed, the income of the person signing the affidavit could be deemed available to the immigrant for three years.

PRWORA and IIRIRA substantially changed the rules regarding affidavits of support and sponsor-deeming of income. As explained in this chapter, the new changes impose greater legal liability on sponsors and make it more difficult for new immigrants to qualify for public benefits even after they have lived in the United States for five years.

### **I. Affidavits of Support<sup>37</sup>**

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#### **A. Definition**

An affidavit of support under PRWORA and IIRIRA is a legally enforceable agreement between the sponsor and the government whereby the sponsor agrees to provide sufficient support to maintain an immigrant at 125 percent of the FPL. The new affidavit of support is Form I-864.

<sup>37</sup> 62 Fed. Reg. 54 346-56, October 20, 1997; 8 C.F.R. Part 213a.

## **B. Effective date**

The new Form I-864 became effective on December 19, 1997. Almost all family-based immigrants who have consular interviews or who are filing adjustment of status applications on or after December 19, 1997, must file the new Form I-864.

## **C. Duration**

New affidavits of support are legally binding upon the sponsor until:

1. The sponsor dies.
2. The immigrant:
  - a. Becomes a U.S. citizen.
  - b. Obtains 40 quarters of creditable Social Security coverage.
  - c. Leaves the United States and gives up Legal Permanent Resident (LPR) status.
  - d. Dies.

## **D. Extent of sponsor liability**

1. If a sponsored immigrant subject to a new affidavit of support receives a federal means-tested public benefit<sup>38</sup> that has not been specifically exempted from this requirement, the sponsor is responsible for repayment of the benefit within 45 days of a request for repayment by a benefit-granting agency.
2. Any federal, state, or local government entity can take legal action against the sponsor to enforce the affidavit of support.
3. The government has up to ten years from the date on which the immigrant last received the public benefit to bring an action for repayment against the sponsor.
4. The sponsor must keep INS informed of her/his current address. Failure to do so can result in fines ranging from \$2,000 to \$5,000.

## **E. Means-tested public benefits**

Only receipt of nonemergency Medicaid, SCHIP, Temporary Assistance for Needy Families (TANF), SSI, and Food Stamps triggers sponsor liability for repayment.

<sup>38</sup> The following have been defined as federal means-tested public benefits: Supplemental Security Income, Food Stamps, TANF, and Medicaid/SCHIP.



## F. State option to use deeming rules

States have the option to use the sponsor-deeming rules when determining immigrants' eligibility for state and local benefit programs. States cannot use sponsor-deeming rules to determine eligibility for:

- Emergency Medicaid.
- Short-term emergency relief.
- Child nutrition programs.
- Public health assistance for immunizations.
- Testing and treatment of communicable diseases.
- Foster care and adoption assistance.
- Services delivered in-kind, at the community level, that are necessary to protect life or safety.

## G. Immigrants who must submit "new" affidavits (Form I-864)<sup>39</sup>

Almost all family-based immigrants, including employment-based immigrants when the petitions are also family-based (such as when a relative is the employer/petitioner/sponsor or a relative owns 5 percent or more of the employing company), are required to submit Form I-864. Exceptions are made only for:

1. Widows/widowers (who must have been married for two years to a citizen, not to an LPR).
2. Battered spouses (pursuant to the Violence Against Women Act).

## H. Who can be a sponsor?

Under the new affidavit of support rules, a petitioner must be a sponsor. A sponsor can be anyone who is:

1. *A U.S. citizen, national, or Legal Permanent Resident;*
2. *At least 18 years of age;*
3. *Domiciled in the United States or any U.S. territory or possession; and*
4. *Able to meet income/assets requirements.*

## II. Sponsor-Deeming

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Since the early 1980s, several federally funded programs such as AFDC, SSI, and Food Stamps have automatically deemed income and resources to immigrants from their sponsors (those persons who sponsor their entry into the United States) to determine the immigrants' eligibility for, and amount

<sup>39</sup> The old I-134 form may still be used for categories of immigrants who are not required to use the I-864 form, such as students, parolees, or diversity immigrants. U.S. INS News Release, *Questions and Answers—Public Charge*, May 25, 1999.

of benefits available under, each of those programs. Under PRWORA, all federal means-tested public benefits, including Medicaid and SCHIP, are subject to new sponsor-to-immigrant-income-deeming rules.

### **A. Deeming defined**

Deeming means that in determining financial eligibility, the benefits-granting agency counts the income and resources of the sponsor and the sponsor's spouse as though they were available to the sponsored immigrant.

### **B. Duration of the attribution period**

Immigrants subject to new affidavits of support are subject to sponsor-to-immigrant deeming of income until they naturalize or have 40 qualifying quarters of coverage.

### **C. Exceptions to deeming rules**

1. *Benefit-granting agencies may not apply sponsor-deeming rules to:*
  - a. Refugees.
  - b. Asylees.
  - c. Battered spouses and their children for one year (where the need for benefits has a substantial connection to the battery or cruelty and may be extended if the abuse has been recognized by a court, Administrative Law Judge, or the INS).
  - d. Indigent immigrants who have been abandoned by their sponsor and would otherwise go without food or shelter (limited to one year).
2. *Some types of benefits are exempt from the deeming rules. These include:*
  - a. Emergency Medicaid.
  - b. Short-term, noncash, in-kind emergency disaster relief.
  - c. Assistance or benefits comparable to benefits provided under the National School Lunch Act and the Child Nutrition Act of 1966.
  - d. Non-Medicaid-funded, public health assistance for immunizations and for testing and treatment of symptoms of communicable diseases whether or not such symptoms are caused by a communicable disease.
  - e. Foster care and adoption assistance.
  - f. In-kind services such as soup kitchens, crisis counseling, and shelters.
3. *State options to apply sponsor-deeming rules to state benefits.*
  - a. In determining the eligibility and the amount of benefits of an immigrant for state public benefits, states have the option to count the income and resources of the immigrant's sponsor and his/her spouse.
  - b. States may not apply sponsor immigrant deeming rules to exempt programs such as Emergency Medicaid, short term, noncash, in-kind disaster relief, public health assistance, programs designated by the attorney general, child nutrition and school lunch programs, among others.

### III. Current Sponsor Liability Issues—Recommendations

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The stricter affidavit of support and sponsor-deeming rules were implemented to ensure that no recent immigrant would become a “public charge” in the future. Since both the INS and the State Department have broad discretion in deciding the likelihood of an applicant’s becoming a public charge, this area is gray and constantly changing. This makes advocates’ role in advising immigrant sponsors very difficult. However, there are advocacy efforts that can maximize the chances that eligible immigrants will receive public benefits, ensure that sponsors will not be discouraged from completing an affidavit of support to sponsor immigrants, and prevent an immigrant from being disqualified for public benefits due to the new sponsor-deeming rules:

- Review the policies of your local and state benefit agencies to determine if any agency requires the sponsor to repay any benefit payments. The decision to demand payment is discretionary, therefore public benefit-granting agencies, particularly those providing health benefits, may be persuaded that becoming a collection agency is antithetical to its mission and is not cost-effective.
- Monitor your local agencies’ interpretation of the federal statute and regulations governing affidavits of support and sponsor-deeming rules. Because the agencies have so much discretion to interpret and implement the federal statute and regulations, they can exercise their authority to interpret ambiguous provisions of the statute in ways that are more favorable to the immigrant.



## Verification of Status, Confidentiality, and Reporting

One of the major barriers to health care access for immigrants is their fear that their use of benefits and accessing of health services may be reported to the INS and that the mere use of benefits will have an adverse impact on their immigration status. Recent changes in the welfare and immigration laws have heightened immigrants' concerns. This chapter reviews the rules governing verification, reporting, and confidentiality, and provides some suggestions to help minimize immigrants' concerns about being reported to the INS.

### I. Verification of Immigration Status, Generally

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Under PRWORA and IIRIRA, the U.S. Attorney General was required to issue new regulations establishing a system to verify the status of immigrants applying for federal public benefits and to establish a fair and nondiscriminatory procedure for a person to establish proof of citizenship. Within 24 months of the date of the regulations, state agencies that administer federal public benefits must have a verification system in place that complies with the regulations.

The U.S. Attorney General issued interim guidance on verification of citizenship and immigration status on November 17, 1997.<sup>40</sup> The U.S. Attorney General's proposed regulations were published on August 4, 1998.<sup>41</sup> They have not yet been finalized.

<sup>40</sup> See *Interim Guidance on Verification of Citizenship, Qualified Alien Status, and Eligibility Under Title IV*, of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 62 Fed. Reg. 61344, November 17, 1997.

<sup>41</sup> See *Verification of Eligibility for Public Benefits*, 63 Fed. Reg. 41662, August 4, 1998 (proposed rule).

Most of PRWORA's verification requirements are not new. Since 1986, various benefit-granting agencies, including state Medicaid agencies, have been required to verify immigration status using a system operated by the INS called the Systematic Alien Verification for Entitlements system (SAVE). The INS has refined and operated SAVE for over ten years. The Attorney General's interim guidance and proposed rules are based on the SAVE system. However, there are some new requirements.

## II. Verification of Immigration Status for Medicaid and SCHIP

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### A. Signed declaration of proper immigration status

An applicant for Medicaid or SCHIP must provide a signed declaration under penalty of perjury that he or she is a citizen or national of the United States, or a qualified immigrant.

If the applicant is a child or is not competent, another individual must complete the same written declaration under the same terms and penalties. However, if an immigrant is applying for benefits on behalf of another person, federal law only allows the agency to verify the status of the person who will actually be receiving the benefits.

An applicant who is not a citizen or national of the United States, and who is not a qualified immigrant, is not required to provide a declaration of satisfactory immigration status.

### B. Documentation

In addition to the signed declaration, adult citizens, nationals, and qualified immigrants who are applying for Medicaid must provide the state with documentation of citizenship or immigration status and the date upon which that status was granted.

Under current federal policy, children who are citizens and who are applying for either Medicaid or a separate state SCHIP program may establish their citizenship on the basis of self-declaration. States are permitted to require further verification as a condition of eligibility.<sup>42</sup> Self-declaration may not be permitted once the Attorney General's regulations are finalized.

Children who are qualified immigrants must present documentation of their immigration status. States must verify this status using SAVE.

<sup>42</sup> *State Medicaid Director's Letter*, Health Care Financing Administration, September 10, 1998.

### C. Methods of documentation

1. *Acceptable documentation for U.S. citizens and nationals include:*
  - a. Birth certificate.
  - b. Religious record showing the date of birth or individual's age at the time the record was made.
  - c. United States passport.
  - d. Report of Birth Abroad of a Citizen of the United States (Form FS-240).
  - e. Certification of Birth (INS Form FS-545).
  - f. U.S. Citizen I.D. Card (INS Form I-197).
  - g. Naturalization Certificate (INS Forms N-550 or N-570).
  - h. Certificate of Citizenship (INS Forms N-560 or N-561).
  - i. Northern Mariana Identification Card (issued by the INS).
  - j. American Indian Card with a classification code "KIC."
  - k. Contemporaneous hospital record of birth in one of the 50 states, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam (on or after April 10, 1988), the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands.
  - l. Evidence in lieu of documentation: Under the Attorney General's proposed rule, states have the option to accept a written declaration made under penalty of law from one or more third parties indicating a reasonable basis for personal knowledge that an applicant who cannot produce evidence of U.S. nationality is a U.S. national.
2. *Acceptable documentation of qualified immigrant status consists of the following:*
  - a. *Legal Permanent Resident.* INS Form I-551, or for recent arrivals, a temporary I-551 stamp in a foreign passport or on Form I-94.
  - b. *Refugee.* INS Form I-94 annotated with stamp showing entry as refugee and date of entry to the United States; INS Forms I-688B annotated "274a.12(a)(3)," I-766 annotated "A3," or I-571.
  - c. *Asylee.* INS Forms O-94 annotated with stamp showing grant of asylum; a grant letter from the INS Asylum Office; Forms I-688B annotated "274a.12(a)(5)" or I-766 annotated "A5."
  - d. *Alien whose deportation has been withheld.* Order of an Immigration Judge showing deportations withheld and the date of the grant, or INS Forms I-688B annotated "274a.12(a)(10)" or I-766 annotated "A10."
  - e. *Alien granted parole for at least one year by the INS.* INS Form I-94 annotated with stamp showing grant of parole and a date showing granting of parole for at least one year.
  - f. *An alien granted conditional entry under immigration law in effect before April 1, 1980.* INS Form I-94 with stamp showing admission under §203(a)(7) of the INA, refugee, conditional entry; or INS Forms I-688B annotated "274a 12(a)(3)" or I-766 annotated "A3."

## E. Expired and missing documents

An applicant who presents expired INS documents or is unable to present any documentation of his or her immigration status should provide the Medicaid agency with his/her alien registration number. If the immigrant is unable to provide his/her alien registration number, the Medicaid agency will refer the immigrant to the local INS district office to obtain evidence of his/her status.

Medicaid agencies are required to provide applicants with a reasonable amount of time to provide documentation and must provide Medicaid eligibility pending verification of immigration status if the applicant meets all other nonimmigration Medicaid eligibility requirements.

## F. Duty to verify immigration status

1. *Federal benefit-granting agencies.* All federal benefit-granting agencies, including state agencies administering federal programs and provider organizations must verify immigration status using procedures established by the Attorney General.
2. *State and local benefit-granting agencies.* Under PRWORA, state and local benefit-granting agencies are not required to verify immigration status. However, under immigration laws, states are authorized to require applicants to provide proof of satisfactory immigration status and they have considerable flexibility to use the SAVE system or establish their own verification procedures.
3. *Nonprofit charitable organizations.* Under PRWORA, nonprofit charitable organizations that provide federal, state, and local public benefits are not required to determine, verify, or otherwise require proof of an applicant's eligibility for such benefits based on the applicant's status as a U.S. citizen, a U.S. noncitizen national, or qualified alien. To be eligible for this exemption, an organization must be both "nonprofit" and "charitable" (see glossary).

A nonprofit charitable organization cannot be penalized for providing federal public benefits to an individual who is not a U.S. citizen, U.S. noncitizen national, or qualified alien, except when it does so either in violation of independent program verification requirements or in the face of a verification determination made by a nonexempt entity.

## G. Nondiscrimination

Various federal civil rights laws and regulations prohibit discrimination by governmental and private entities on the basis of race, color, national



origin, gender, religion, age, and disability.<sup>43</sup> Therefore, verification procedures must be administered in a nondiscriminatory way. Providers and benefit-granting agencies are prohibited from singling out individuals who look foreign or requiring certain groups or individuals to provide additional documentation. All similarly situated individuals should be treated in the same manner.

In recognizing the “particular potential for discrimination on the basis of national origin,” the Attorney General’s interim guidance warns against “obvious or subtle” forms of discrimination, ranging from:

1. *Denials or delays of determinations of eligibility for benefits because of race, color, or national origin.*
2. *Denials because the applicants “have ethnic surnames or origins outside the U.S.” or because they “look or sound foreign” or actions based on assumptions of such characteristics.*
3. *Imposition of additional eligibility requirements on ethnic or racial minorities because of their ethnicity or race.*<sup>44</sup> “It may be discriminatory to demand a specific applicant present three documents to establish her identity merely because she speaks Spanish or looks Asian, while allowing English-speaking persons and non-Asians to present only one identity document. It may also be a violation of Title VI to assume, based on an applicant’s national origin, that his or her documents are fraudulent.”

## H. Exempt programs

Some benefits are not federal public benefits or are exempt from the law. If the federal program does not provide a “federal public benefit” or is otherwise exempt, the benefit provider is not required to, and should not attempt to, verify an applicant’s status, unless otherwise required or authorized to do so by law, because all immigrants, regardless of their immigration status, are eligible for such benefits.

## I. Determination of Benefits

In most circumstances, a provider should determine whether an applicant otherwise meets the specific program requirements for benefit eligibility before initiating the verification process.

<sup>43</sup> They include Title VI of the Civil Rights Act of 1964, 42 U.S.C. §2000d et seq.; §504 of the Rehabilitation Act of 1973, 29 U.S.C. §794, the Americans with Disabilities Act of 1990, 42 U.S.C. §12101 et seq.; the Age Discrimination Act of 1975, 42 U.S.C. §6101 et seq.; and the Fair Housing Act, 42 U.S.C. §3601 et seq.

<sup>44</sup> The guidance explains that there is no single immigration document that will establish every immigrant’s qualifications to receive benefits under PRWORA.

### III. Privacy and Confidentiality

The Medicaid program operates under strict privacy protections. By law, federal and state Medicaid authorities must:

- Safeguard information regarding applicants for and recipients of Medicaid benefits.<sup>45</sup>
- Not disclose information to an outside entity unless it relates directly to the administration of the state plan.<sup>46</sup>

When implementing verification requirements:

- Benefit-granting agencies should be sensitive to privacy interests. Citizenship and immigration status information should be used only for purposes of verifying the applicants' eligibility for benefits.
- Governmental entities may use the information to the extent provided under PRWORA (see reporting requirements below).<sup>47</sup>

The Privacy Act<sup>48</sup> and state and local privacy protections and program requirements may also provide protection for immigrants.<sup>49</sup>

### IV. Reporting

There is much confusion and ambiguity concerning PRWORA's new reporting requirements.

#### A. Mandatory reporting under Section 404

*PRWORA, Section 404, requires agencies that administer SSI, housing assistance programs under Sections 6 and 8 of the U.S. Housing Act of 1937, or block grants under TANF programs to make a quarterly report to the INS of the name and other identifying information of persons the agency knows are not legally present in the United States.*<sup>50</sup>

<sup>45</sup> §1902(a)(7) of the Social Security Act, 42 U.S.C. 1396a(a)(7).

<sup>46</sup> *Id.* State Medicaid agencies, for example, are prohibited from providing information about the receipt of benefits or the dollar amount of those benefits to the INS, the State Department, or immigration judges. The only exception would be if the disclosures were necessary to assist the state to collect outstanding debts incurred for the receipt of benefits paid. See *Letter from Sally Richardson to State Medicaid Directors*, December 17, 1997.

<sup>47</sup> Interim Guidance on Verification of Citizenship, 62 Fed. Reg. 61344, November 17, 1997.

<sup>48</sup> 5 U.S.C. 552a.

<sup>49</sup> For example, *California Welfare & Institutions Code*, §10500 states that persons administering public assistance shall secure aid "without attempting to elicit any information not necessary to carry out" the program.

<sup>50</sup> Six federal agencies, including HHS, DOJ, and INS, issued a notice in the Federal Register defining what it means to "know" that an immigrant is not lawfully present in the United States. According to the notice, an entity is not required to make quarterly reports to the INS unless it has knowledge of an individual who is not lawfully present. An entity will "know" an immigrant is not lawfully

**This provision does not apply to the Medicaid or other health programs.** However, in many states, the same agency that is responsible for TANF eligibility determinations is also responsible for making Medicaid eligibility determinations. Forty-eight states actually use a single or combined application form for TANF and Medicaid.

## B. Preemption of “sanctuary ordinances”

1. *PRWORA, Section 434, and IIRIRA, Section 642, both contain provisions that are intended to preempt sanctuary ordinances.* These are ordinances that have been adopted by over 20 jurisdictions to protect immigrants who report crimes or seek assistance from public authorities.
2. *Both provisions prohibit restrictions on communication of information with the INS regarding the citizenship or immigration status of any individual.* Although these provisions do not negate existing privacy protections, they create enormous potential for breaches in confidentiality.

## V. Recommendations to Minimize Concerns about Reporting and Confidentiality

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PRWORA’s reporting and verification requirements are having a major negative impact on immigrant access to health services. Immigrants are discouraged from applying for Medicaid for fear of being reported to the INS despite their eligibility. The following recommendations provide suggestions to protect their rights and privacy:

- To the greatest extent possible, urge your state to permit self-attestation and third-party declarations as alternatives to requiring an applicant to produce documentary evidence that the applicant is a U.S. national.
- Monitor your state verification and reporting procedures, as well as your state privacy laws. Some state policy directives concerning verification and reporting have been confusing, and sometimes contrary to federal guidelines. For example, in New York, Social Services Law

present only as a result of a finding of fact or conclusion of law that is: (1) made as part of a formal determination by the entity; (2) subject to administrative review; and (3) supported by an INS determination, such as a final order of deportation. A response from the SAVE system that an immigrant has no record or is ineligible for benefits does not equal “knowing” an immigrant is not lawfully present. Unless necessary to determine eligibility, an entity does not have to make a formal determination as to whether the immigrant is lawfully present. Responsibility of certain entities to notify Immigration and Naturalization Service of any alien who entity knows is not lawfully present in United States, 65 Fed. Reg. 58301-03, September 28, 2000.

Section 122(3) provides that “each social services district shall report to the [Department of Social Services] . . . the name and address and other identifying information known to it, with respect to any alien known to be unlawfully in the United States.” Advocates in New York are seeking clarification to minimize the risk that undocumented immigrants who seek emergency care and other health services will be reported to INS in violation of federal law and policy.

- Applicants who are very old or are mentally incapacitated may have difficulty producing the types of documentation required under existing policies. Civil rights laws including Title VI and the Americans with Disabilities Act may help win accommodations that make it easier for some applicants to prove their status.
- Advocate for separate applications for those programs requiring verification and reporting and for those that do not. In most states, the agency responsible for processing TANF applications is also responsible for processing Medicaid applications, and most states are using a single application for both programs.
- If they don’t ask, they can’t tell. Make sure that your state application procedures only ask for information that is absolutely necessary to make the eligibility determination. Eligibility workers never need to ask whether an applicant is undocumented or not lawfully present. If the information is not being collected, it cannot be reported.
- Publicize the confidentiality protections of the Medicaid statute. Include them on the application forms.
- Minimize the potential for workers and others to make unauthorized disclosures by making sure your state agency has clear policies and rules about the process for appropriate communications with INS. This is especially important considering an agency’s obligation to comply with civil rights laws.
- Train eligibility workers so they clearly understand the verification and reporting requirements for the different federal and state benefit programs. Eligibility workers and their supervisors are likely to be confused about their reporting obligations, and sorting them out may be easier said than done. For example, in the District of Columbia, the Office of Income Maintenance (which is responsible for processing TANF, food stamp, and Medicaid applications) distributed a notice informing recipients that the agency is required by law to inquire as to immigration status and report the information to INS in almost all situations where a recipient would be applying for benefits, including Medicaid benefits. This notice was subsequently withdrawn. There have also been reports that eligibility workers insist that all parents provide their own Social Security Numbers and verification, even when only the child is applying for benefits. These actions are clearly wrong and are sending an incorrect message to immigrants.

- Ask your state and local agencies to make it clear to applicants that only those applicants who are receiving covered federal benefits are required to provide verification of immigration status. Applications for medical assistance often routinely ask for Social Security Numbers and other identifying information contributing to immigrants' fear of being reported to INS. Although CMS State Medicaid Manual Section 3211.9 makes clear that "not qualified" immigrants who are undocumented do not have to provide a Social Security Number in order to receive Emergency Medicaid, the failure or refusal to fill in the blanks on a preprinted form may itself raise anxiety.
- Encourage your governor, cabinet secretary, department head, or other appropriate state official to issue executive orders to clarify and coordinate reporting requirements to assure confidentiality and protection of antidiscrimination laws.
- If any public or private agency operating any program or activity receiving federal funds or other federal financial assistance appears to be making determinations based on race, color, or national origin in violation of civil rights laws, consider pursuing a complaint with the Office for Civil Rights. (See Appendix D.)



## Public Charge Determinations

### NOTE

Keep in mind that public charge determinations have nothing to do with whether or not an immigrant is eligible to receive a public benefit. Benefit-granting agencies such as the Medicaid agency or the welfare department do not make public charge determinations.

Under U.S. immigration law, a person who is likely to become a “public charge” can be excluded from entering or reentering the United States as an immigrant, denied permanent resident status, or, under very limited circumstances, deported. Immigrants’ fear of being found a public charge, especially in the wake of PRWORA, has deterred many immigrants from seeking and accepting public benefits, including health care benefits, even when they are lawfully entitled to receive them.

On May 26, 1999, the Immigration and Naturalization Service issued clarifying guidance and a proposed rule on public charge determinations.<sup>51</sup> The guidance and rule provide comprehensive information about how and under what circumstances public charge determinations are made. Among other things, the guidance and rule provide: (1) a clear definition of the term “public charge” and (2) a description and list of the kinds of benefits that will and will not result in a public charge finding. This chapter describes the new guidance and its potential to improve immigrant access to health care.

### I. The Meaning of Public Charge

*Public charge* is a term used by the INS to identify an immigrant who has or is likely to become primarily dependent on the government for subsistence as demonstrated either by:

- Receipt of public cash assistance for income maintenance; or
- Institutionalization for long-term care at government expense.

<sup>51</sup> *Inadmissibility and Deportability on Public Charge Grounds: Field Guidance on Deportability and Inadmissibility on Public Charge Grounds*, Proposed Rule and Notice, 64 Fed. Reg. 28676, May 26, 1999.

## A. Receipt of public cash assistance

The types of public benefits considered to be public cash assistance for income maintenance and therefore relevant to the public charge determination include:

1. *Supplemental Security Income.*
2. *Temporary Assistance to Needy Families.*
3. *State and local cash assistance programs for income maintenance (such as General Assistance).*

## B. Cash benefits not considered public cash assistance

Some types of cash benefits are *not* considered to be public cash assistance for income maintenance. These include:

1. *Supplemental “cash” benefits that are paid to TANF recipients that are excluded from the term “assistance” under TANF program rules.<sup>52</sup>*
2. *Cash benefits that are not intended for income maintenance such as the Low-Income Home Energy Assistance Program (LIHEAP),<sup>53</sup> which pays benefits to help low-income families purchase heating oil and fuel; food stamp benefits paid in cash;<sup>54</sup> payments made to help families pay for child care;<sup>55</sup> educational assistance; and non-recurring and short-term crisis benefits.*
3. *Cash benefits that have been earned, such as government pension benefits, veterans’ benefits, and Social Security benefits under Title II.<sup>56</sup>*

## C. Institutionalization for long-term care at government expense

The guidance and proposed rule do not clearly define what is meant by institutionalization for long-term care at government expense. The guidance and rule do make clear that short-term institutionalization for periods of

<sup>52</sup> TANF regulations list the following exclusions: (1) nonrecurrent, short-term benefits that: (i) are designed to deal with a specific crisis situation or episode of need; (ii) are not intended to meet recurrent or ongoing needs; and, (iii) will not extend beyond four months; (2) work subsidies, i.e., payment to employers or third parties to help cover the costs of employees’ wages, benefits, supervision, and training; (3) supportive services such as child care and transportation provided to families who are employed; (4) refundable earned income tax credits; (5) contributions to, and distributions from, Individual Development Accounts; (6) services such as counseling, case management, peer support, child care information and referral, transitional services, job retention, job advancement, and other employment-related services that do not provide basic income support; and, (7) transportation benefits provided under a Job Access or Reverse Commute project, pursuant to section 404(k) of the Act, to an individual who is not otherwise receiving assistance. 45 CFR 260.31.

<sup>53</sup> See 42 U.S.C. §8621 et seq.

<sup>54</sup> See e.g., 7 U.S.C. §2026 (b).

<sup>55</sup> See the Child Care and Development Block Grant Program (CCDBGP), 42 U.S.C. §9858 et seq.

<sup>56</sup> See 42 U.S.C. §401 et seq.



rehabilitation does not demonstrate primary dependence on the government. Arguably, the public charge question should only be relevant if the institutionalization is permanent and the government support substantial.<sup>57</sup>

## II. Noncash Public Benefits That Are Not, by Themselves, Relevant to a Public Charge Determination

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Noncash, supplemental public benefits are not relevant to the public charge determination. These include, among others:

- Food stamps.<sup>58</sup>
- Medicaid benefits (other than Medicaid payments for long-term care).<sup>59</sup>
- Benefits under the State Children’s Health Insurance Program.<sup>60</sup>
- Other types of health insurance and health services benefits such as emergency medical assistance, immunizations, testing for and treatment of communicable diseases, and use of health clinics.
- Nutrition programs including the Special Supplemental Nutrition Program for Women, Infants and Children,<sup>61</sup> the Child Nutrition Act,<sup>62</sup> and the Emergency Food Assistance Act.<sup>63</sup>
- Emergency disaster relief.
- Housing benefits.
- Child care services.
- Energy benefits.<sup>64</sup>
- Foster care and adoption benefits.
- Transportation vouchers, or other noncash transportation services.
- Educational benefits including Head Start and aid for elementary, secondary, or higher education.
- Noncash benefits funded under TANF.<sup>65</sup>
- State and local supplemental, noncash benefits that serve purposes similar to the federal programs listed in this paragraph.
- Other federal, state, or local public benefit programs under which benefits are provided in-kind, through vouchers, or any other medium of exchange other than payment of cash assistance for income maintenance.

<sup>57</sup> See letter from Kevin Thurm, Deputy Secretary of Health and Human Services, to Doris Meissner, Commissioner, INS, March 25, 1999, printed at 64 Fed. Reg. 28686, May 26, 1999.

<sup>58</sup> See 7 U.S.C. §2011 et seq.

<sup>59</sup> See 42 U.S.C. §1396 et seq.

<sup>60</sup> See 42 U.S.C. §1397aa et seq.

<sup>61</sup> See 42 U.S.C. §1786.

<sup>62</sup> See 42 U.S.C. §1771 et seq.

<sup>63</sup> See 7 U.S.C. §7501 et seq.

<sup>64</sup> See e.g., 42 U.S.C. §8621 et seq.

<sup>65</sup> See Note 2.

### III. Factors Considered in Making Public Charge Decisions

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#### A. The totality of the circumstances test

By law, public charge decisions are made by immigration or consular officers based on the totality of the circumstances.<sup>66</sup> At minimum, an immigration or consular officer will consider the immigrant's age, health, family status, assets, resources, financial status, education, and skills, as well as any Affidavit of Support filed by the immigrant's sponsor. No single factor, except for the lack of a sufficient Affidavit of Support, is supposed to control the public charge decision.

#### B. Treatment of exempt benefits

While the receipt of noncash supplemental benefits such as Medicaid, by itself, is not relevant to the public charge decision, a person receiving Medicaid may still be found a public charge if, under the totality of the circumstances test, the immigration or consular officer determines that the person is or is likely to become dependent on public benefits for subsistence.

#### C. Past receipt of public benefits

Past receipt of cash benefits and prior institutionalization for long-term care will not necessarily mean that an immigrant will be found inadmissible as a public charge or ineligible to adjust status. The decision must be made in light of the totality of the circumstances, including the length of time during which the immigrant previously received benefits or was institutionalized, and how long ago the benefits were received. The negative implication of past receipt of cash benefits for income maintenance or institutionalization for long-term care may be overcome by positive factors demonstrating that the immigrant is unlikely to become dependent on the government in the future.

#### D. Bonds and cash deposits

Although entirely discretionary, the INS may accept a suitable, legally binding public charge bond or cash deposit as insurance against becoming a public charge.

<sup>66</sup> Proposed 8 C.F.R. Part 237, Subpart G, §212.104. Every public charge decision will be made on a case-by-case basis, *Id.*

## IV. Use of Benefits by Family Members

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Public cash benefits for income maintenance received by a relative will not be attributed to the immigrant seeking admission or adjustment of status unless the benefits represent the immigrant's sole support. If the benefits are attributed to the immigrant because they are his/her sole support, they must be considered along with all of the other factors as described in Section III(A).

## V. Immigrants Exempt from Public Charge Determinations

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By law, the following immigrants are exempt from public charge determinations:

- Refugees and asylees at the time of admission and adjustment of status to legal permanent residency.
- Amerasian immigrants at the time of admission.
- Cuban and Haitian entrants at adjustment.
- Nicaraguans and other Central Americans who are adjusting their status under the Nicaraguan Adjustment Central American Relief Act (NACARA).
- Haitians who are adjusting their status under the Haitian Refugee Immigration Fairness Act of 1998.
- Immigrants who enter the United States prior to January 1, 1972, and who are otherwise "registry" eligible.
- Other immigrants who are exempted by future legislation.

## VI. Deportation and Public Charge

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Deportation on public charge grounds is extremely rare. An immigrant can only be deported on public charge grounds if the immigrant became a public charge within five years after entry into the United States.<sup>67</sup> Before deporting an immigrant on public charge grounds, the INS must demonstrate that:

- The government entity that provided or is providing the public cash assistance for income maintenance or is paying the costs of long-term institutionalization has a legal right to seek repayment of those benefits against the immigrant or another obligated party such as a family member;

### NOTE

The benefit-granting agency need not make a demand for repayment if the INS proves that there was no one against whom repayment could have been enforced. Even then, an immigrant cannot be deported on public charge grounds if the immigrant can prove that the causes that led to becoming a public charge arose after entry to the United States.

<sup>67</sup> The five-year period begins each time the immigrant enters the United States, unless the immigrant is a Legal Permanent Resident.

- The public entity providing the benefit demanded repayment of the benefit within five years of the immigrants' entry into the United States.
- The immigrant or the obligated party failed to repay the benefits.
- There is a final administrative or court judgment obligating the immigrant or another party to repay the benefit.
- The benefit-granting agency has taken all actions necessary to enforce the judgment, including collection action.

## **VII. Legal Permanent Residents (Green Card Holders)**

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A Legal Permanent Resident is not subject to a public charge determination, unless he/she has traveled outside of the United States for more than 180 days.

## **VIII. Citizenship and Public Charge**

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Legal permanent residents who apply for citizenship are not subject to public charge determinations. There is no public charge test for naturalization purposes and no one can lose their citizenship because they have received public benefits.

## **IX. Repayment of Benefits Received**

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Immigration officers and immigration judges do not have authority to make immigrants repay public benefit-granting agencies for assistance received. Requests for repayment can only be made by the benefit-granting agency and any request by INS and State Department officers is improper.

## **X. Recommendations for Helping Immigrants Overcome Their Concerns about Public Charge**

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Despite the issuance of the guidance and proposed rule, many immigrants remain fearful that use of public benefits, including health care, will result in a public charge determination and adversely impact their immigration status. Misinformation and rumors continue to spread. Public education is key to helping immigrants make informed choices about the types of benefits that can be used with little or no effect on their immigration status.

- Health care providers and benefit-granting agencies should work through community-based organizations, churches, and other entities that have language-appropriate and culturally sensitive staff and are

trusted within immigrant communities to help educate immigrants about public charge rules.

- Work with state and local officials to help train caseworkers, enrollment brokers, outreach workers, and others about the new guidance so that they can help explain the rules to immigrants who are seeking benefits for themselves or their families.
- Meet with INS officials locally to find out what INS is doing to inform your community about the new public charge guidance. Suggest and pursue collaborations to disseminate information, including public service announcements and written information.
- Meet with and help educate the immigration bar and immigration judges. Immigration attorneys may not understand the relationship between the receipt of public benefits and their client's immigration status. Some have discouraged their clients from seeking or maintaining noncash public benefits such as Medicaid. It is therefore very important to work with the immigration bar to insure that immigration attorneys are aware of the new guidance and proposed rule.
- Monitor implementation and follow up on problems with local INS offices and state and local officials. Although the guidance and proposed rule are clear, immigrants may still experience misapplication of the rules. It is important to document these problems and report them to the INS through the regional offices and to the Commissioner in Washington, D.C.

**See Appendix E: A Quick Guide to "Public Charge" and Receipt of Public Benefits** issued by the INS in both English and Spanish.



## Linguistic and Cultural Access in Health Care Settings<sup>68</sup>

Overcoming language and cultural barriers to health care is critical to the well being of the nearly 32 million people in the United States who speak a language other than English at home. Immigrants with limited English proficiency (LEP) often face substantial communication problems at every level in the health care delivery system, from applying for benefits and scheduling appointments to understanding how and when to take medications. When health care providers are unable to communicate with their patients, they risk missing or misinterpreting symptoms and can end up providing inappropriate, even dangerous, medical care.

While both federal and state laws require access to linguistically appropriate health care, these laws are little known and rarely enforced. The result has been an unhealthy reliance on untrained interpreters and family members. Recently there have been several federal efforts underway to address the problem, however. This chapter provides an overview of the laws governing language access, explains federal initiatives to address services to LEP persons, and provides recommendations for improving language access services in health care settings.

<sup>68</sup> For a comprehensive discussion of language access in health care settings, including a review of federal and state laws requiring language access, see *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities*, the National Health Law Program for the Henry J. Kaiser Family Foundation, January 1998, available by calling 800-656-4533.

## I. Language Access Responsibilities Under Federal Law

### A. Title VI of the Civil Rights Act of 1964<sup>69</sup>

1. *Title VI of the Civil Rights Act of 1964 states:* No person in the United States shall, on grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.
2. *Actions prohibited under Title VI:* The Title VI statute and regulations prohibits intentional discrimination as well as practices and policies that have the effect of subjecting individuals to discrimination. However, enforcement of disparate impact cases brought by private individuals may be severely limited by a recent U.S. Supreme Court case, *Alexander v. Sandoval*. The court held that there is no implied private right of action to enforce disparate-impact regulations promulgated under Title VI. However, this case does not affect administrative enforcement of Title VI through the Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services (DHHS). Federal fund recipients may not, directly or through their contracts with others, on the grounds of race, color, or national original, take actions that have the effect of:
  - a. Denying an individual any service or the opportunity to participate in the program.
  - b. Providing services or benefits to an individual that are different from, or provided in a different manner, than those provided to others.
  - c. Subjecting an individual to segregation.
  - d. Restricting an individual's enjoyment of any privilege enjoyed by others.
  - e. Treating an individual differently from others in determining whether he or she satisfies any admission, enrollment, eligibility or other requirement for a service.
  - f. Denying an individual the opportunity to participate as a member of a planning or advisory body which is an integral part of the program.<sup>70</sup>
3. *Title VI and health care providers.* Because federal funding of health care is pervasive, nearly every health care provider is bound by Title VI. The U.S. Department of Health and Human Services has long recognized that Title VI requires linguistic accessibility to health care. In addition, the Office for Civil Rights (OCR) within HHS has consistently interpreted Title VI to require the provision of qualified interpreter services and translated materials at no cost to patients.

<sup>69</sup> 42 U.S.C. §2000d; see also 45 C.F.R. §80, app A (2001) (listing examples of federal financial assistance, including Medicare, Medicaid, and Maternal and Child Health grants).

<sup>70</sup> 45 C.F.R. §80.3(b).



4. *OCR and language access.* OCR plays a crucial role in defining a health care provider's obligations under the law. OCR regional offices are responsible for investigating formal complaints regarding discrimination against national origin minorities due to linguistic barriers.<sup>71</sup>

On August 30, 2000, OCR released its LEP Guidance reiterating existing law and providing more explicit guidance for ensuring compliance with Title VI.<sup>72</sup> OCR issued the LEP Guidance for two reasons: 1) to clarify federal fund recipients' legal obligations under Title VI, which effectively covers most health care facilities, providers, and social service agencies, and 2) to inform the general public that health and social service providers must ensure that LEP persons have meaningful access to their programs and services.

The LEP Guidance explains that the key to providing meaningful access is to ensure that the LEP person and the provider can communicate effectively. This means that language assistance must be provided to any LEP individual at no cost to the LEP person. The guidance specifically identifies four key elements for compliance:

- a. a thorough assessment of the language needs of the population to be served, as well as the needs of each LEP individual;
- b. the development of a comprehensive written policy on language access, including the provision of oral language assistance and the translation of written materials;
- c. staff training to ensure that staff understands the policy and is capable of carrying it out; and
- d. vigilant monitoring and regular oversight of the language assistance program.

Using these elements as guideposts, OCR will review the "totality of the circumstances" to determine whether LEP persons can meaningfully access the services and benefits of the recipients. However, OCR will not require all of these elements if one or more of these options "would be so financially burdensome as to defeat the legitimate objectives"<sup>73</sup> of a recipient's program or "if there are equally effective alternatives" to ensure meaningful access for LEP persons.

With regard to oral interpretation, the recipient must provide trained and competent interpreters or other language assistance in a timely

<sup>71</sup> See Appendix D for information about how to file a complaint with the Office for Civil Rights.

<sup>72</sup> *Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency*, HHS, 65 Fed. Reg. 52762-52774, August 30, 2000 at Appendix H.

<sup>73</sup> The issue of costs for interpreter and translation services has been partially addressed by the Health Care Financing Administration (HCFA), which issued a letter to all State Medicaid Directors on August 31, 2000. The letter reiterated the availability of federal matching funds for states expenditures related to the provision of oral interpretation and written translation administrative activities and services SCHIP and Medicaid recipients. *State Medicaid Director's Letter*, HCFA, August 31, 2000 at: <http://www.hcfa.gov/medicaid/smd83100.htm>

manner for any LEP person. It also describes the various options available for oral language assistance, including the use of bilingual staff, staff interpreters, outside interpreters, or the use of a telephone interpreter service (as long as it is not the sole language assistance option, unless other options are unavailable). For the translation of written materials, the Guidance designates “safe harbor” provisions to assure recipients when OCR will find them in compliance with Title VI.<sup>74</sup>

According to the OCR LEP Guidance, the LEP individual may use a family member or friend, but only if the provider has informed the LEP person of their right to free interpreter services and the LEP individual declines such services (and as long as the effectiveness of services is not compromised or confidentiality is not breached). The Guidance explains that the offer and declination of interpreter be present to ensure accurate interpretation if the LEP person chooses to use his/her own interpreter.

A model program can be created by:<sup>75</sup>

- a. Establishing a formal written language assistance program;
- b. Identifying and assessing the languages that are likely to be encountered and estimating the number of LEP persons in the service area;
- c. Posting of signs in areas of public contact in different languages informing the LEP person of his/her right to free interpreter services and inviting her to identify herself as needing language assistance;
- d. Using “I speak” cards so patients can identify their primary languages;
- e. Requiring the staff to record the language needs of the client in his/her medical record;
- f. Employing sufficient bilingual staff in the appropriate languages in patient and client contact positions that are competent and trained as interpreters;
- g. Contracting with interpreting services that can provide competent interpreters in the appropriate language in a timely manner;
- h. Making formal arrangements with community groups for competent and timely interpreter services by community volunteers;
- i. Making arrangements with a telephone language line;

<sup>74</sup> Notably, the following provisions are not mandatory requirements and the LEP Guidance notes that the failure to meet these provisions will not necessarily result in a finding of noncompliance. These “safe harbors” state: 1) if the LEP language group constitutes 10% or 3,000, whichever is less, of the eligible population to be served or likely to be directly affected, the recipient should translate written materials that are available in English; 2) if the LEP language group constitutes 5% or 1,000, whichever is less, of the same population as above, vital documents, such as information that is critical for accessing the services or benefits or is required by law, should be translated; and 3) if the total number of the 5% or 10% trigger is less than 100 LEP persons or the LEP language group does not meet either 1) or 2), the recipient can provide notice of the right to receive oral interpretation of the written materials to LEP persons.

<sup>75</sup> For a model settlement agreement incorporating many of these components, see the OCR/Maine Medical Center Resolution Agreement at: [http://healthlaw.org/docs/OCR\\_MMC.pdf](http://healthlaw.org/docs/OCR_MMC.pdf). <http://www.healthlaw.org>.

- j. Translating written materials including application forms, instructional, informational, and other key documents into appropriate non-English languages, as well as provision of oral document interpretation assistance for those persons whose language does not exist in written form;
- k. Developing procedures for effective telephone communication between staff and LEP persons, including instructions for staff on how to access interpreters;
- l. Providing notice to and training of all staff, particularly patient and client staff, about the recipient’s Title VI obligations and its language assistance policies;
- m. Inserting notices in appropriate languages about the LEP person’s right to free interpreters and other language assistance in brochures, pamphlets, manuals and other public information materials, and to staff;
- n. Providing notice to the public regarding the provider’s language assistance policies and procedures;
- o. Providing notice to and consultation with community organizations that represent LEP groups regarding problems and solutions, including standards and procedures for using their members as interpreters;
- p. Adopting a procedure to resolve complaints regarding the provision of language assistance, and notifying clients of their right, and how to file a Title VI complaint with HHS; and
- q. Appointing a senior level employee to coordinate the language assistance program and to ensure regular monitoring of the program.

The OCR LEP Guidance will greatly facilitate the process of opening the doors to health care and social services for people who are LEP and is a critically important affirmative step toward removing linguistic barriers for LEP persons. However, healthcare providers should go further than the OCR LEP Guidance to maximize the goal of the Guidance: ensuring “meaningful access” and effective communication to health and social services for all LEP persons.

### C. Other federal initiatives

- a. **Executive Order 13166.** On August 11, 2000, President Clinton issued an Executive Order (EO) mandating that all federal agencies develop and implement a plan to improve access to its federally conducted programs by eligible LEP persons. It also stresses the need for compliance with Title VI for all federally funded recipients and requires that each agency providing federal financial assistance issue a Title VI guidance consistent with the Department of Justice’s LEP Guidance. DOJ issued a “Clarifying Memorandum Regarding Limited English Proficiency and Executive Order 13166” on October 26, 2001, which included some questions and answers about the EO. It affirmed both

the current Administration's and DOJ's commitment to effectively implementing the EO for both recipients of federal funds and the departments/agencies themselves.

**b. DHHS, Office of Minority Health's (OMH) National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care.** Cultural and linguistic competence is the ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs of their patients. The fourteen CLAS standards are proposed as a means to correct current inequities that exist in the provision of health care services and respond to the need to ensure that all people in the health care delivery system receive equitable and effective treatment in a culturally and linguistically appropriate manner. Health care organizations and providers are encouraged to use the standards to make their practices more culturally and linguistically accessible. They should integrate these standards throughout their organization and work in partnership with the communities being served. The standards address culturally competent care, language access standards, and organizational supports for cultural competence. (See Appendix I.)

### **C. The Hill-Burton Act**

Enacted by Congress in 1946, the Hill-Burton Act encouraged the construction and modernization of public and nonprofit community hospitals and health centers. In return for receiving these funds, recipients agreed to comply with a "community service obligation" that exists in perpetuity. OCR has consistently taken the position that this obligation requires Hill-Burton fund recipients to address the needs of LEP patients.

### **D. Medicaid**

Current Medicaid regulations explicitly require state programs to operate consistent with Title VI of the Civil Rights Act. Centers for Medicare and Medicaid Services (CMS), the agency in charge of Medicaid at the federal level, requires states to communicate with beneficiaries both orally and in writing in a language understood by the beneficiary and to provide interpreters at Medicaid hearings.<sup>76</sup> Current Medicaid regulations also provide heightened protections for people who reside in long-term care facilities and to children and adolescents who are part of Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Arguably, the costs of translation services are routine administrative expenditures of the Medicaid program; therefore, the state is eligible to receive federal financial participation (FFP), a substantial cost savings.

<sup>76</sup> CMS, State Medicaid Manual §§2900.4 and 2902.9, March 1990.

Proposed federal regulations implementing the Medicaid managed care provisions of the Balanced Budget Act of 1997, published in the *Federal Register* on September 29, 1998, (and revised in August 2001) would require that: state agencies establish a methodology for determining the “prevalent languages” spoken by populations in a given geographic area and to make information available in those languages; state agencies ensure that Managed Care Organizations (MCOs) provide services in a culturally competent manner to all enrollees, including translation services; and MCOs provide toll-free numbers to enable enrollees to register complaints and grievances and that these toll-free numbers have adequate TTY and interpreter capability.

### **E. Medicare**

Medicare is the federal health insurance program that covers people aged 65 or older, people of any age with permanent kidney failure, and certain disabled people under age 65. Medicare provides reimbursement to Medicare-participating hospitals for bilingual services to inpatients and has initiated pilot programs employing the use of bilingual forms and educational materials.

### **F. Federal categorical grant programs**

Community health centers and health centers that serve migrant workers receiving federal funding must agree to provide services in the language and cultural context most appropriate to their patients.

### **G. The Emergency Medical Treatment and Active Labor Act**

The Emergency Medical Treatment and Active Labor Act of 1986 requires hospitals that participate in the Medicare program and have an emergency department to treat patients in an emergency (including women in labor) without regard to their ability to pay. EMTALA sets forth diagnosis and treatment responsibilities that may be difficult or impossible to meet for hospitals that fail to overcome language barriers with their patients.

## **II. Language Access Responsibilities Under State Law**

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In recent years, state legislatures and administrative agencies have begun to recognize the growing need for linguistically appropriate health care and to adopt measures that require or encourage health care providers to take steps to overcome language barriers.

### **A. Language access laws**

A few states have passed comprehensive language access laws that set forth a general responsibility for health care facilities to ensure communication with LEP patients. Some of these laws, such as those passed in California, Massachusetts, and New York, detail specific guidance to providers on what

they must do. In other states, such as Illinois, the legislation notes the importance of translation services, but leaves it largely to the health care provider to decide on the services it will offer. Many more states have tied language access laws to specific categories of health services. Not surprisingly, states have reserved some of the most stringent requirements for mental health and long-term care facilities. Many states also have enacted provisions that encourage or require both state agencies and social service agencies with whom they contract to provide language appropriate services to LEP patients. Model legislation in California, called the Dymally-Alatorre Bilingual Services Act, imposes direct obligations on state and local agencies to provide appropriate translation services. The Act requires, for example, that state agencies translate materials explaining their services into languages spoken by five percent or more of the populations that they serve and employ sufficient numbers of bilingual persons to ensure access for non-English speaking persons.<sup>77</sup>

## **B. State civil rights laws**

State civil rights laws provide another source of authority for the imposition of language access requirements on health care providers. For example, California's civil rights statute prohibits recipients of state funds from discriminating on the basis of ethnic identification, religion, age, sex, color, or physical or mental disability.

## **C. Malpractice laws**

State statutes and common law rules governing professional malpractice are yet another important source of language access obligations. Inadequate communication with patients may result in liability under tort principles in three ways. First, providers may discover that they are liable for damages resulting from treatment in the absence of informed consent. Second, providers face potential claims that their failure to bridge communication gaps breaches professional standards of care. Third, a provider's violation of language access laws may raise a presumption of negligence in some states.

## **D. English-only laws**

At least eighteen states have enacted laws that make English the official state language. While many of these laws are purely symbolic, some require public officials to speak English—and no other language—when conducting state business. Even the strictest of these laws, however, includes exceptions for law enforcement and public health activities. The effect on language access of a public health exception contained in such laws is hard to measure. Some state agencies may interpret the exception broadly, while other agencies may choose to invoke the exception only in very specific public health activities involving, for example, infectious diseases.

<sup>77</sup> A list of some state laws requiring language access is included in Appendix F.

### III. Language Access Responsibilities in the Private Sector

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The provision of publicly financed health care services is rapidly being delegated to the private sector, with significant effect on the provision of language services. Two developments are particularly noteworthy—the increased reliance on for-profit managed care plans and the growing influence of private accreditation organizations.

#### A. Managed care

Some innovative HMOs are employing novel programs to provide linguistically appropriate services to LEP patients. Harvard Pilgrim Health Care in New England, for example, has adopted interpreting policies that encourage prescheduling of appointments and use of on-staff interpreters. State governments also can play an important role by adopting baseline standards that managed care companies doing business in the state must meet. While there has been little legislative activity to date in this area, about half of the 80 or so Medicaid managed care contracts reviewed for this manual addressed the need for culturally sensitive services. California, for example, has not only passed legislation that encourages assessment of the linguistic accessibility of managed care plans, but also has inserted noteworthy linguistic accessibility provisions in its Medicaid managed care contracts, including provisions that require health plans to assess the language capability of their service areas and to develop plans explaining how they will serve LEP populations within those service areas.

#### B. Accrediting agencies

State and federal agencies are increasingly relying on private accreditation entities to set standards and monitor compliance with those standards. Both the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), which accredits hospitals and other health care institutions (e.g., psychiatric facilities, home health agencies), and the National Committee for Quality Assurance (NCQA), which accredits managed care organizations and behavioral health MCOs, have adopted standards that require language access in health care.

JCAHO standards require hospitals to employ policies that provide effective communication means for each patient served. For example, on admission, patients must be informed of their rights. If these rights are listed on written notices and postings that the patient cannot understand, then the patient should be informed of his or her rights in a manner that he or she can understand. The NCQA accreditation process calls for MCOs to be able to provide materials in languages understood by LEP enrollees if they serve major non-English speaking populations (at least 10 percent of membership). NCQA's Health Plan Employer Data and Information Set (HEDIS) 3.0 presents a set of performance measures for commercial, Medicare, and Medicaid managed

care plans. It includes questions regarding bilingual doctors and staff, availability of trained interpreters, and whether materials are printed in languages other than English.

## IV. Recommendations

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Much work must be done to assure that health providers comply with their legal obligations to provide culturally and linguistically accessible services. Here are a number of suggestions:

- Help educate health care providers and purchasers (such as Medicaid agencies) about the importance of providing culturally and linguistically accessible services to LEP populations. This includes informing them about their legal obligations under federal and state law and the availability of funding to cover language services for SCHIP or Medicaid recipients. (See HCFA “Dear State Medicaid Director” letter, dated Aug. 31, 2000.) (See Appendices F and H.)
- Assess state and local laws that promote and require language accessibility. Work with others to enact stronger legislation.
- Use and adapt NHELP’s Language Access Assessment tool to determine the availability of translation services in the local health care market. Highlight best practices.
- Contact the OCR regional office in your area and get to know the staff. Refer appropriate cases for investigation.
- Assess whether the state Medicaid agency promotes and provides appropriate language access services at eligibility centers and other points of contact. Work with your state Medicaid agency to incorporate language access requirements in all managed care contracts.
- State agencies and health plans must ensure that affected LEP consumers’ views are understood and incorporated. Insist that LEP consumers are represented on the state’s Medical Care Advisory Committee and other state and local advisory panels and task forces.
- Increase efforts to collect data on LEP health status and utilization.
- Encourage health care providers to adopt and implement the OMH CLAS standards.



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## APPENDIX

## A

## 2001 Federal Poverty Level (FPL) Guidelines

### Listed by Yearly Income Effective May 1, 2001

Family Size	100% of FPL	150% of FPL	185% of FPL	200% of FPL	300% of FPL
1	\$ 8,590	\$12,885	\$15,891	\$17,180	\$25,770
2	\$11,610	\$17,415	\$21,478	\$23,220	\$34,830
3	\$14,630	\$21,945	\$27,065	\$29,260	\$43,890
4	\$17,650	\$26,475	\$32,652	\$35,300	\$52,950
5	\$20,670	\$31,005	\$38,239	\$41,340	\$62,010
6	\$23,690	\$35,535	\$43,826	\$47,380	\$71,070
7	\$26,710	\$40,065	\$49,413	\$53,420	\$80,130
8	\$29,730	\$44,595	\$55,000	\$59,460	\$89,190
Over 8, add for each child	+\$3,020	+ \$4,530	+ \$5,586	+ \$6,040	+\$9,060

### Listed by Hourly Income\* Effective May 1, 2001

Family Size	100% of FPL	150% of FPL	185% of FPL	200% of FPL	300% of FPL
1	\$ 4.13	\$ 6.20	\$ 7.64	\$ 8.26	\$12.39
2	\$ 5.58	\$ 8.38	\$10.33	\$11.16	\$16.75
3	\$ 7.03	\$10.56	\$13.02	\$14.06	\$21.11
4	\$ 8.48	\$12.74	\$15.71	\$16.96	\$25.47
5	\$ 9.93	\$14.92	\$18.40	\$19.86	\$29.83
6	\$11.38	\$17.10	\$21.09	\$22.76	\$34.19
7	\$12.83	\$19.28	\$23.78	\$25.66	\$38.55
8	\$14.28	\$21.46	\$26.47	\$28.56	\$42.91
Over 8, add for each child	+\$1.45	+ \$2.18	+ \$2.69	+ \$2.90	+\$4.36

\*Based on a full-time job for one year, 2,080 hours.

Source: [www.safetyweb.org/reference/fplguide.htm](http://www.safetyweb.org/reference/fplguide.htm)



## Know Your Medicaid Rights

If you are applying for or are receiving Medicaid, federal law protects you. Here's how:

- You have the right to apply for Medicaid on the first day that you seek it;
- You have the right to bring someone with you to help you with the application;
- You have the right to have a translator who speaks your language. Written material must be translated or explained in a language you understand;
- You have the right to have a decision made about your application within 45 days, or if the application is based on disability, within 90 days of applying;
- You have the right (in most states) to receive coverage beginning with the third month prior to the date of application. This is called retroactive Medicaid;
- You have the right to receive treatment and services that are necessary to treat your medical condition. You cannot be denied services based on the type of illness you have or your diagnosis;
- You have the right to receive treatment and services without discrimination based on national origin, race, color, sex or disability;
- You have the right to go to any doctor or health care clinic that will accept your Medicaid card, unless you are getting your health care through a health maintenance organization (managed care plan);
- You have the right to continue to receive Medicaid. The Medicaid agency must find that you are not eligible before you can be cut off;
- You have the right to receive notice before your Medicaid is cut off and to have a hearing if you disagree with a decision to stop your benefits or give you less than what you were getting.



## State Health Programs for Immigrants Under Welfare Reform

Selected Tables from

### Patchwork Policies:

### State Assistance for Immigrants under Welfare Reform

Wendy Zimmerman: Karen C. Tumlin

The Urban Institute May 1999

**TABLE 8 State-Funded Medicaid for Immigrants during the Five-Year Bar**

State	Limited Immigrant Groups	Sponsor-Deeming <sup>1</sup>	Limited Benefits	Naturalization Requirement	Residency Requirement
California					
Illinois	X <sup>2</sup>	<sup>3</sup>			
Massachusetts					
Maryland	X <sup>4</sup>				
Virginia	X <sup>5</sup>	(not available)			
Washington		X <sup>6</sup>			X <sup>7</sup>
Pennsylvania		X			
Connecticut		X			X <sup>8</sup>
Minnesota		X			
Hawaii		X			
Rhode Island	X <sup>9</sup>				
Nebraska		X <sup>10</sup>			
Delaware		X			
Maine		X			

**Notes:** All state data presented above were current as of summer/fall 1998, unless otherwise noted.

1. Unless otherwise noted, sponsor-deeming, for immigrants entering under the new affidavit of support, will be imposed until the immigrant naturalizes or meets the 40-quarter exemption.
2. Illinois provides coverage only to immigrant children and pregnant women.
3. Illinois has not yet decided if it will impose deeming.
4. Maryland provides coverage to immigrant children (under age 18), full-time students expected to complete high school before the end of the calendar year, and pregnant women.
5. Virginia provides coverage to immigrant children (under age 19) and those immigrants receiving Medicaid and living in long-term care facilities on June 30, 1997.
6. Washington has not yet implemented sponsor-deeming. The state has indicated that deeming will be imposed for five years.
7. In Washington, noncitizens must have lived in the state for 12 months to receive benefits. There is no similar requirement for citizens in the state's regular Medicaid program.
8. In Connecticut, noncitizens must have lived in the state for six months to receive benefits. There are exemptions to this residency requirement for the mentally ill and victims of domestic violence. There is, however, no similar requirement for citizens on the regular Medicaid program.
9. Rhode Island provides coverage to immigrant children and pregnant women.
10. As of August 1998, deeming had not yet been implemented in Nebraska.

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**TABLE 13 State Health Insurance Programs for the Elderly and Disabled**

State	Limited Populations	Qualified Immigrants Ineligible		Sponsor-Deeming Imposed <sup>1</sup>	Coverage Less Than Medicaid	Duration of Assistance Is Limited	Residency Requirement	Naturalization Requirement
		Pre-enactment	Post-enactment					
California <sup>2</sup>				X <sup>3</sup>		X <sup>4</sup>	X <sup>5</sup>	
New York	No state health insurance program that serves the elderly and disabled.							
Texas	No state health insurance program that serves the elderly and disabled.							
Florida	No state health insurance program that serves the elderly and disabled.							
New Jersey <sup>6</sup>	X <sup>7</sup>		X <sup>8</sup>	X <sup>9</sup>	X <sup>10</sup>	X <sup>11</sup>		X <sup>12</sup>
Illinois <sup>13</sup>	X <sup>14</sup>		X <sup>15</sup>	X <sup>10</sup>				
Arizona	No state health insurance program that serves the elderly and disabled.							
Massachusetts	No state health insurance program that serves the elderly and disabled.							
Maryland <sup>16</sup>	X <sup>17</sup>				X <sup>10,18</sup>			
Virginia	No state health insurance program that serves the elderly and disabled.							
Washington <sup>19</sup>	X <sup>20</sup>			X <sup>21</sup>	X <sup>10</sup>			
Michigan <sup>22</sup>	—	—	—	—	X	—	—	—
Pennsylvania <sup>23</sup>	X <sup>24</sup>			X <sup>25</sup>	X <sup>10</sup>	X <sup>26</sup>		
Colorado <sup>27</sup>				X <sup>28</sup>	X <sup>10</sup>			
Oregon	No state health insurance program that serves the elderly and disabled.							
Connecticut <sup>29</sup>				X <sup>30</sup>	X <sup>10</sup>		X <sup>31</sup>	X <sup>32</sup>
Georgia	No state health insurance program that serves the elderly and disabled.							
North Carolina	No state health insurance program that serves the elderly and disabled.							
Minnesota <sup>33</sup>				X	X <sup>10</sup>		X <sup>34</sup>	
Nevada	Health insurance program is not statewide. State mandates counties to provide assistance; eligibility rules vary by county.							
Hawaii	No state health insurance program that serves the elderly and disabled.							
Ohio	No state health insurance program that serves the elderly and disabled.							
Wisconsin <sup>35</sup>	No state health insurance program that serves the elderly and disabled.							
New Mexico	No state health insurance program that serves the elderly and disabled.							
Missouri <sup>36</sup>	X <sup>37</sup>				X <sup>10</sup>			
Utah <sup>38</sup>			X <sup>39</sup>		X <sup>40</sup>			
Louisiana	No state health insurance program that serves the elderly and disabled.							
Rhode Island <sup>41</sup>	X <sup>42</sup>				X <sup>43</sup>	X <sup>44</sup>		
Kansas <sup>45</sup>	X <sup>46</sup>		X	X <sup>47</sup>	X <sup>40</sup>			
Oklahoma	No state health insurance program that serves the elderly and disabled.							
Alabama	No state health insurance program that serves the elderly and disabled.							
Idaho	No state health insurance program that serves the elderly and disabled.							
Tennessee	No state health insurance program that serves the elderly and disabled.							
District of Columbia	No state health insurance program that serves the elderly and disabled.							
Indiana	No state health insurance program that serves the elderly and disabled.							
Iowa	No state health insurance program that serves the elderly and disabled.							
Nebraska	No state health insurance program that serves the elderly and disabled.							
Arkansas	No state health insurance program that serves the elderly and disabled.							
Mississippi	No state health insurance program that serves the elderly and disabled.							
Kentucky	No state health insurance program that serves the elderly and disabled.							
Delaware	No state health insurance program that serves the elderly and disabled.							
New Hampshire	No state health insurance program that serves the elderly and disabled.							
Maine <sup>48</sup>				X	X <sup>40</sup>			



State	Limited Populations	Qualified Immigrants Ineligible		Sponsor-Deeming Imposed <sup>1</sup>	Coverage Less Than Medicaid	Duration of Assistance Is Limited	Residency Requirement	Naturalization Requirement
		Pre-enactment	Post-enactment					
Alaska <sup>49</sup>					X <sup>40,50</sup>			
South Carolina <sup>51</sup>	–	–	–	–	X	–	–	–
West Virginia <sup>52</sup>	No state health insurance program that serves the elderly and disabled.							
Vermont <sup>53</sup>					X <sup>54</sup>			
Wyoming <sup>55</sup>					X <sup>56</sup>			
Montana	No state health insurance program that serves the elderly and disabled.							
South Dakota	No state health insurance program that serves the elderly and disabled.							
North Dakota	No state health insurance program that serves the elderly and disabled.							

Notes: All state data presented above were current as of summer/fall 1998, unless otherwise noted.

1. Unless otherwise noted, sponsor-deeming, for immigrants entering under the new affidavit of support, will be imposed until the immigrant naturalizes or meets the 40-quarter exemption.
2. California law mandates counties to provide General Relief (GR), including medical assistance, to needy persons who do not qualify for federally funded assistance. The state sets minimum standards for the program, including minimum grant levels and eligibility rules. Specific program eligibility rules and services vary by county. Immigrant eligibility for the program, however, is standard statewide. The information presented is for Los Angeles County, which represents 61 percent of the state’s GR caseload. Only GR cash recipients are eligible for the GR Health Plan in Los Angeles County.
3. Deeming in Los Angeles County lasts for three years, even for immigrants entering under the new affidavit of support.
4. Assistance for “employables” in Los Angeles County is available for 5 months out of any 12-month period. Therefore, this time limit applies only to elderly, nondisabled recipients.
5. In Los Angeles County, GR recipients must have lived in the county for at least 15 days.
6. New Jersey has two programs providing health insurance for which uninsured elderly and disabled residents could qualify. The Charity Care program is available to all uninsured individuals with incomes up to 200 percent of the federal poverty level. A sliding-fee scale is used for individuals between 200 and 300 percent of the federal poverty level. Elderly and disabled residents who qualify for the cash component of the General Assistance (GA) program are eligible for the state’s GA-Medical program.
7. Elderly and disabled individuals (meeting other program criteria) are eligible for New Jersey’s Charity Care program. Elderly individuals are not categorically eligible for the GA-Medical program. Only temporarily or permanently disabled persons (at least 18 years old) are eligible.
8. Post-enactment qualified immigrants are eligible for the Charity Care program (because the state does not verify immigrant status in this program). Post-enactment qualified immigrants, however, are ineligible for New Jersey’s GA-Medical program.
9. Sponsor-deeming is not imposed on the Charity Care program. Deeming is imposed for three years on New Jersey’s GA-Medical program.
10. State program provides a comprehensive range of services, including both inpatient and outpatient care, but less coverage than Medicaid. These programs may also provide other services.
11. There is no time limit on New Jersey’s Charity Care program. Noncitizens who are eligible to naturalize are limited to six months of assistance under New Jersey’s GA-Medical program. Citizens are limited to five years.
12. Immigrants who are eligible to naturalize must do so within six months to retain GA-Medical assistance in New Jersey. According to U.S. law, to be eligible to naturalize Legal Permanent Residents married to U.S. citizens must have lived in the United States for at least three years and all other Legal Permanent Residents must have lived in the United States for five years. If immigrants do not naturalize within six months of first receiving GA-Medical benefits, they will be declared ineligible for GA. Immigrants are not terminated from GA, however, if they have completed a naturalization application and were unable to naturalize solely because of an Immigration and Naturalization Service (INS) backlog in processing applications.
13. Illinois state law requires all local units to run GA-Medical programs. This information is for the city of Chicago and approximately 60 other localities that receive state funds and follow state guidelines. Approximately 1,400 localities do not receive state funds and set their own benefit and eligibility rules.
14. Elderly individuals are not categorically eligible for GA in Illinois’ state-funded programs. Only those individuals over age 55 who have no recent work history and who are considered unemployable are eligible.
15. Post-enactment immigrants are eligible for the state-funded programs in Illinois only after a five-year bar.
16. This information is for Maryland’s Primary Care program and the Public Assistance for Adults program.

17. Elderly individuals are not categorically eligible for Primary Care in Maryland. Only disabled individuals (with a medical disability that precludes employment for at least three months) are eligible if they are eligible for Maryland's GA program but not for Medicaid. All state residents who meet the program's income criteria and are ineligible for Medicaid are eligible for the state Pharmacy Assistance program.
18. State program provides only specialized services (such as prescriptions).
19. Washington has three programs providing health care for which uninsured elderly and disabled residents could qualify. These programs are GA-Unemployable, the Medically Indigent program, and the Basic Health Plan.
20. Elderly individuals are not categorically eligible for GA-Unemployable in Washington. Only temporarily or permanently disabled individuals (persons with a disability preventing work for at least 90 days) are eligible. Uninsured individuals not eligible for Medicaid are eligible for the Medically Indigent program or Basic Health Plan (if they meet these programs' income requirements).
21. Although Washington has decided to impose sponsor-deeming on these programs, deeming is not currently being implemented because the state has not decided how to implement deeming.
22. Our survey contains no information on health insurance programs in Michigan. This information is for Michigan's State Medical program, taken from Lipson et al., 1997. The "—" signifies that we know of a program's existence, but do not have complete eligibility information for that program.
23. This information is for Pennsylvania's General Assistance Medical Assistance program.
24. Elderly individuals are not categorically eligible for GA Medical Assistance in Pennsylvania. Only disabled individuals (with a temporary or permanent disability); persons with active participation in a drug or alcohol program, which precludes employment caretakers of disabled persons who are deemed necessary; and victims of domestic violence are eligible. Recipients cannot be eligible for Medicaid.
25. Currently, sponsor-deeming is not being imposed, although Pennsylvania is considering imposing it.
26. In Pennsylvania, assistance is available for only nine months in a lifetime to persons unemployable because of active participation in drug and alcohol treatment programs.
27. This information is for the medical portion of Colorado's Old Age Pension program and the Colorado Indigent Care Program.
28. Sponsor-deeming will be applied to Colorado's Old Age Pension only in cases in which the sponsor is not a relative.
29. This information is for Connecticut's General Assistance Medical program.
30. Sponsor-deeming will be imposed for three years, for all immigrants including those entering under the new affidavit of support, if allowed by Connecticut's attorney general. Before welfare reform, the state Supreme Court declared sponsor-deeming unconstitutional for GA-Medical. It remains to be seen if welfare reform will negate this court decision.
31. All noncitizens must have lived in Connecticut for at least six months to be eligible for GA-Medical benefits. There is no similar requirement for citizens on this program.
32. Noncitizens receiving GA in Connecticut must verify contact with the INS regarding naturalization to receive benefits.
33. This information is for Minnesota's General Assistance Medical program and the Minnesota Care program.
34. The residency requirement applies only to the Minnesota Care program. Recipients must have lived in the state for six months before applying.
35. There is no state mandate that counties must run health insurance programs in Wisconsin. Counties opting to run medical assistance programs, however, can cover 50 percent of their program costs with state funds from the state's medical block grant program. In addition, counties can receive state funds from this block grant only for nonmedical programs (such as cash assistance) if they also run medical assistance programs. States with medical and nonmedical programs can recoup up to 40 percent of the costs for their nonmedical programs from the state.
36. This information is for Missouri's General Assistance Medical program.
37. Elderly individuals are not categorically eligible for Missouri's GA-Medical program. Temporarily (disability lasting at least 90 days) and permanently disabled individuals are eligible. Caretakers of disabled individuals are also eligible.
38. This information is for Utah's Medical Assistance Program.
39. Post-enactment qualified immigrants are eligible for assistance in Utah only after a five-year bar.
40. State program provides a limited range of services including only inpatient or emergency services.
41. This information is for Rhode Island's GA-Medical program.
42. Elderly individuals are not categorically eligible for the GA-Medical program in Rhode Island. Only disabled individuals awaiting a Supplemental Security Income (SSI) Notes determination and persons with a temporary disability are eligible. Persons with a temporary disability may receive assistance for one or two months. Disabled couples may also receive benefits, but they are assessed separately as two individuals.
43. Services covered under Rhode Island's GA-Medical program include physician services and prescription drugs. Although the program does not cover these costs directly, hospitals are required to absorb the costs of inpatient and outpatient services.
44. Assistance in Rhode Island is available only until a final SSI determination is made. There are no special exceptions for immigrants who are no longer eligible for SSI.

45. This information is for Kansas's GA-Medical program.
46. Elderly individuals are not categorically eligible for GA-Medical assistance in Kansas. Only disabled persons and their caretakers are eligible.
47. Currently, deeming lasts for three years, even for those immigrants entering under the new affidavit of support. For immigrants entering under the new affidavit, the state will eventually impose deeming until the immigrant naturalizes or meets the 40-quarter exemption.
48. This information is for the medical component of Maine's GA program. Although the GA programs in Maine are county administered, 95 percent of the towns in Maine have adopted a standard state GA program under which medical assistance is provided.
49. This information is for Alaska's Chronic and Acute Medical Assistance (CAMA) program or GR-Medical component.
50. Pregnancy-related services are not covered under CAMA, although these services were covered under Alaska's old GR-Medical program (CAMA's precursor).
51. Our survey contains no information on health insurance programs in South Carolina. This information is for the Medically Indigent Assistance program, taken from the National Health Law Program's (NHLP) 1997 Manual on State and Local Responsibility for Indigent Health Care (NHLP Web site). The "—" signifies that we know of a program's existence, but do not have complete eligibility information for that program.
52. Our survey contains no information on health insurance programs in West Virginia. The National Health Law Program's 1997 Manual on State and Local Responsibility for Indigent Health Care (NHLP Web site) indicates that the state mandates its counties to run several public health services, though services vary by county.
53. This information is for Vermont's GA-Medical program.
54. Only limited services are covered under Vermont's GA-Medical program.
55. This information is for Wyoming's state-funded prescription program.
56. Three prescriptions per month and access to oxygen containers are available to recipients of Wyoming's prescription program.

**TABLE 14 State Health Insurance Programs for Families with Children**

State	Limited Populations	Qualified Immigrants Ineligible		Sponsor-Deeming Imposed <sup>1</sup>	Coverage Less Than Medicaid	Duration of Assistance Is Limited	Residency Requirement	Naturalization Requirement
		Pre-enactment	Post-enactment					
California <sup>2</sup>				X <sup>3</sup>		X <sup>4</sup>	X <sup>5</sup>	
New York <sup>6</sup>	X <sup>7</sup>							
Texas	No state health insurance program that serves families with children.							
Florida <sup>8</sup>	X <sup>9</sup>				X <sup>10</sup>			
New Jersey <sup>11</sup>	X <sup>12</sup>		X <sup>13</sup>	X <sup>14</sup>	X <sup>15</sup>	X <sup>16</sup>		X <sup>17</sup>
Illinois <sup>18</sup>			X <sup>19</sup>		X <sup>15</sup>			
Arizona	No state health insurance program that serves families with children.							
Massachusetts <sup>20</sup>	X <sup>21</sup>							
Maryland	No state health insurance program that serves families with children.							
Virginia	No state health insurance program that serves families with children.							
Washington <sup>22</sup>	X <sup>23</sup>			X <sup>24</sup>	X <sup>15</sup>			
Michigan <sup>25</sup>	—	—	—	—	X	—	—	—
Pennsylvania <sup>26</sup>				<sup>27</sup>	X <sup>15</sup>	X <sup>28</sup>		
Colorado <sup>29</sup>	X <sup>30</sup>				X <sup>31</sup>			
Oregon	No state health insurance program that serves families with children.							
Connecticut <sup>32</sup>				X <sup>33</sup>	X <sup>15</sup>		X <sup>34</sup>	X <sup>35</sup>
Georgia	No state health insurance program that serves families with children.							
North Carolina	No state health insurance program that serves families with children.							
Minnesota <sup>36</sup>	X <sup>37</sup>			X	X <sup>15</sup>		X <sup>38</sup>	
Nevada	Health insurance program is not statewide. State mandates counties to provide assistance; eligibility rules vary by county.							
Hawaii	No state health insurance program that serves families with children.							
Ohio	No state health insurance program that serves families with children.							
Wisconsin <sup>39</sup>	No state health insurance program that serves families with children. <sup>40</sup>							
New Mexico	No state health insurance program that serves families with children.							
Missouri	X <sup>41</sup>				X <sup>15</sup>			
Utah <sup>42</sup>			X <sup>43</sup>		X <sup>44</sup>			
Louisiana	No state health insurance program that serves families with children.							
Rhode Island	No state health insurance program that serves families with children.							
Kansas	No state health insurance program that serves families with children.							
Oklahoma	Information about health insurance programs is not available for this state.							
Alabama	No state health insurance program that serves families with children.							
Idaho	No state health insurance program that serves families with children.							
Tennessee	No state health insurance program that serves families with children.							
District of Columbia	No state health insurance program that serves families with children..							
Indiana	No state health insurance program that serves families with children.							
Iowa	X <sup>45</sup>				X <sup>46</sup>		X <sup>47</sup>	
Nebraska	No state health insurance program that serves families with children.							
Arkansas	No state health insurance program that serves families with children.							
Mississippi	No state health insurance program that serves families with children.							
Kentucky	No state health insurance program that serves families with children..							
Delaware	No state health insurance program that serves families with children.							
New Hampshire <sup>48</sup>	X <sup>49</sup>	(not available)	(not available)		X <sup>15</sup>			
Maine <sup>50</sup>				X	X <sup>44</sup>			

State	Limited Populations	Qualified Immigrants Ineligible		Sponsor-Deeming Imposed <sup>1</sup>	Coverage Less Than Medicaid	Duration of Assistance Is Limited	Residency Requirement	Naturalization Requirement
		Pre-enactment	Post-enactment					
Alaska <sup>51</sup>					X <sup>44,52</sup>			
South Carolina <sup>53</sup>	—	—	—	—	X	—	—	—
West Virginia <sup>54</sup>	No state health insurance program that serves families with children.							
Vermont <sup>55</sup>					X <sup>56</sup>			
Wyoming <sup>57</sup>					X <sup>58</sup>			
Montana	No state health insurance program that serves families with children.							
South Dakota	No state health insurance program that serves families with children.							
North Dakota	No state health insurance program that serves families with children.							

Notes: All state data presented above were current as of summer/fall 1998, unless otherwise noted.

1. Unless otherwise noted, sponsor-deeming, for immigrants entering under the new affidavit of support, will be imposed until the immigrant naturalizes or meets the 40-quarter exemption.
2. California law mandates counties to provide General Relief (GR), including medical assistance, to needy persons who do not qualify for federally funded assistance. The state sets minimum standards for the program, including minimum grant levels and eligibility rules. Specific program eligibility rules and services vary by county. Immigrant eligibility for the program, however, is standard statewide. The information presented is for Los Angeles County, which represents 61 percent of the state’s GR caseload. Only GR cash recipients are eligible for the GR Health Plan in Los Angeles.
3. Deeming in Los Angeles County lasts for three years, even for those immigrants entering under the new affidavit of support.
4. Assistance for “employables” in Los Angeles County is available for 5 months out of any 12-month period.
5. In Los Angeles County, GR recipients must have lived in the county for at least 15 days.
6. This information is for New York’s Child Health Plus program.
7. Children ages 0 to 18 are eligible for Child Health Plus in New York, but their parents are ineligible.
8. This information is for Florida’s Healthy Kids and Children’s Medical Services (CMS) programs.
9. Children ages 0 to 19 are eligible for CMS and children ages 5 to 19 are eligible for Florida Healthy Kids, but their parents are ineligible.
10. Services provided under Florida’s CMS program are comparable to Medicaid. Services provided under Florida Healthy Kids are slightly less comprehensive than those provided under Medicaid.
11. This information is for New Jersey’s Charity Care and General Assistance (GA)-Medical programs.
12. In New Jersey’s GA-Medical program, only emancipated minors (at least 16 years old) are eligible. Children and their parents are eligible for Charity Care.
13. Post-enactment qualified immigrants are eligible for the Charity Care program (because the state does not verify immigrant status in this program). Post-enactment qualified immigrants, however, are ineligible for New Jersey’s GA-Medical program.
14. Sponsor-deeming is not imposed on the Charity Care program. Deeming is imposed for three years on New Jersey’s GA-Medical program.
15. State program provides a comprehensive range of services, including both inpatient and outpatient care, but less coverage than Medicaid does. These programs may also provide other services.
16. There is no time limit on New Jersey’s Charity Care program. Noncitizens who are eligible to naturalize are limited to six months of assistance under New Jersey’s GA-Medical program. Citizens are limited to five years.
17. Noncitizens who are eligible to naturalize must do so within six months to retain GA-Medical assistance in New Jersey. According to U.S. law, to be eligible to naturalize Legal Permanent Residents married to U.S. citizens must have lived in the United States for at least three years and all other Legal Permanent Residents must have lived in the United States for five years. If immigrants do not naturalize within six months of first receiving GA benefits, they will be declared ineligible for GA. Immigrants are not terminated from GA, however, if they completed a naturalization application and were unable to naturalize solely because of an Immigration and Naturalization Service (INS) backlog in processing applications.
18. Illinois’ state law requires all local units to run GA-Medical programs. This information is for the city of Chicago and approximately 60 other localities that receive state funds and follow state guidelines. Approximately 1,400 localities do not receive state funds and set their own benefit and eligibility rules.
19. Post-enactment immigrants are eligible for Illinois’ state-funded programs only after a five-year bar.
20. This information is for Massachusetts’ Children’s Medical Security Plan.

21. Children ages 0 to 18 are eligible for the Children's Medical Security Plan in Massachusetts, but their parents are ineligible.
22. Washington has three key programs providing health care for uninsured families with children. These programs are the Basic Health plan, Children's Health program, and the Medically Indigent program.
23. In Washington, children ages 0 to 18 are eligible for the Children's Health program. Children and their parents are eligible for the Basic Health Plan and the Medically Indigent program. In addition, pregnant women in their first two trimesters and unattached children living with a guardian are eligible for medical assistance under the GA-Unemployable program.
24. Although Washington has decided to impose sponsor-deeming on these programs, deeming is not currently being implemented because the state has not decided how to implement it.
25. Our survey contains no information on health insurance programs in Michigan. This information is for Michigan's State Medical program, taken from Lipson, et al., 1997. The "—" signifies that we know of a program's existence, but do not have complete eligibility information for that program.
26. This information is for Pennsylvania's General Assistance Medical Assistance program.
27. Currently, sponsor-deeming is not being imposed, although Pennsylvania is considering implementing it.
28. In Pennsylvania, assistance is available for only nine months in a lifetime to persons unemployable because of active participation in drug and alcohol treatment programs.
29. This information is for Colorado's Indigent Care Program (CICP) and Children's Basic Health Plan (CBHP).
30. Children ages 0 to 18 are eligible for CBHP, but their parents are ineligible. Children and their parents are eligible for CICP.
31. Services provided under CBHP are comparable to those provided under Medicaid. The CICP provides less comprehensive services, covering inpatient and outpatient services at hospitals and clinics.
32. This information is for Connecticut's GA-Medical program.
33. Sponsor-deeming will be imposed for three years, for all immigrants including those entering under the new affidavit of support, if allowed by Connecticut's attorney general. Before federal welfare reform, the state Supreme Court declared sponsor-deeming unconstitutional for GA medical. It remains to be seen if welfare reform will negate this court decision.
34. All noncitizens must have lived in Connecticut for six months to be eligible for GA-Medical. There is no similar requirement for citizens on this program.
35. Noncitizens receiving GA-Medical in Connecticut must verify contact with the INS regarding naturalization to receive benefits.
36. This information is for Minnesota's GA-Medical Care program and the Minnesota Care program.
37. Only unattached children and emancipated minors are eligible for Minnesota's GA-Medical Care program. Children and their parents are eligible for Minnesota Care.
38. The residency requirement applies only to the Minnesota Care program. Recipients must have lived in the state six months before applying.
39. There is no state mandate that counties must run health insurance programs in Wisconsin. Counties opting to run medical assistance programs, however, can cover 50 percent of their program costs with state funds from the state's medical block grant program. In addition, counties can receive state funds from this block grant only for nonmedical programs (such as cash assistance) if they also run medical assistance programs. States with medical and nonmedical programs can recoup up to 40 percent of the costs for their nonmedical programs from the state.
40. However, unattached children are eligible for GA-Medical assistance in New Mexico. Benefits and eligibility vary by county.
41. Only emancipated minors are eligible for GA (and GA-Medical services) in Missouri.
42. This information is for Utah's Medical Assistance Program.
43. Post-enactment qualified immigrants are eligible for assistance in Utah only after a five-year bar.
44. State program provides a limited range of services including only inpatient or emergency services.
45. Children ages 0 to 21 are eligible for Iowa's health programs, but their parents are ineligible.
46. Limited services are provided under Iowa's health insurance program.
47. To be eligible to receive health services in Iowa, an applicant must have lived in the same county for at least six weeks.
48. This information is for New Hampshire's Healthy Kids program.
49. Only children are eligible for New Hampshire's Healthy Kids program.
50. This information is for Maine's GA-Medical program.
51. This information is for Alaska's Chronic and Acute Medical Assistance (CAMA) program or GR-Medical component.
52. Pregnancy-related services are not covered under CAMA although these services were covered under Alaska's old GR-Medical program (CAMA's precursor).
53. Our survey contains no information on health insurance programs in South Carolina. This information is for the Medically Indigent Assistance program, taken from the National Health Law Program's (NHeLP) 1997 Manual on State and Local Responsibility for Indigent Health Care (NHeLP Web site). The "—" signifies that we know of a program's existence, but do not have complete eligibility information for that program.

54. Our survey contains no information on health insurance programs in West Virginia. The National Health Law Program's 1997 Manual on State and Local Responsibility for Indigent Health Care (NHeLP Web site) indicates that the state mandates its counties to run several public health services, though services vary by county.
55. This information is for Vermont's GA-Medical program.
56. Limited services are covered under Vermont's GA-Medical program.
57. This information is for Wyoming's state-funded prescription program.
58. Three prescriptions per month and access to oxygen containers are available to recipients of Wyoming's prescription program.

**TABLE 15 State Health Insurance Programs for Employable Adults with Children**

State	Limited Populations	Qualified Immigrants Ineligible		Sponsor-Deeming Imposed <sup>1</sup>	Coverage Less Than Medicaid	Duration of Assistance Is Limited	Residency Requirement	Naturalization Requirement
		Pre-enactment	Post-enactment					
California <sup>2</sup>				X <sup>3</sup>		X <sup>4</sup>	<sup>5</sup>	
New Jersey <sup>6</sup>			X <sup>7</sup>	X <sup>8</sup>	X <sup>9</sup>	X <sup>10</sup>		X <sup>11</sup>
Washington <sup>12</sup>				X <sup>13</sup>	X <sup>9</sup>			
Pennsylvania <sup>14</sup>				<sup>15</sup>	X <sup>9</sup>	X		
Minnesota <sup>16</sup>				X	X <sup>9</sup>			X <sup>17</sup>
Utah <sup>18</sup>			X <sup>19</sup>		X <sup>20</sup>			
Maine <sup>21</sup>				X	X <sup>20</sup>			
Alaska <sup>22</sup>					X <sup>20,23</sup>			
South Carolina <sup>24</sup>		—	—	—	X		—	—
Vermont <sup>25</sup>					X <sup>26</sup>			
Wyoming <sup>27</sup>								

**Notes:** All state data presented above were current as of summer/fall 1998, unless otherwise noted.

1. Unless otherwise noted, sponsor-deeming, for immigrants entering under the new affidavit of support, will be imposed until the immigrant naturalizes or meets the 40-quarter exemption.
2. California law mandates counties to provide General Relief (GR), including medical assistance, to needy persons who do not qualify for federally funded assistance. The state sets minimum standards for the program, including minimum grant levels and eligibility rules. Specific program eligibility rules and services vary by county. Immigrant eligibility for the program, however, is standard statewide. The information presented is for Los Angeles County, which represents 61 percent of the state's GR caseload. Only GR cash recipients are eligible for the GR Health Plan in Los Angeles County.
3. In Los Angeles County, deeming applies for only three years, even for immigrants entering under the new affidavit of support.
4. Assistance for "employables" in Los Angeles County is available for 5 months out of any 12-month period.
5. In Los Angeles County, GR recipients must have lived in the county for at least 15 days.
6. This information is for New Jersey's Charity Care and General Assistance (GA)-Medical programs.
7. Post-enactment qualified immigrants are eligible for the Charity Care program (because the state does not verify immigrant status in this program). Post-enactment qualified immigrants, however, are ineligible for New Jersey's GA-Medical program.
8. Sponsor-deeming is not imposed on the Charity Care program. Deeming is imposed for three years on New Jersey's GA-Medical program.
9. State program provides a comprehensive range of services, including both inpatient and outpatient care, but less coverage than Medicaid. These programs may also provide other services.
10. There is no time limit on the Charity Care program. Noncitizens who are eligible to naturalize are limited to six months of assistance under New Jersey's GA-Medical program. Citizens are limited to five years.
11. Immigrants who are eligible to naturalize must do so within six months to retain GA-Medical assistance in New Jersey. According to U.S. law, to be eligible to naturalize Legal Permanent Residents married to U.S. citizens must have lived in the United States for at least three years and all other Legal Permanent Residents must have lived in the United States for five years. If immigrants do not naturalize within six months of first receiving GA-Medical benefits, they will be declared ineligible for GA. Immigrants are not terminated from GA, however, if they have completed a naturalization application and were only unable to naturalize solely because of an Immigration and Naturalization Service (INS) backlog in processing applications.
12. This information is for Washington's Medically Indigent program and Basic Health Plan.
13. Although Washington has decided to impose sponsor-deeming on these programs, deeming is not currently being implemented because the state has not decided how to implement it.
14. This information is for Pennsylvania's GA-Medical program.
15. Currently, sponsor-deeming is not being imposed, although Pennsylvania is considering implementing it.
16. This information is for the Minnesota Care program.
17. All applicants for Minnesota Care must have lived in the state for at least six months.
18. This information is for Utah's Medical Assistance program.
19. Post-enactment qualified immigrants are eligible for assistance in Utah only after a five-year bar.
20. State program provides a limited range of services including only inpatient or emergency services.
21. This information is for Maine's GA-Medical program.



22. This information is for Alaska's Chronic and Acute Medical Assistance (CAMA) program or GR-Medical component.
23. Pregnancy-related services are not covered under CAMA although these services were covered under Alaska's old GR-Medical program (CAMA's precursor).
24. Our survey contains no information on health insurance programs in South Carolina. This information is for the Medically Indigent Assistance program, taken from the National Health Law Program's (NHLP) 1997 Manual on State and Local Responsibility for Indigent Health Care (NHLP Web site). The "—" signifies that we know of a program's existence, but do not have complete eligibility information for that program.
25. This information is for Vermont's GA-Medical program.
26. Limited services are covered under Vermont's GA-Medical program.
27. This information is for Wyoming's state-funded prescription program.
28. Three prescriptions per month and access to oxygen containers are available to recipients of Wyoming's prescription program.

**TABLE 16 Unqualified Immigrants' Eligibility for Public Benefits**

State	General Assistance		Medicaid	Health Insurance		Prenatal Care		Long-Term Care <sup>1</sup>	
	PRUCOL Eligibility	Undocumented Eligibility	PRUCOL Eligibility	PRUCOL Eligibility	Undocumented Eligibility	PRUCOL Eligibility	Undocumented Eligibility	PRUCOL Eligibility	Undocumented Eligibility
California			■	*	*	■	■	■	
New York	■		■ <sup>2</sup>	■ <sup>3</sup>	■ <sup>3</sup>	■	■	■ <sup>2</sup>	
Texas	N/A	N/A		N/A	N/A	■	■	■ <sup>4</sup>	
Florida	N/A	N/A		■ <sup>5</sup>	■ <sup>5</sup>				
New Jersey	■ <sup>6</sup>		■ <sup>7</sup>	■ <sup>8</sup>	■ <sup>8</sup>			■ <sup>9</sup>	
Illinois						■	■		
Arizona				N/A	N/A				
Massachusetts	■		■ <sup>10</sup>	■ <sup>11</sup>	■ <sup>11</sup>	■	■	■ <sup>12</sup>	
Maryland	■			■ <sup>13</sup>	■ <sup>13</sup>	■	■		
Virginia	N/A	N/A	■ <sup>14</sup>	N/A	N/A	—	—	■ <sup>15</sup>	
Washington	■		■ <sup>16</sup>	■ <sup>17</sup>	■ <sup>17,18</sup>	■	■	■	
Michigan			■	—	—	—	—	■ <sup>19</sup>	
Pennsylvania	■		■	■		—	—	■ <sup>19</sup>	
Colorado	■		■ <sup>20</sup>	■ <sup>21</sup>		■		■ <sup>22</sup>	
Oregon				N/A	N/A				
Connecticut	■		■	■		N/A	N/A	■	
Georgia	N/A	N/A		N/A	N/A	■	■		
North Carolina	N/A	N/A		N/A	N/A	N/A	N/A		
Minnesota			■ <sup>23</sup>	■ <sup>24</sup>	■ <sup>23</sup>	■	■	■	■
Nevada	N/A	N/A		*	*	N/A	N/A		
Hawaii	■			N/A	N/A	■	■	■	
Ohio			■ <sup>25</sup>	N/A	N/A	■ <sup>25</sup>		■ <sup>25</sup>	
Wisconsin	N/A	N/A		*	*	N/A	N/A		
New Mexico				*	*	—	—	Undecided	Undecided
Missouri	■		■	■ <sup>26</sup>		■	■		
Utah						N/A	N/A	—	—
Louisiana	N/A	N/A		N/A	N/A	N/A	N/A		
Rhode Island			■	N/A	N/A	■	■	—	—
Kansas						N/A	N/A		
Oklahoma	N/A	N/A		N/A	N/A	N/A	N/A	■	
Alabama	N/A	N/A		N/A	N/A	N/A	N/A	—	—
Idaho	*	*		N/A	N/A	N/A	N/A		
Tennessee	N/A	N/A		N/A	N/A	N/A	N/A	■	
Dist. of Columbia				N/A	N/A	—	—	—	—
Indiana	*	*		N/A	N/A	N/A	N/A		
Iowa	*	*		■ <sup>27</sup>	■ <sup>27</sup>	■	■		
Nebraska				*	*	N/A	N/A		
Arkansas	N/A	N/A		N/A	N/A	N/A	N/A	■ <sup>19</sup>	
Mississippi	N/A	N/A	■ <sup>28</sup>	N/A	N/A	N/A	N/A	■ <sup>19</sup>	
Kentucky	N/A	N/A		N/A	N/A	■	■		
Delaware			■	N/A	N/A	■		■ <sup>29</sup>	
New Hampshire	*	*		—	—	■	■		
Maine	■		■			■		■	
Alaska	■		■ <sup>25</sup>	■		N/A	N/A	■ <sup>25</sup>	

State	General Assistance		Medicaid	Health Insurance		Prenatal Care		Long-Term Care <sup>1</sup>	
	PRUCOL Eligibility	Undocumented Eligibility	PRUCOL Eligibility	PRUCOL Eligibility	Undocumented Eligibility	PRUCOL Eligibility	Undocumented Eligibility	PRUCOL Eligibility	Undocumented Eligibility
South Carolina	N/A	N/A		—	—	—	—	—	—
West Virginia	N/A	N/A		*	*	—	—	—	—
Vermont	■			■		■	■		
Wyoming	N/A	N/A		■ <sup>30</sup>	■	■	■		
Montana	N/A	N/A		N/A	N/A	N/A	N/A	■ <sup>19</sup>	
South Dakota	N/A	N/A		*	*				
North Dakota	N/A	N/A	■ <sup>25</sup>	N/A	N/A	N/A	N/A	■ <sup>19</sup>	

Notes:

- = Benefits provided to this group
- = No information available
- \* = State mandates counties to run program, but unqualified immigrant eligibility varies by county
- N/A = Program does not exist in this state.

PRUCOL = Permanently Residing Under Color of Law

All state data presented above were current as of summer/fall 1998, unless otherwise noted.

Health insurance programs are state- and/or county-funded health programs providing primary health care to low-income individuals and families. These programs include medical components of state General Assistance (GA) programs and other state assistance programs. Only programs that are operated statewide are included. In addition, we included state children’s health programs that were operational before federal welfare reform, even if these programs now use federal Children’s Health Insurance Program funds. See tables 13 to 15 for eligibility and other information on these programs. State GA programs include statewide programs providing cash or in-kind assistance to low-income populations not eligible for federal assistance. These programs are also state- and/or county-funded. In some categories, states may have more than one applicable program. In these instances, conflicting immigrant eligibility information is always noted in the footnotes.

1. All immigrants previously considered PRUCOL for Medicaid are eligible, unless otherwise noted.
2. In New York, only immigrants who were receiving Medicaid and living in a residential health facility licensed, operated, or funded by the Office of Mental Health, the Office of Mental Retardation, or the Office of Developmental Disabilities as of 8/4/97 are eligible. In addition, immigrants who were receiving Medicaid and were diagnosed with AIDS as of 8/4/97 are eligible.
3. Only children are eligible for New York’s health insurance program (Child Health Plus).
4. Only those PRUCOL immigrants receiving long-term care as of 8/22/96 remain eligible in Texas.
5. Only children are eligible for Florida’s Healthy Kids program.
6. Only pre-enactment PRUCOLs are eligible for General Assistance (GA) in New Jersey. The state is considering making those unqualified immigrants who were previously considered PRUCOL ineligible for GA because they are not eligible for naturalization (and cannot fulfill the state’s six-month naturalization requirement).
7. In New Jersey, only immigrants who were living in a nursing facility as of 1/16/97 are eligible for state-funded Medicaid.
8. New Jersey has two health insurance programs: Charity Care and GA-Medical. There is no verification of immigrant status in the Charity Care program. Therefore, all immigrants, including the undocumented, receive assistance. Only pre-enactment PRUCOL immigrants are eligible for the GA-Medical program.
9. In New Jersey, only those PRUCOL immigrants living in a nursing facility as of 1/16/97 remain eligible.
10. Massachusetts’ definition of PRUCOL is broader than the old federal definition for Medicaid. The state’s definition includes all immigrants who have been granted some kind of immigration status (other than nonimmigrant status), have a formal Immigration and Naturalization Service (INS) application for status pending, or have proof that INS knows they are in the country and is not planning to deport them.
11. Only children are eligible for Massachusetts’ Children’s Medical Security Plan.
12. Only the following PRUCOL immigrants are eligible in Massachusetts: (1) those in long-term care facilities as of 6/30/97; (2) those receiving Medicaid as of 6/30/98; and (3) those with an application pending for long-term care as of 7/1/97.

13. This information is for Maryland's Pharmacy Assistance program, which provides prescriptions for Maryland GA recipients.
14. In Virginia, only PRUCOL immigrants who were receiving long-term care on 6/30/97 and PRUCOL children (under age 19) are eligible for state-funded Medicaid.
15. Only those PRUCOL immigrants who were already receiving long-term care on 6/30/97 remain eligible in Virginia.
16. Post-enactment PRUCOL immigrants are subject to a one-year residency requirement in Washington.
17. This information is for four Washington programs: GA-Unemployed (GA-U), the Children's Health Program, the Medically Indigent program, and the Basic Health Plan.
18. Undocumented immigrants are not eligible for Washington's GA-U program.
19. Only those PRUCOL immigrants who were receiving long-term care on 8/22/96 remain eligible for the state program.
20. Colorado's definition of PRUCOL is broader than the old federal definition for Medicaid. The state's definition includes all immigrants with actual or prospective permanent residence or whose physical presence in the United States is known and allowed by the INS. Only immigrants receiving nursing facility or home- and community-based services as of 7/1/97 are eligible for state-funded Medicaid.
21. This information is for Colorado's Old Age Pension and Colorado Indigent Care programs.
22. In Colorado, only those PRUCOL immigrants who were receiving long-term care as of 7/1/97 remain eligible.
23. Minnesota's definition of PRUCOL is broader than the old federal definition for Medicaid and includes all immigrants except nonimmigrants and the undocumented.
24. This information is for Minnesota's GA Medical Care and Minnesota Care programs. Undocumented immigrants are not eligible for Minnesota Care. Only those undocumented immigrants who are under age 18, over age 65, or disabled are eligible for GA-Medical.
25. Only pre-enactment PRUCOLs are eligible for the state program.
26. This information is for Missouri's GA-Medical program.
27. In Iowa, only children ages 0 to 21 are eligible for the Physician Diagnosis and Treatment program.
28. In Mississippi, only PRUCOL immigrants who were receiving Medicaid as of 8/22/96 remain eligible.
29. In Delaware, PRUCOL immigrants were denied long-term care between 1/1/97 and 6/30/97.
30. This information is for Wyoming's state-funded prescription program.

## How to File a Complaint with the U.S. Office for Civil Rights

If you believe you have been discriminated against because of your race, color or national origin, you may file a complaint with the U.S. Office for Civil Rights (OCR).

You have to file your complaint within 180 days (6 months) of when the discrimination happened.

You can write your own letter or use OCR's Discrimination Complaint Form.

You can send your complaint to the OCR Regional Office for your state or to the Washington, D.C. headquarters:

**U.S. Department of Health and Human Services  
Office for Civil Rights  
Washington, D.C. 20201  
202-619-0403**

Your complaint must state:

- Your name, address and telephone number.
- You must sign your name.

If you file a complaint for someone else, include your name, address and telephone number and state your relationship to that person.

- Name and address of the institution or agency you believe discriminated against you.
- How, why and when you believe you were discriminated against.
- Any other relevant information.

Once the complaint is filed, OCR staff will review it and decide whether they have grounds to begin an investigation. If discrimination is found, OCR will negotiate with the institution or agency to voluntarily correct the problems. If negotiations do not work, OCR may bring an action to take away the institution's or agency's federal funding.

If you file a complaint or provide information to OCR about discrimination, the law protects you against retaliation. Notify OCR immediately if anyone takes any action against you because you have complained.



# A Quick Guide to “Public Charge” and Receipt of Public Benefits

**Department of Justice  
Immigration and Naturalization Service**

## SUMMARY

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October 18, 1999

This guide provides a summary of how receiving public benefits in the United States may or may not affect an alien under the “public charge” provisions of the immigration laws.

Aliens applying to become Lawful Permanent Residents (LPRs) (who do not yet have a “green card”) –

- An alien will **not** be considered a “public charge” for using:
  - HEALTH CARE BENEFITS**, including programs such as Medicaid, the State Children’s Health Insurance Program (SCHIP), prenatal care, or other free or low-cost medical care at clinics, health centers, or other settings (other than long-term care in a nursing home or similar institution)
  - FOOD PROGRAMS**, such as Food Stamps, WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children), school meals, or other food assistance
  - OTHER PROGRAMS THAT DO NOT GIVE CASH**, such as public housing, child care, energy assistance, disaster relief, Head Start, or job training or counseling
- INS **may consider** an alien’s use of the following in deciding whether to issue a “green card:”
  - CASH WELFARE**, such as Supplemental Security Income (SSI), cash Temporary Assistance for Needy Families (TANF), and state General Assistance
  - INSTITUTIONALIZATION** for long-term care, such as residing in a nursing home or mental health facility at government expense

**Note:** INS will not consider CASH WELFARE or NON-CASH PROGRAMS received by an alien’s children or other family members for public charge purposes, unless the cash welfare is the family’s only means of support.

Aliens who are LPRs (who already have a “green card”) –

- LPRs **cannot** lose their status (have their “green card” revoked) if they, their children, or other family members use:

**HEALTH CARE, FOOD PROGRAMS, or other NON-CASH PROGRAMS**

**CASH WELFARE** (\*see note below for exception)

**LONG-TERM CARE** (\*see note below for exception)

**Notes:**

- LPRs who **leave the country for more than 6 months** at a time can be questioned about whether they are “public charges” when they return, and the use of cash welfare or long-term care may be considered.
- In very rare circumstances, LPRs who use cash welfare or long-term care within their **first 5 years** in the United States for reasons (such as an illness or disability) that existed **before** their entry to the United States could be considered deportable as a public charge.

**REFUGEES AND PEOPLE GRANTED ASYLUM** can use **any** public benefits, including cash welfare, health care, food programs, and other non-cash programs without hurting their chances of getting a “green card.”

**SPONSORING RELATIVES:** Using benefits, including cash welfare, health care, food programs, and other non-cash benefits, **does not prevent citizens and LPRs** from sponsoring relatives. However, sponsors must submit an Affidavit of Support showing that they have enough money (alone or with a co-sponsor) to support their relatives at 125 percent of the poverty level.

**BECOMING A NATURALIZED U.S. CITIZEN:** LPRs (who already have a “green card”) **cannot be turned down** for U.S. citizenship for lawfully receiving any public benefits for which they are eligible.

Need More Information? For more information about “public charge”:

- Please see the INS Web site at [www.ins.usdoj.gov](http://www.ins.usdoj.gov) for a fact sheet and questions and answers. Information is available in several languages under Public Affairs.

For more information about how to enroll in benefit programs:

- Please contact the appropriate federal, state or local service agency. Helpful contacts include:

*For SCHIP: 877-543-7669 (calls are free)*

*For Food Stamps: 800-221-5689 (calls are free)*

*For Medicaid or TANF: [www.hhs.gov](http://www.hhs.gov)*

*For WIC: [www.fns.usda.gov](http://www.fns.usda.gov)*



# Guía Breve Relativa a la Noción de “Carga Pública” y al Recibo de Beneficios Públicos

**Department of Justice  
Immigration and Naturalization Service**

## SUMMARY

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October 18, 1999

La presente guía explica resumidamente cómo el recibo de beneficios públicos en los Estados Unidos puede o no afectar a los extranjeros según las disposiciones de “carga pública” que figuran en las leyes de inmigración.

Extranjeros que solicitan la Residencia Permanente Lícita; es decir que todavía no tienen una *Green Card* (tarjeta verde)

- Un extranjero **no** será considerado como “carga pública” por recibir:
  - LOS BENEFICIOS DE ATENCION DE SALUD**, incluido el programa de *Medicaid*, el CHIP (Programa de Seguro de Salud para los Niños), la atención prenatal u otro tipo de atención médica gratuita o barata, en consultorios, centros de salud u otras instituciones (que no sea la atención a largo plazo en un hogar de ancianos u otra institución de esa índole).
  - LOS PROGRAMAS DE ALIMENTOS**, por ejemplo *Food Stamps* (sellos para la compra de alimentos), el WIC (Programa Especial de Nutrición Suplementaria para Mujeres, Recién Nacidos y Niños), comidas escolares u otro tipo de asistencia alimenticia.
  - OTROS PROGRAMAS NO MONETARIOS**, por ejemplo vivienda pública, servicios de guardería, ayuda en materia de energía, socorro en caso de desastre, el programa preescolar educativo y cultural *Head Start*, ni asesoramiento o capacitación en el trabajo.
- El INS, al expedir la tarjeta verde **podrá considerar** si el extranjero recibe los siguientes beneficios:
  - ASISTENCIA SOCIAL MONETARIA**, por ejemplo el *Supplemental Security Income* (Ingreso de Seguridad Suplementario), el TANF (Asistencia Temporal Monetaria para las Familias Necesitadas) y la asistencia general del Estado.

**INSTITUCIONALIZACIÓN** para la atención a largo plazo, por ejemplo la residencia en un hogar de ancianos o institución de salud mental por cuenta del gobierno.

**Nota:** El INS **no** considerará los programas de **ASISTENCIA SOCIAL MONETARIA** ni los **PROGRAMAS NO MONETARIOS** recibidos por los hijos u otros familiares del extranjero para fines de carga pública, **a menos que la asistencia social monetaria sea la única forma de subsistencia familiar.**

Los extranjeros que **sean** residentes permanentes lícitos (que ya tengan una tarjeta verde)

- Los residentes permanentes lícitos **no podrán** perder su condición como tales (revocación de la tarjeta verde) si ellos, sus hijos u otros familiares se benefician de:

**ATENCION DE SALUD, PROGRAMAS DE ALIMENTOS,** u otros **PROGRAMAS NO MONETARIOS**

**ATENCION SOCIAL MONETARIA** (\*véase a continuación la nota de la excepción.)

**ATENCION A LARGO PLAZO** (\*véase a continuación la nota de la excepción.)

**Notas:**

- A los residentes permanentes lícitos que **abandonen el país por más de 6 meses seguidos** se les podrá preguntar si reciben beneficios públicos cuando regresen a los Estados Unidos. y se podrán tener en cuenta los beneficios de la asistencia social monetaria o de atención a largo plazo.
- En muy raras circunstancias, los residentes permanentes lícitos que se beneficien de la asistencia social monetaria o la atención a largo plazo en sus **primeros cinco años** en los Estados Unidos por ciertas razones (por ejemplo, enfermedad o discapacidad) que existían **antes** de su entrada en los Estados Unidos se podrían considerar deportables como carga pública.

**LOS REFUGIADOS Y LOS ASILADOS** podrán recibir **cualquier** beneficio público, incluidos la atención social monetaria, la asistencia de salud, los programas de alimentos y otros programas no monetarios, sin perjuicio de sus posibilidades de obtener la tarjeta verde.

**FAMILIARES PATROCINADORES:** El recibo de beneficios, incluidos la asistencia social monetaria, la atención de salud, los programas de alimentos y otros beneficios no monetarios, **no impide que los ciudadanos y los residentes permanentes legales** patrocinen a familiares. Sin embargo, los patrocinadores deben presentar una Declaración Jurada de Sustento en la que indiquen que tienen suficiente dinero (sólos o con un copatrocinador) para sostener a sus familiares a un 125 por ciento del nivel de pobreza.

**CIUDADANIA ESTADOUNIDENSE POR NATURALIZACION:** A los residentes permanentes legales (que ya tienen una tarjeta verde) **no se les puede negar** la ciudadanía estadounidense por el hecho de recibir lícitamente cualesquiera beneficios públicos a los que tengan derecho.

¿Necesita Más Información? Si necesita más información sobre “carga pública”:

- Visite el sitio del INS en la Web [www.ins.usdoj.gov](http://www.ins.usdoj.gov) para consultar la hoja de datos y la sección de preguntas y respuestas. La información está disponible en varios idiomas bajo *Public Affairs* (Asuntos Públicos).

Si desea más información sobre cómo inscribirse en los programas de beneficios:

- Póngase en contacto con el organismo de servicios pertinente a nivel federal, estatal o local. La siguiente información le será de utilidad:

*Para CHIP: 877-543-7669 (las llamadas son gratuitas)*

*Para Food Stamps: 800-221-5689 (las llamadas son gratuitas)*

*Para Medicaid o TANF: [www.hhs.gov](http://www.hhs.gov)*

*Para WIC: [www.fns.usda.gov](http://www.fns.usda.gov)*



# Summary of State Law Requirements Addressing Language and Cultural Needs in Health Care

**Source: Ensuring Linguistic Access in Health Care Settings:  
Legal Rights and Responsibilities**

**Prepared by: National Health Law Program**

**Jane Perkins/January 1998**

**Supported by a grant from the  
Henry J. Kaiser Family Foundation, Menlo Park, California**

<b>Provisions</b>	<b>Requirements</b>
Alaska Statutes §§ 47.30.735 and 745	During 30- and 90-day involuntary commitment hearings, patients have the right to an interpreter.
Alaska Statutes § 47.30.860	When practicable, notices and documents served on mental patients must be explained in a language understood by the patient or the patient's adult designee.
Alaska Statutes § 47.30.855	Patient rights must be explained in languages understood by mental patients.
Alaska Statutes § 47.30.675	All applicants for voluntary treatment must receive an explanation of rights in languages that they understand.
Arizona Administrative Code R9-21-305(B)(9)	Case management services employed by the Department of Health Services must assess communication skills of each eligible mentally ill client, including clients' ability to read, hear, understand and speak English.
25 Arkansas Statutes § 15-101	Non-English speaking persons are entitled to the assistance of interpreters in administrative proceedings. If an individual cannot afford to pay for an interpreter, the agency may appoint an interpreter for them.
22 California Code of Regulations § 98211(c)	Recipients of state funds may not discriminate against ethnic minorities by failing to provide alternative communication services for individuals who are unable to read, speak or write the English language, except when the state determines that such a requirement would place an undue burden on the recipient. Alternative means of communication include, but are not limited to, interpreter services and written materials.
California Welfare and Institutions Code §§ 5804, 5868	County mental health demonstration programs and children's mental health programs must make provisions for staff with necessary linguistic skills to remove barriers to mental health care for non-English speaking patients.
22 California Code of Regulations § 73501	Intermediate care facilities must use interpreters and other methods to ensure adequate communication between staff and patients.
California Welfare and Institutions § 14552(e)	An adult day care provider serving a "substantial number" of participants of a particular racial group, must employ staff of that particular racial or linguistic group at all times. The term "substantial number" is not defined.
22 California Code of Regulations § 54401	Adult day care centers must include ethnic and linguistic staff as indicated by participant characteristics.

Provisions	Requirements
California Health and Safety Code § 1259	General acute care hospitals must provide language assistance services for language groups that comprise 5% or more of the facility population. Acute care hospitals must develop policies on the provision of interpreter services to LEP patients and must review these policies on an annual basis. To the extent possible as determined by the hospital, these policies must ensure the availability of interpreter services 24 hours a day to LEP patients who are part of a language group that comprises at least five percent of the population of the geographic area served by the hospital. Hospitals also must (1) post foreign language notices that advise patients and their families of the availability of interpreters, the procedure for obtaining an interpreter, and directions on how to make complaints to state authorities about interpreter services; (2) notify their employees of their commitment to provide interpreters to all patients who request them; (3) prepare and maintain a list of qualified interpreters; (4) identify and record their patients' primary languages in hospital records; (5) review standardized forms to determine which should be translated; (6) consider providing non-bilingual staff with picture and phrase sheets from communication with LEP patients, and (7) consider establishing community liaison groups to enable LEP communities to ensure the adequacy of interpreter services. State licensing agencies are empowered to enforce these requirements through administrative sanctions.
California Government Code § 11513(d)	States must make available certified interpreters to non-English speaking individuals upon request to interpret at administrative hearings.
California Welfare and Institutions Code § 7290 et seq.	State and local agencies must provide bilingual services to non-English speaking persons. Local agencies must provide services for languages spoken by substantial numbers of non-English speaking persons, defined as five percent or more of the population served by a state or local facility. Both state and local agencies must employ sufficient bilingual persons, who are proficient in both the English language and foreign language spoken by patients, to ensure that non-English speaking persons enjoy the same level of services enjoyed by English speaking persons. Every two years, state agencies must conduct surveys of local offices to determine the number of bilingual employees and the number and percentage of non-English speaking persons served by each office, broken down by language.
9 California Code of Regulations § 862, 22 California Code of Regulations §§ 70577, 71507, 72453, 73399, 77099 and 79313	Mental health treatment facilities must post notice of patients' rights in English and Spanish.
22 California Code of Regulations §§ 79111, 79113	Chemical dependence recovery hospitals must post notice of patients' rights in English or the predominant language of the community and must explain these rights in a language or medium that the patient understands.
California Welfare and Institutions Code § 4503	State hospitals and community care facilities must post notice of the rights of developmentally disabled persons in Spanish and English.
California Health and Safety Code § 1599.74	Department of Health Licensing is directed to translate enumerated patient rights into Spanish, Chinese, and every other language spoken by 1% or more of the state's nursing home population. Nursing facilities must give translated versions to non-English speaking patients upon admission.
California Health and Safety Code § 124300	Local health departments are directed to make family planning pamphlets and circulars available in languages spoken by 10% or more of the county's population.
16 California Code of Regulations § 1003	Dental health experimental programs must post notices describing the nature and intent of the program in English and a second language if warranted by the needs of the local community.
22 California Code of Regulations § 79799	Correctional facilities must post notice of rights of inmate-patients in English and Spanish.
California Welfare and Institutions Code § 14191, 22 California Code of Regulations §§ 51305.4, 70707.4	Physicians and hospitals performing voluntary, nonemergency sterilizations on Medi-Cal beneficiaries must provide informed consent forms in English and Spanish.
California Welfare and Institutions Code § 5325	Individuals subjected to involuntary mental health treatment must receive an explanation of their rights in a language and modality that is accessible to them.

Provisions	Requirements
California Health and Safety Code § 1568.02(c)(4)	Residential care facilities for persons with chronic, life-threatening illness must demonstrate ability to provide linguistic services for non-English speaking patients as a condition of licensure.
22 Code of California Regulations §§ 72528, 73524	Nursing facilities must obtain informed consent from non-English speaking patients through use of an interpreter who is fluent in English and patients' language for the use of psychotherapeutic drugs, physical restraints, or devices that may lead to loss of ordinary body function.
California Welfare and Institutions Code § 10746	Informational materials about state administration of public assistance must be produced in both English and Spanish.
17 California Code of Regulations § 6824(b)(3)(B)	Medicaid beneficiaries who cannot understand English must be informed "appropriately" of the Early Periodic Screening Diagnosis and Treatment program.
California Welfare and Institutions Code § 14007.5(j)	Local offices must explain Medicaid alien eligibility rules to aliens who are not fluent in English in a language that is understood by them.
California Welfare and Institutions Code §§ 4710.8(d) and 4712(k)	State or service delivery agency must provide non-English speaking claimants with interpreters at fair hearings and informal meetings challenging decisions regarding services for the developmentally disabled.
Colorado Revised Statutes § 26-4-703(d)(3)	Directing the Department of Health Services to consider the special cultural and linguistic needs of patients in developing a Medicaid waiver.
Regulations of Connecticut State Agencies § 17-134d-41	Coordinating, Assessment and Monitoring Agencies that provide assessment and case management services for patients receiving long term care or community based services recipients must provide or access necessary services for non-English speaking and bilingual individuals.
Connecticut General Statutes § 19a-490g	Requiring Department of Public Health to develop a bilingual consumer guide on home health services.
16 Delaware Code § 5161	Mental health hospitals and residential centers must display patient rights in English and Spanish and must provide a list of rights to each patient.
District of Columbia Code § 31-2711(a)	Establishing the Office of Interpreter Services to facilitate the use of interpreters in administrative, judicial, and legislative proceedings.
Florida Statutes § 381.026(4)(b)(7)	A patient in a health care facility who does not speak English has the right to be provided an interpreter when receiving medical services, "if the facility has a person readily available who can interpret on behalf of the patient."
Florida Administrative Code § 59A-3.207	Each hospital offering emergency services must post notices in English and Spanish clearly stating patients' rights to receive such services and hospital's capacity to provide such services.
Florida Code §§ 636.015, 641.305 and 641.421	Prepaid limited health service organizations, health maintenance organizations, and prepaid health clinics that negotiate contract in languages other than English, must provide non-English speaking members with written translations of their contract. These translations must be identical to their English language versions, must be approved in advance by the Department of Insurance, and must be certified as accurate translations.
Hawaii Revised Statutes Annotated § 321-301	Establishing state sponsored bilingual health education aide program to assist in the provision of health education and public health services to non-English speaking and limited English speaking persons.
Hawaii Revised Statutes Annotated § 334-13	Establishing a bilingual mental health division within the Department of Health to provide outreach, education, case finding, screening, referral, consultation, crisis stabilization, community support and client advocacy.
405 Illinois Compiled Statutes 75/1	State-operated mental health and developmental facilities must provide qualified Spanish speaking interpreters to overcome barriers to care and treatment of at least one percent of the facilities total annual admissions for inpatient or outpatient care consists of patients of Hispanic descent.
405 Illinois Compiled Statutes 5/3-204	Patients admitted to mental health facilities who do not understand English must receive an explanation of all communications required by law in their primary language.
405 Illinois Compiled Statutes 5/3-205	Patients admitted to mental health facilities who do not understand English must receive an explanation of their legal rights in their primary language "within a reasonable time before any hearing is held."

Provisions	Requirements
210 Illinois Compiled Statutes 87/5 et seq., 77 Illinois Administrative Code § 250.265	Because access to information regarding basic health care services is an essential right, communication barriers must be removed by proper arrangements for interpreters or bilingual professional staff. To accomplish these goals, a health care facility may take one or more of nine enumerated steps to provide interpretation and/or translation services to patients in language groups constituting 5 percent or more of the population of the health facility's service area. Health care facilities may (1) review existing policies on the use of interpreters, including the availability of staff interpreters; (2) adopt and review annually new policies for providing language assistance to LEP patients that "shall include procedures for providing, to the extent possible as determined by the facility, the use of an interpreter whenever a language or communication barrier exists, except where the patient, after being informed of the availability of the interpreter service, chooses to use a family member or friend who volunteers to interpret"; (3) prepare lists of qualified interpreters; (4) identify and track patient language needs; (5) notify employees of the facility's commitment to provide interpreters to all who request them; (6) review standardized forms to determine which should be translated; (7) develop community liaison groups to obtain feedback about the adequacy of interpreter policies; (8) provide non-bilingual staff with phrase and picture sheets to assist them in communicating with LEP patients; (9) post notices advising patients of the availability of interpreter services.
59 Illinois Administrative Code § 112.20	Mental health and developmental disability facilities must notify non-English speaking patients and their guardians of the right to challenge diagnoses of mentally retardation and resulting placement and treatment.
20 Illinois Compiled Statutes §§ 2310/55.66	The Department of Public Health is required to publish and distribute pamphlets to women on reproductive health issues
89 Illinois Administrative Code §§ 302.30(c) and 308.30(b)	In delivering social services to children and their families, the Department of Children and Family Services shall ensure compliance with Title VI of the Civil Rights Act of 1964 and any other state or federal laws that prohibit discrimination in service delivery on account of the inability to speak or comprehend the English language.
89 Illinois Administrative Code § 140.461	Federally qualifies health centers must comply with federal and state laws and regulations governing the provision of adequate notice to persons who are unable to read or understand the English language.
89 Illinois Administrative Code § 716.200(d)(2)	Providers contracting with the Department of Rehabilitative Services to provide case management services to persons with AIDS must agree to comply with the Title VI of the Civil Rights Act of 1964 and any state or federal laws that prohibit discrimination in service delivery on account of the inability to speak or comprehend the english language.
89 Illinois Administrative Code § 1200.10(d)(1)	Information, forms and applications distributed by the Division of Specialized Care for Children shall be available in English and Spanish.
Kansas Administrative Regulations § 28-4-550(h)(1)(A) and (w)	Informed consent for services under part H of the Individuals With Disabilities Education Act (IDEA) must be obtained from parent(s) in their native language.
40 Louisiana Revised Statutes § 1299.35.6.B(2)(4)	Specified oral information and written materials about abortion and abortion alternatives must be provided to the patient at least 24 hours before the procedure is performed. If an interpreter is necessary to explain this information, the State of Louisiana shall bear the costs.
5 Maine Revised Statutes § 51	State must provide qualified interpreters or utilize a professional telephone-based interpretation service when a non-English speaking person is subject of a proceeding before an agency or a court.
114.3 Code of Massachusetts Regulations §§ 3.02 and 3.06	Home health agencies may apply for adjustment in rates for provision of interpreters to non-English speaking patients.
102 Code of Massachusetts Regulations §§ 3.03(6)(a)(1)(a) and 6.05(6)(a)(1)(a)	Group care facilities for children must obtain records of the primary language of children in their care.



Provisions	Requirements
105 Code of Massachusetts Regulations § 127.021	As a condition of licensing, mammography facilities must provide specified information to patients. The official commentary to this regulation states that facilities that serve linguistically diverse patients should use reasonable means to communicate the required information to patients who are not proficient in reading English.
105 Code of Massachusetts Regulations §§ 150.001 and 150.004(H)	Skilled nursing facilities for AIDS patients must provide access to sufficient bilingual services to meet the cultural and language needs of non-English speaking residents.
105 Code of Massachusetts Regulations §§ 160.303(B)(1)	Substance abuse treatment facilities must keep data listing primary language spoken by patients of other than English.
105 Code of Massachusetts Regulations § 130.615(C) and (E)	Maternal-newborn service must make available health education materials and activities in languages spoken by any non-English speaking groups that comprise at least 10% of the population served and must have translation services available to ensure that families who speak these languages receive ongoing information about the condition and progress of the mother and infant.
117 Code of Massachusetts Regulations §§ 8.08(d)	Community health centers must post notice of the availability of free care in any language spoken by 10% or more of the residents in the centers' service area.
Michigan Statutes Annotated § 14.15(b) and (c)	Consequences of abortion must be explained in language understood by patients and consent forms must be printed in English, Aramaic and Spanish.
Minnesota Statutes §§ 144.651(4)	Health care facilities must make reasonable accommodations to inform non-English speaking patients of their legal rights.
Minnesota Statutes § 148B71(1)	Mental health facilities must make reasonable accommodations to inform non-English speaking patients of their legal rights.
Minnesota Statutes § 256.01 (13)	Mandating pilot projects for legal assistance for individuals applying for or receiving aid through county social service agencies.
40 Nevada Revised Statutes § 442.253(1) and (3)	Consequences of abortion must be explained in language understood by patient and consent forms must be written in language understood by her.
8 New Jersey Administrative Code §§ 31B-4.37(a)(1), 31B-4.41C	Hospitals must post notices regarding availability of charity care in Spanish, English and any other language spoken by more than 10% of the population of the hospital's service area.
8 New Jersey Administrative Code §§ 33-4.10(a)(8), 33A1.29(b)(3)(ii)-4.10(a)(8)	For approval of certificate of need, hospital must show how the project will promote access for racial and ethnic minorities and must document effective communication between the staff of the proposed project and non-English speaking people.
26 New Jersey Revised Statutes § 2-168	Department of Health must disseminate informational brochure on breast cancer in English and Spanish.
26 New Jersey Revised Statutes § 2H-12.8.h.	Patients have the right to expect that within their capacity, hospitals will make reasonable response to request for services, including the services of an interpreter if 10% or more of the population of the hospital's service area speaks that language.
8 New Jersey Administrative § Code 33E-1.5a	For approval of certificate of need for intensive cardiac care units, hospitals should have bilingual clinical personnel available who can overcome language barriers and know and understand cultural differences among patients to the extent possible.
30 New Jersey Revised Statutes § 4-27.11	Patients admitted to psychiatric facilities have the right to examinations and services provided through interpreters in their primary means of communication at the earliest possible time.
8 New Jersey Administrative Code §§ 42A-6.10, 42B-6.6(e)	Drug and alcohol treatment facilities must provide interpreter services if their patient population is non-English speaking.
8 New Jersey Administrative Code §§ 43H-6.1(a)(14)	Rehabilitation hospitals must provide interpreter services if their patient population is non-English speaking.
8 New Jersey Administrative Code §§ 43F-6.6	Adult day care centers must provide interpreter services if their patient population is non-English speaking.
30 New Jersey Statutes § 1-1.1	Requiring the Department of Human Services to establish a comprehensive social services information hotline operating in Spanish and English.

Provisions	Requirements
10 New Jersey Administrative Code § 74-1.3	To meet requirements for bilingual services, Medicaid managed care plans must be able to provide services in Spanish and English and in any other language spoken by more than ten percent of its Medicaid enrollee.
10 New York Comp. Codes R. & Reg. § 405.7(a)(7)	Hospitals must provide skilled interpreters and translations of all significant forms to ensure effective oral and written communication with all persons receiving treatment regardless of language. Interpreters and translations shall be regularly available for non-English speaking groups comprising more than one percent of a hospital's service area. Interpreters must be available in inpatient and outpatient settings within 20 minutes and in emergency rooms within 10 minutes of a request to hospital administration by the patient, the patient's family, the patient's representative or a health care provider.
New York Consolidated Laws Service, Mental Hygiene § 41.47(f)(3)	Directing the Office of Mental Health and local mental health agencies to consider the availability of services of non-English speaking persons as part of the process of contracting with community support services programs.
New York Consolidated Laws Service, Mental Hygiene §§ 7.09(h)(i) and 13.09(e) (1995)	Directing the Office of Mental Health and Office of Mental Retardation and Developmental Disabilities to promulgate rules that address the communications needs of non-English speaking persons and to require facilities to use reasonable means to accommodate the language needs of non-English speaking patients.
New York Consolidated Law Service, Mental Hygiene § 81.07(b)	Orders to show cause in proceedings for appointment of a guardian must be translated into languages other than English when necessary to apprise patients of proceedings.
14 New York Consolidated Law Service, Mental Hygiene § 21.7	Non-English speaking mental patients must be provided with qualified translation services to facilitate written communication.
New York Consolidated Law Service, Social Services § 473-a.4.(c)(vii) (1995)	Petition for involuntary commitment must state that if a patient is non-English speaking, reasonable efforts have been made to communicate with her.
10 North Carolina Administrative Code § 50B.0203(c)(5)	Requiring the county department of social services to verify eligibility information when an applicant is unable to speak English.
Ohio Administrative Code § 5124-2-01(D)(4)	Hospitals and mental health clinical facilities must ensure that all non-English speaking patients meet with a client advocate who can explain their rights regarding involuntary commitment within 24 hours of admission.
Ohio Administrative Code, Chapter 3793, § 2-1-12(G)	Licensed referral and information services for drug and alcohol addiction must provide access to patients who speak a language other than English.
Ohio Administrative Code, Chapter 5101, § 3-2-0717(D)(3)	Hospitals receiving state payments for indigent must post notice of patient rights to free care.
55 Pennsylvania Administrative Code § 1140.41(12)	Providers that contract with state's Healthy Beginnings Plus program must ensure use of qualified interpreters for each non-English speaking patient.
35 Pennsylvania Statutes § 449.36	Health care practitioners that treat non-English speaking Medicare beneficiaries must post translated signs of patient rights supplied by Pennsylvania's Bureau of Professional and Occupational Affairs.
28 Pennsylvania Administrative Code §§ 201.29(k) and 201.30(h)	Nursing homes must make arrangements to communicate patient rights to non-English speaking patients.
28 Pennsylvania Administrative Code § 553.12	Ambulatory surgery patients who do not speak English shall have access to an interpreter where possible.
28 Pennsylvania Administrative Code § 201.29(x)	Hospitals must translate notices of patient rights for non-English speaking patients.
35 Pennsylvania Statutes § 449.36(c)	Hospitals must post translated notices of patient rights for non-English speaking Medicare beneficiaries
23 Rhode Island General Laws § 17.5-18(3)	Nursing homes serving non-English speaking patients must attempt to find interpreters to allow patients to exercise their rights.
25 Texas Administrative Code § 29.609(c)(3)	Disproportionate share hospitals must post notices of right to charity care in English and Spanish.
25 Texas Administrative Code § 405.88	Facilities for the mentally retarded must make necessary provisions to assess non-English speaking individuals.

Provisions	Requirements
40 Texas Administrative Code 25 §§ 147.35(10), 153.36(13) Texas Health and Safety Code §§ 161.132(e), 161.134(j), 161.135(h), 321.002(h), 25 Texas Administrative Code §§ 133.52(b)(2); 135.54(a), 40 Texas administrative Code 148.141(b)	Alcohol and drug abuse education programs and drug offender education programs must make provisions for persons who are unable to read or speak English. Facilities and hospitals offering mental health, rehabilitation and alcohol and chemical dependency services must post notice of patient rights, patient abuse reporting responsibilities, and right to be free from retaliation for reporting violations of law, in English and a second language representative of the demographic makeup of the community served by the facility.
Texas Health and Safety Code § 161.136(a)	State health care regulatory agencies are empowered to require mental health services providers to furnish patients with brochures in English and Spanish summarizing laws prohibiting sexual exploitation of patients.
25 Texas Administrative Code § 404.161(f), 404.162(d)	Mental health facilities must provide patient rights brochures to teens and children in English and Spanish.
25 Texas Administrative Code § 405.626	Department of Mental Health and Mental Retardation must print patient rights handbook for mentally retarded in Spanish and English.
Utah Administrative Code § R501-2-9(J)	Human service programs that contract with the state must employ staff as necessary to communicate with consumers whose primary language is not English.
18 Vermont Statutes Annotated § 1852	Hospital patients who do not understand English have a right to an interpreter "if the language barrier presents a continuing problem to patient understanding of the care and treatment being provided."
33 Vermont Statutes Annotated § 7301	Nursing homes must make reasonable accommodations to communicate patient rights to non-English speaking residents.
Washington Administrative Code §§ 440-22-160 and 440-22-310(b)	Chemical dependency service providers must make available certified interpreters or other acceptable alternatives for persons with Limited English Proficiency and must accommodate Limited English Proficiency and cultural differences.
Washington Revised Code § 74.04.025(1)	The department of Social and Health Services and the Office of Administrative Hearings shall insure that bilingual services are provided to non-English speaking recipients and applicants. The department shall employ bilingual staff if the number of applicants and recipients sharing the same language equals or exceeds fifty percent of the average caseload of a full-time caseworker. The department shall ensure bilingual services to supplement staff through contracts with other sources. Initial client contact materials must inform clients in their primary language of the availability of interpreting services. Notices to clients must contain written communications in their primary language informing them of the significance of the communication, and how to obtain assistance in responding to it. DSHS must ensure that sufficient resources are available to allow patients to respond to notices in a timely fashion. Basic informational pamphlets must be translated into Spanish, Vietnamese, Cambodian, Laotian, Chinese and other languages determined to be primary languages by DSHS.
Washington Administrative Code § 246-452-010	Written explanation about charity care must be provided in any language spoken by more than ten percent of the population in the hospital's service area and must be interpreted for other non-English speaking patients.



# Language Access Questionnaire for Managed Care Contractors That Receive Federal Funding

**Prepared by: National Health Law Program**

**Jane Perkins/August 1999**

**Supported by a grant from the  
Henry J. Kaiser Family Foundation, Menlo Park, California**

## **Explanation for Using This Assessment Tool**

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This assessment tool is designed to assist managed care plans, consumer advocates, community-based organizations, and other interested persons with surveying managed care contractors' ability to provide linguistically accessible health care services.

The questions in this assessment tool are guided by requirements of Title VI of the Civil Rights Act, as set forth in compliance decisions and guidance memoranda from the U.S. Department of Health and Human Services Office for Civil Rights. Private accreditation standards also address availability of linguistically accessible services. These are incorporated into this tool, as well—questions marked by\* are suggested in the National Committee for Quality Assurance's current set of performance measures, HEDIS 3.0.

In this document, "interpreter services" means the use of qualified interpreters, namely persons who have received some training on medical interpretation and the ethics of interpreting. This does not include friends or family members (particularly adolescents) unless they have received such training.

## Demographic Assessment

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Has the managed care plan (plan) compiled a demographic profile of the population it serves (plans to serve)?	YES	NO
By ethnic/race group?	YES	NO
By primary language spoken?	YES	NO
If so, what groupings/languages are reflected on the profile?		
Does the plan determine each patient's primary language?	YES	NO
If so, when?		
If so, how?		
Does the plan use "I Speak" cards?	YES	NO
Do the plan's contracting providers use "I Speak" cards?	YES	NO
Does the plan collect and maintain records of the patient's utilization of health services:		
By race/ethnicity?	YES	NO
By primary language?	YES	NO
Is the patient's primary language noted on their medical records?	YES	NO
Is the plan working with any community-based organizations that are familiar with the language needs of the persons living in the service area or moving to the service area?	YES	NO
If so, describe.		

## Written Policy

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Does the managed care plan have a designated person on staff who coordinates language access activities?	YES	NO
If so, please name.		
Does the plan have a written policy on the provision of language interpreter services?	YES	NO
If so, is a description of this policy made available to plan members?	YES	NO
If so, how and when is this made available?	YES	NO

In what languages is the policy made available?

Do the plan’s contracting health care providers have written policies on the provision of language interpreter services?

YES NO

If so, which providers?

And if so, is a description of this policy made available to patients?

YES NO

If so, how and when is this made available?

In what languages is the policy made available?

Do plan staff/contracting health providers receive information about/training on the written policy?

YES NO

If so, when? how?

## Staffing Patterns

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By language spoken, how many of the plan’s providers fluently speak a language other than English, as follows:

- Primary care providers
- OB/GYN and prenatal care providers
- Mental health and chemical dependency providers
- Dental providers
- Physician’s assistants
- Nurses
- Member services staff
- 24-hour emergency staff
- Other medical professionals (list)

For each of the above categories, what proportion of the entire staff do the bilingual/multilingual providers represent?

The following chart may be used:

Language Spoken	Provider Type	Bilingual #	Total #	Limits on Availability
	Primary care provider			
	OB/GYN/Prenatal			
	Mental health/Chemical dependency			
	Dental			
	Physician’s assistants			
	Nurses			
	Member services			
	24-hour emergency staff			
	Other medical professionals			
Language Spoken	Provider Type	Bilingual #	Total #	Limits on Availability
	Primary care provider			
	OB/GYN/Prenatal			
	Mental health/Chemical dependency			
	Dental			
	Physician’s assistants			
	Nurses			
	Member services			
	24-hour emergency staff			
	Other medical professionals			
Language Spoken	Provider Type	Bilingual #	Total #	Limits on Availability
	Primary care provider			
	OB/GYN/Prenatal			
	Mental health/Chemical dependency			
	Dental			
	Physician’s assistants			
	Nurses			
	Member services			
	24-hour emergency staff			
	Other medical professionals			

Are providers monitored to make sure they are qualified to interpret services? YES NO

If so, how?

Is ability to speak a language other than English a factor in hiring decisions with respect to member services staff? YES NO



Is ability to speak a language other than English a factor in hiring decisions with respect to contracting health care providers?	YES	NO
If so, which providers?		
Has the presence of bilingual health care providers increased over the last three years?	YES	NO

## Use of Interpreter Services for Member Services

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Does the plan use interpreter services to:

Explain enrollment and plan use processes?	YES	NO
Assist with enrollment/disenrollment?	YES	NO
Explain early and periodic screening, diagnosis and treatment for children?	YES	NO
Explain freedom of choice of family planning services?	YES	NO
Offer appointment scheduling and transportation assistance?	YES	NO
Explain grievance and complaint processes?	YES	NO
Other points of contact?	YES	NO

Are interpreter services provided during grievance and state fair hearings?	YES	NO
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For each of the areas above where interpreter services are provided, what sort of interpreter services are used:

- Non-provider staff interpreters
- Contract interpreters
- Telephone services
- Community-based organizations
- Language banks

Please explain by:

- (1) description of service;
- (2) type of agreement;
- (3) restrictions on availability, i.e. time of day, geographic area, other;
- (4) steps taken to assure that the interpreters are qualified.

The following chart may be used:

Activity	Languages Spoken	Interpreter Services Used	Restrictions on Availability
Explain enrollment and plan use processes			
Assist with enrollment/disenrollment			
Explain EPSDT			
Explain free choice of family planning providers			
Offer transportation assistance			
Offer appointment scheduling assistance			
Appointment reminders			
Explain complaint processes			
Provide interpreters at complaint hearings			
Other points of contact			

Are interpreters monitored to make sure they are qualified to interpret services? YES NO

If so, how?

Describe how the plan provides telephone assistance to persons who have limited English proficiency.

Does the plan offer interpreter services at no cost to the members? YES NO

If so, when are these services offered?

If not, under what circumstances are members charged for these services?

And under what payment arrangements?

Does the plan use family and friends to interpret? YES NO

Does the plan allow minors to interpret for parents? YES NO

If so, under what circumstances?

## Use of Interpreter Services During Medical Visits

Are family and friends used to interpret medical visits? YES NO

If so, under what circumstances?

Are minors used to interpret medical visits for their parents? YES NO

If so, under what circumstances?

Are interpreter services provided during medical visits? YES NO

If so, during what points of contact (e.g. check ups, immunizations, specialty care visits, pharmacy, durable medical equipment, follow up visit, telephone consultation)

If so, what sort of interpreter services are used:

- Non-provider staff interpreters
- Contract interpreters
- Telephone services
- Community-based organizations
- Language banks

Please explain by:

- (1) type of agreement;
- (2) restrictions on availability, i.e. time of day, geographic area, other;
- (3) steps taken to assure that the interpreters are qualified.

The following chart may be used:

Service/Activity (point of contact)	Languages Spoken	Interpreter Services Used	Restrictions on Availability

Are interpreters monitored to ensure they are qualified? YES NO

If so, how?

Are interpreter services offered at no cost to the patient? YES NO

If so, when are these services offered?

If not, under what circumstances are members charged for these services?

And under what payment arrangements?

Is contracting provider staff trained on the use of interpreters?

YES NO

If so, which provider?

Who is trained?

How often?

## Written Translations

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\*Provide an inventory of all materials for members and patients printed in languages other than English. Attach sample copies.

Are there set criteria for deciding:

(1) which materials will be translated;

YES NO

(2) who will translate the materials;

YES NO

(3) which languages will be translated?

YES NO

Are materials pre-tested?

YES NO

If so, which materials?

And, under what circumstances?

Are there signs posted in offices/facilities in languages other than English?

YES NO

If so, what is the subject matter/what languages/where is the posting?

## Complaints

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Does the plan monitor the availability of interpreter services at provider sites?

YES NO

If so, which sites?

How?

Does the plan have patient satisfaction surveys that include questions directed at limited English-speaking members/patients? If so please provide a copy.

YES NO

If any of the following have occurred, please describe:

Have any grievances been filed against the health plan because of language access problems?

Have any state-level appeals been filed against the health plan because of language access problems?

Have any complaints been filed against the health plan because of language access problems with the:

State department of insurance?

State civil rights commission/office for minority health?

Federal Office for Civil Rights?

Does the plan maintain records of disenrollments?	YES	NO
If so, do disenrollments that have occurred affect a race/ethnic group disproportionately?	YES	NO
If so, are any disenrollments from the plan attributable to language access problems?	YES	NO
Does the plan maintain complaint logs with the member services department?	YES	NO
If so, are any complaints attributable to language access problems?	YES	NO

If the answers to any of the questions in this section is “yes,” what steps have been taken in response to the grievance/complaint?



# Title VI of the Civil Rights Act of 1964: Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency

**65 Fed. Reg. 52762-74 (Aug. 30, 2000)**

**Department of Health and Human Services  
Office for Civil Rights**

**AGENCY:** Office for Civil Rights, HHS.

**ACTION:** Notice of policy guidance with request for comment.

**SUMMARY:** The United States Department of Health and Human Services (HHS) is publishing policy guidance on Title VI's prohibition against national origin discrimination as it affects limited English proficient persons.

**DATES:** This guidance is effective immediately. Comments must be submitted on or before October 30, 2000. OCR will review all comments and will determine what modifications to the policy guidance, if any, are necessary.

**ADDRESSES:** Interested persons should submit written comments to

Carole Brown  
Office for Civil Rights, Room 506F  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

Comments may also be submitted by email at [lepcoms@os.dhhs.gov](mailto:lepcoms@os.dhhs.gov).

**FOR FURTHER INFORMATION CONTACT:**

Carole Brown *or* Ronald Copeland  
Office for Civil Rights, Room 506F  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

Telephone: 202-619-0805 or 202-619-0553; TDD: 800-537-7697

Arrangements to receive the policy in an alternative format may be made by contacting the named individuals.

**SUPPLEMENTARY INFORMATION:** Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d et. seq. and its implementing regulation at 45 CFR Part 80 provide that no person shall be subjected to discrimination on the basis of race, color or national origin under any program or activity that receives Federal financial assistance.

The purpose of this policy guidance is to clarify the responsibilities of providers of health and social services who receive Federal financial assistance from the U.S. Department of Health and Human Services (HHS) (“recipients,” “providers,” or “covered entities”), and assist them in fulfilling their responsibilities to Limited English Proficient (LEP) persons, pursuant to Title VI of the Civil Rights Act of 1964. The policy guidance reiterates HHS’ longstanding position that in order to avoid discrimination against LEP persons on grounds of national origin, health and social service providers must take adequate steps to ensure that such persons receive the language assistance necessary to afford them meaningful access to their services, free of charge. The guidance also clarifies for health and social service providers, and members of the public, that a recipient/covered entity must ensure that eligible LEP persons have meaningful access to programs and services. The guidance also provides examples of policies and practices that OCR would find violative of Title VI, and sets out the policies, procedures and other steps that recipients can take to ensure meaningful access to their programs by LEP persons.

The guidance does not impose any new requirements but reiterates longstanding Title VI principles that OCR has been enforcing for over 30 years. The guidance discusses methods by which recipient/covered entities can meet their obligation to provide oral interpretation to LEP persons. The guidance also outlines the general parameters of a recipient/covered entity’s obligation to provide translation of written materials, providing examples that illustrate both the importance of such translation and the flexibility that recipients have in meeting this obligation.

For recipient/covered entities who desire greater certainty in understanding some specific circumstances under which OCR will find them in compliance with the obligation to translate written materials, the guidance contains “safe harbors.” A recipient/covered entity that translates written materials under circumstances outlined in the “safe harbor” provisions will have assurance that OCR will find it in compliance with its Title VI obligation regarding translation of written materials. These “safe harbor” provisions are not mandatory requirements and do not establish numerical thresholds that trigger a requirement for the translation of documents into languages other than English. They are one way for a recipient/covered entity to be assured that it has met the obligation to translate. In fact, the guidance explicitly states that the failure to meet the “safe harbors” will not result in a finding of noncompliance, but that OCR will review a number of other factors in determining compliance.



During the past 30 years, OCR has provided substantial technical assistance to recipient/covered entities who were seeking to ensure that LEP persons can meaningfully access their programs or services. This guidance synthesizes that experience so as to better assist recipient/covered entities in meeting their responsibilities and also stresses OCR's legal obligation and commitment to seeking voluntary compliance by recipient/covered entities and its commitment to providing technical assistance. OCR will continue to be available to provide such assistance.

This policy guidance addresses situations and issues presented by HHS-funded health and social service programs and is not necessarily transferable to other federal programs or contexts.

The text of the guidance appears below. Appendix A to the guidance is a series of questions and answers that provides a useful summary of a number of the major aspects of the guidance.

Dated: August 3, 2000

Thomas E. Perez,

Director, Office for Civil Rights Policy Guidance

## **Title VI Prohibition Against National Origin Discrimination as It Affects Persons with Limited English Proficiency**

### **A. Background**

English is the predominant language of the United States. According to the 1990 Census, English is spoken by 95% of its residents. Of those U.S. residents who speak languages other than English at home, the 1990 Census reports that 57% above the age of four speak English "well to very well."

The United States is also, however, home to millions of national origin minority individuals who are "limited English proficient" (LEP). That is, they cannot speak, read, write or understand the English language at a level that permits them to interact effectively with health care providers and social service agencies. Because of these language differences and their inability to speak or understand English, LEP persons are often excluded from programs, experience delays or denials of services, or receive care and services based on inaccurate or incomplete information. In the course of its enforcement activities, OCR has found that persons who lack proficiency in English frequently are unable to obtain basic knowledge of how to access various benefits and services for which they are eligible, such as the State Children's Health Insurance Program (SCHIP), Medicare, Medicaid or Temporary Assistance to Needy Families (TANF) benefits, clinical research programs, or basic health care and social services. For example, many intake interviewers and other front line employees who interact with LEP individuals are neither bilingual nor trained in how to properly serve an LEP person. As a result, the LEP applicant all too often is either turned away, forced

to wait for substantial periods of time, forced to find his/her own interpreter who often is not qualified to interpret, or forced to make repeated visits to the provider's office until an interpreter is available to assist in conducting the interview.

The lack of language assistance capability among provider agency employees has especially adverse consequences in the area of professional staff services, such as health services. Doctors, nurses, social workers, psychologists, and other professionals provide vitally important services whose very nature requires the establishment of a close relationship with the client or patient that is based on empathy, confidence and mutual trust. Such intimate personal relationships depend heavily on the free flow of communication between professional and client. This essential exchange of information is difficult when the two parties involved speak different languages; it may be impeded further by the presence of an unqualified third person who attempts to serve as an interpreter.

Some health and social service providers have sought to bridge the language gap by encouraging language minority clients to provide their own interpreters as an alternative to the agency's use of qualified bilingual employees or interpreters. Persons of limited English proficiency must sometimes rely on their minor children to interpret for them during visits to a health or social service facility. Alternatively, these clients may be required to call upon neighbors or even strangers they encounter at the provider's office to act as interpreters or translators.

These practices have severe drawbacks and may violate Title VI of the Civil Rights Act of 1964. In each case, the impediments to effective communication and adequate service are formidable. The client's untrained "interpreter" is often unable to understand the concepts or official terminology he or she is being asked to interpret or translate. Even if the interpreter possesses the necessary language and comprehension skills, his or her mere presence may obstruct the flow of confidential information to the provider. This is because the client would naturally be reluctant to disclose or discuss intimate details of personal and family life in front of the client's child or a complete stranger who has no formal training or obligation to observe confidentiality.

When these types of circumstances are encountered, the level and quality of health and social services available to persons of limited English proficiency stand in stark conflict to Title VI's promise of equal access to federally assisted programs and activities. Services denied, delayed or provided under adverse circumstances have serious and sometimes life threatening consequences for an LEP person and generally will constitute discrimination on the basis of national origin, in violation of Title VI. Accommodation of these language differences through the provision of effective language assistance will promote compliance with Title VI. Moreover, by ensuring accurate

client histories, better understanding of exit and discharge instructions, and better assurances of informed consent, providers will better protect themselves against tort liability, malpractice lawsuits, and charges of negligence.

Although OCR's enforcement authority derives from Title VI, the duty of health and human service providers to ensure that LEP persons can meaningfully access programs and services flows from a host of additional sources, including federal and state laws and regulations, managed care contracts, and health care accreditation organizations.<sup>1</sup> In addition, the duty to provide appropriate language assistance to LEP individuals is not limited to the health and human service context. Numerous federal laws require the provision of language assistance to LEP individuals seeking to access critical services and activities. For instance, the Voting Rights Act bans English-only elections in certain circumstances and outlines specific measures that must be taken to ensure that language minorities can participate in elections. See 42 U.S.C. 1973b(f)(1). Similarly, the Food Stamp Act of 1977 requires states to provide written and oral language assistance to LEP persons under certain circumstances. 42 U.S.C. Section 2020(e)(1) and (2). These and other provisions reflect the sound judgment that providers of critical services and benefits bear the responsibility for ensuring that LEP individuals can meaningfully access their programs and services.

OCR issued internal guidance to its staff in January 1998 on a recipient's obligation to provide language assistance to LEP persons. That guidance was intended to ensure consistency in OCR's investigation of LEP cases. This current guidance clarifies for recipient/covered entities and the public, the legal requirements under Title VI that OCR has been enforcing for the past 30 years.

This policy guidance is consistent with a Department of Justice (DOJ) directive noting that recipient/covered entities have an obligation pursuant to Title VI's prohibition against national origin discrimination to provide oral and written language assistance to LEP persons.<sup>2</sup> It is also consistent with a government-wide Title VI regulation issued by DOJ in 1976, "Coordination of Enforcement of Nondiscrimination in Federally Assisted Programs," 28 C.F.R. Part 42, Subpart F, that addresses the circumstances in which recipient/covered entities must provide written language assistance to LEP persons.<sup>3</sup>

<sup>1</sup> A description of these requirements is included as Appendix B to this policy guidance.

<sup>2</sup> The DOJ directive was issued on August 11, 2000.

<sup>3</sup> The DOJ coordination regulations at 28 C.F.R. Section 42.405(d)(1) provide that "[w]here a significant number or proportion of the population eligible to be served or likely to be directly affected by a federally assisted program (e.g., affected by relocation) needs service or information in a language other than English in order effectively to be informed of or to participate in the program, the recipient shall take reasonable steps, considering the scope of the program and the size and concentration of such population, to provide information in appropriate languages to such persons. This requirement applies with regard to written material of the type which is ordinarily distributed to the public."

## B. Legal Authority

### 1. Introduction

Over the last 30 years, OCR has conducted thousands of investigations and reviews involving language differences that impede the access of LEP persons to medical care and social services. Where the failure to accommodate language differences discriminates on the basis of national origin, OCR has required recipient/covered entities to provide appropriate language assistance to LEP persons. For instance, OCR has entered into voluntary compliance agreements and consent decrees that require recipients who operate health and social service programs to ensure that there are bilingual employees or language interpreters to meet the needs of LEP persons seeking services. OCR has also required these recipient/covered entities to provide written materials and post notices in languages other than English. See *Mendoza v. Lavine*, 412 F.Supp. 1105 (S.D.N.Y. 1976); and *Asociacion Mixta Progresista v. H.E.W.*, Civil Number C72-882 (N.D. Cal. 1976). The legal authority for OCR's enforcement actions is Title VI of the Civil Rights Act of 1964, the implementing regulations, and a consistent body of case law. The legal authority is described below.

### 2. Statute and Regulation

Section 601 of Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d et. seq. states: "No person in the United States shall on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

Regulations implementing Title VI, provide in part at 45 CFR Section 80.3 (b):

- "(1) A recipient under any program to which this part applies may not, directly or through contractual or other arrangements, on ground of race, color, or national origin:
- (i) Deny an individual any service, financial aid, or other benefit provided under the program;
  - (ii) Provide any service, financial aid, or other benefit to an individual which is different, or is provided in a different manner, from that provided to others under the program;
- (2) A recipient, in determining the types of services, financial aid, or other benefits, or facilities which will be provided under any such program or the class of individuals to whom, or the situations in which such services, financial aid or other benefits, or facilities will be provided . . . may not directly, or through contractual or other arrangements, utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination, because of their race, color or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the

*program with respect to individuals of a particular, race, color or national origin.” (emphasis added).*

### 3. Case Law

Extensive case law affirms the obligation of recipients of federal financial assistance to ensure that LEP persons can meaningfully access federal-assisted programs.

The U.S. Supreme Court, in *Lau v. Nichols*, 414 U.S. 563 (1974), recognized that recipients of Federal financial assistance have an affirmative responsibility, pursuant to Title VI, to provide LEP persons with meaningful opportunity to participate in public programs. In *Lau v. Nichols*, the Supreme Court ruled that a public school system’s failure to provide English language instruction to students of Chinese ancestry who do not speak English denied the students a meaningful opportunity to participate in a public educational program in violation of Title VI of the Civil Rights Act of 1964.

The Lau decision affirmed the U.S. Department of Health, Education and Welfare’s Policy Memorandum issued on May 25, 1970, titled “Identification of Discrimination and the Denial of Services on the Basis of National Origin,” 35 FR 11,595. The memorandum states in part: “Where the inability to speak and understand the English language excludes national origin minority group children from effective participation in the educational program offered by a school district, the district must take affirmative steps to rectify the language deficiency in order to open its instructional program to these students.”

As early as 1926, the Supreme Court recognized that language rules were often discriminatory. In *Yu Cong Eng et al. v. Trinidad*, Collector of Internal Revenue, 271 U.S. 500 (1926), the Supreme Court found that a Philippine Bookkeeping Act that prohibited the keeping of accounts in languages other than English, Spanish and Philippine dialects violated the Philippine Bill of Rights that Congress had patterned after the U.S. Constitution. The Court found that the Act deprived Chinese merchants, who were unable to read, write or understand the required languages, of liberty and property without due process.

In *Gutierrez v. Municipal Court of S.E. Judicial District*, 838 F.2d 1031,1039 (9th Cir. 1988), *vacated as moot*, 490 U.S. 1016 (1989), the court recognized that requiring the use of English only is often used to mask national origin discrimination. Citing *McArthur, Worried About Something Else*, 60 Int’l J. Soc. Language, 87, 90-91 (1986), the court stated that because language and accents are identifying characteristics, rules that have a negative effect on bilingual persons, individuals with accents, or non-English speakers may be mere pretexts for intentional national origin discrimination.

Another case that noted the link between language and national origin discrimination is *Garcia v. Gloor*, 618 F.2d 264 (5th Cir. 1980) *cert. denied*, 449 U.S. 1113 (1981). The court found that on the facts before it a workplace English-only rule did not discriminate on the basis of national origin since the complaining employees were bilingual. However, the court stated that “to a person who speaks only one tongue or to a person who has difficulty using another language other than the one spoken in his home, language might well be an immutable characteristic like skin color, sex or place of birth.” *Id.* at 269.

The Fifth Circuit addressed language as an impermissible barrier to participation in society in *U.S. v. Uvalde Consolidated Independent School District*, 625 F.2d 547 (5th Cir. 1980). The court upheld an amendment to the Voting Rights Act which addressed concerns about language minorities, the protections they were to receive, and eliminated discrimination against them by prohibiting English-only elections.

Most recently, the Eleventh Circuit in *Sandoval v. Hagan*, 197 F. 3d 484 (11th Cir. 1999), *petition for cert. filed*, May 30, 2000, held that the State of Alabama’s policy of administering a driver’s license examination in English only was a facially neutral practice that had an adverse effect on the basis of national origin, in violation of Title VI. The court specifically noted the nexus between language policies and potential discrimination based on national origin. That is, in *Sandoval*, the vast majority of individuals who were adversely affected by Alabama’s English-only driver’s license examination policy were national origin minorities.

In the health and human service context, a recipient’s failure to provide appropriate language assistance to LEP individuals parallels many of the fact situations discussed in the cases above and, as in those cases, may have an adverse effect on the basis of national origin, in violation of Title VI.

The Title VI regulations prohibit both intentional discrimination and policies and practices that appear neutral but have a discriminatory effect. Thus, a recipient/covered entity’s policies or practices regarding the provision of benefits and services to LEP persons need not be intentional to be discriminatory, but may constitute a violation of Title VI if they have an adverse effect on the ability of national origin minorities to meaningfully access programs and services. Accordingly, it is useful for recipient/covered entities to examine their policies and practices to determine whether they adversely affect LEP persons. This policy guidance provides a legal framework to assist recipient/covered entities in conducting such assessments.

## C. Policy Guidance

### 1. Who Is Covered

All entities that receive Federal financial assistance from HHS, either directly or indirectly, through a grant, contract or subcontract, are covered by this policy guidance. Covered entities include: (1) Any state or local agency, private institution or organization, or any public or private individual that; (2) operates, provides or engages in health, or social service programs and activities and that; (3) receives federal financial assistance from HHS directly or through another recipient/covered entity. Examples of covered entities include but are not limited to hospitals, nursing homes, home health agencies, managed care organizations, universities and other entities with health or social service research programs, state, county and local health agencies, state Medicaid agencies, state, county and local welfare agencies, programs for families, youth and children, Head Start programs, public and private contractors, subcontractors and vendors, physicians, and other providers who receive Federal financial assistance from HHS.

The term Federal financial assistance to which Title VI applies includes but is not limited to grants and loans of Federal funds, grants or donations of Federal property, details of Federal personnel, or any agreement, arrangement or other contract which has as one of its purposes the provision of assistance. (See 45 CFR Section 80.13(f); and Appendix A to the Title VI regulations, 45 CFR Part 80, for additional discussion of what constitutes Federal financial assistance.)

Title VI prohibits discrimination in any program or activity that receives Federal financial assistance. What constitutes a program or activity covered by Title VI was clarified by Congress in 1988, when the Civil Rights Restoration Act of 1987 (CRRA) was enacted. The CRRA provides that, in most cases, when a recipient/covered entity receives Federal financial assistance for a particular program or activity, all operations of the recipient/covered entity are covered by Title VI, not just the part of the program that uses the Federal assistance. Thus, all parts of the recipient's operations would be covered by Title VI, even if the Federal assistance is used only by one part.

### 2. Basic Requirements Under Title VI

A recipient/covered entity whose policies, practices or procedures exclude, limit, or have the effect of excluding or limiting, the participation of any LEP person in a federally-assisted program on the basis of national origin may be engaged in discrimination in violation of Title VI. In order to ensure compliance with Title VI, recipient/covered entities must take steps to ensure that LEP persons who are eligible for their programs or services have meaningful access to the health and social service benefits that they provide. The most important step in meeting this obligation is for recipients of Federal financial

assistance such as grants, contracts, and subcontracts to provide the language assistance necessary to ensure such access, at no cost to the LEP person.

The type of language assistance a recipient/covered entity provides to ensure meaningful access will depend on a variety of factors, including the size of the recipient/covered entity, the size of the eligible LEP population it serves, the nature of the program or service, the objectives of the program, the total resources available to the recipient/covered entity, the frequency with which particular languages are encountered, and the frequency with which LEP persons come into contact with the program. There is no “one size fits all” solution for Title VI compliance with respect to LEP persons. OCR will make its assessment of the language assistance needed to ensure meaningful access on a case by case basis, and a recipient/covered entity will have considerable flexibility in determining precisely how to fulfill this obligation. OCR will focus on the end result—whether the recipient/covered entity has taken the necessary steps to ensure that LEP persons have meaningful access to its programs and services.

The key to providing meaningful access for LEP persons is to ensure that the recipient/covered entity and LEP person can communicate effectively. The steps taken by a covered entity must ensure that the LEP person is given adequate information, is able to understand the services and benefits available, and is able to receive those for which he or she is eligible. The covered entity must also ensure that the LEP person can effectively communicate the relevant circumstances of his or her situation to the service provider.

In enforcing Title VI and its application to LEP persons over the last 30 years, OCR has found that effective language assistance programs usually contain the four elements described in section 3 below. In reviewing complaints and conducting compliance reviews, OCR will consider a program to be in compliance when the recipient/covered entity effectively incorporates and implements these four elements. The failure to incorporate or implement one or more of these elements does not necessarily mean noncompliance with Title VI, and OCR will review the totality of the circumstances to determine whether LEP persons can meaningfully access the services and benefits of the recipient/covered entity.

### **3. Ensuring Meaningful Access to LEP Persons**

#### *(a) Introduction—The Four Keys to Title VI Compliance in the LEP Context*

The key to providing meaningful access to benefits and services for LEP persons is to ensure that the language assistance provided results in accurate and effective communication between the provider and LEP applicant/client about the types of services and/or benefits available and about the applicant’s or client’s circumstances. Although HHS recipients have considerable



flexibility in fulfilling this obligation, OCR has found that effective programs usually have the following four elements:

- *Assessment*—The recipient/covered entity conducts a thorough assessment of the language needs of the population to be served;
- *Development of comprehensive written policy on language access*—The recipient/covered entity develops and implements a comprehensive written policy that will ensure meaningful communication;
- *Training of staff*—The recipient/covered entity takes steps to ensure that staff understands the policy and is capable of carrying it out; and
- *Vigilant monitoring*—The recipient/covered entity conducts regular oversight of the language assistance program to ensure that LEP persons meaningfully access the program.

The failure to implement one or more of these measures does not necessarily mean noncompliance with Title VI, and OCR will review the totality of the circumstances in each case. If implementation of one or more of these options would be so financially burdensome as to defeat the legitimate objectives of a recipient/covered entity's program, or if there are equally effective alternatives for ensuring that LEP persons have meaningful access to programs and services, OCR will not find the recipient/covered entity in noncompliance.

*(b) Assessment*

The first key to ensuring meaningful access is for the recipient/covered entity to assess the language needs of the affected population. A recipient/covered entity assesses language needs by:

- identifying the non-English languages that are likely to be encountered in its program and by estimating the number of LEP persons that are eligible for services and that are likely to be directly affected by its program. This can be done by reviewing census data, client utilization data from client files, and data from school systems and community agencies and organizations;
- identifying the language needs of each LEP patient/client and recording this information in the client's file;
- identifying the points of contact in the program or activity where language assistance is likely to be needed;
- identifying the resources that will be needed to provide effective language assistance; identifying the location and availability of these resources; and identifying the arrangements that must be made to access these resources in a timely fashion.

*(c) Development of Comprehensive Written Policy on Language Access*

A recipient/covered entity can ensure effective communication by developing and implementing a comprehensive written language assistance program that includes policies and procedures for identifying and assessing the language needs of its LEP applicants/clients, and that provides for a range of oral language assistance options, notice to LEP persons in a language they can understand of the right to free language assistance, periodic training of staff, monitoring of the program, and translation of written materials in certain circumstances.<sup>4</sup>

*(1) Oral language interpretation*—In designing an effective language assistance program, a recipient/covered entity develops procedures for obtaining and providing trained and competent interpreters and other oral language assistance services, in a timely manner, by taking some or all of the following steps:

- Hiring bilingual staff who are trained and competent in the skill of interpreting;
- Hiring staff interpreters who are trained and competent in the skill of interpreting;
- Contracting with an outside interpreter service for trained and competent interpreters;
- Arranging formally for the services of voluntary community interpreters who are trained and competent in the skill of interpreting
- Arranging/contracting for the use of a telephone language interpreter service. See Section 3(e)(2) for a discussion on “Competence of Interpreters.”

The following provides guidance to recipient/covered entities in determining which language assistance options will be of sufficient quantity and quality to meet the needs of their LEP beneficiaries:

**Bilingual Staff**—Hiring bilingual staff for patient and client contact positions facilitates participation by LEP persons. However, where there are a variety of LEP language groups in a recipient’s service area, this option may be insufficient to meet the needs of all LEP applicants and clients. Where this option is insufficient to meet the needs, the recipient/covered entity must provide additional and timely language assistance. Bilingual staff must be trained and must demonstrate competence as interpreters.

<sup>4</sup> The Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973 both provide similar prohibitions against discrimination on the basis of disability and require entities to provide language assistance such as sign language interpreters for hearing impaired individuals or alternative formats such as braille, large print or tape for vision impaired individuals. In developing a comprehensive language assistance program, recipient/covered entities should be mindful of their responsibilities under the ADA and Section 504 to ensure access to programs for individuals with disabilities.

**Staff Interpreters**—Paid staff interpreters are especially appropriate where there is a frequent and/or regular need for interpreting services. These persons must be competent and readily available.

**Contract Interpreters**—The use of contract interpreters may be an option for recipient/covered entities that have an infrequent need for interpreting services, have less common LEP language groups in their service areas, or need to supplement their in-house capabilities on an as-needed basis. Such contract interpreters must be readily available and competent.

**Community Volunteers**—Use of community volunteers may provide recipient/covered entities with a cost-effective method for providing interpreter services. However, experience has shown that to use community volunteers effectively, recipient/covered entities must ensure that formal arrangements for interpreting services are made with community organizations so that these organizations are not subjected to ad hoc requests for assistance. In addition, recipient/covered entities must ensure that these volunteers are competent as interpreters and understand their obligation to maintain client confidentiality. Additional language assistance must be provided where competent volunteers are not readily available during all hours of service.

**Telephone Interpreter Lines**—A telephone interpreter service line may be a useful option as a supplemental system, or may be useful when a recipient/covered entity encounters a language that it cannot otherwise accommodate. Such a service often offers interpreting assistance in many different languages and usually can provide the service in quick response to a request. However, recipient/covered entities should be aware that such services may not always have readily available interpreters who are familiar with the terminology peculiar to the particular program or service. It is important that a recipient/covered entity not offer this as the only language assistance option except where other language assistance options are unavailable (e.g., in a rural clinic visited by an LEP patient who speaks a language that is not usually encountered in the area).

(2) *Translation of Written Materials*—An effective language assistance program ensures that written materials that are routinely provided in English to applicants, clients and the public are available in regularly encountered languages other than English. It is particularly important to ensure that vital documents, such as applications, consent forms, letters containing important information regarding participation in a program (such as a cover letter outlining conditions of participation in a Medicaid managed care program), notices pertaining to the reduction, denial or termination of services or benefits, of the right to appeal such actions or that require a response from beneficiaries, notices advising LEP persons of the availability of free language assistance, and other outreach materials be translated into the non-English language of each regularly encountered LEP group eligible to be served or

likely to be directly affected by the recipient/covered entity's program. However, OCR recognizes that each federally-funded health and social service program has unique characteristics. Therefore, OCR will collaborate with respective HHS agencies in determining which documents and information are deemed to be vital.

As part of its overall language assistance program, a recipient must develop and implement a plan to provide written materials in languages other than English where a significant number or percentage of the population eligible to be served or likely to be directly affected by the program needs services or information in a language other than English to communicate effectively. 28 CFR Section 42.405(d)(1). OCR will determine the extent of the recipient/covered entity's obligation to provide written translation of documents on a case by case basis, taking into account all relevant circumstances, including the nature of the recipient/covered entity's services or benefits, the size of the recipient/covered entity, the number and size of the LEP language groups in its service area, the nature and length of the document, the objectives of the program, the total resources available to the recipient/covered entity, the frequency with which translated documents are needed, and the cost of translation.

One way for a recipient/covered entity to know with greater certainty that it will be found in compliance with its obligation to provide written translations in languages other than English is for the recipient/covered entity to meet the guidelines outlined in paragraphs (A) and (B) below.

Paragraphs (A) and (B) outline the circumstances that provide a "safe harbor" for recipient/covered entities. A recipient/covered entity that provides written translations under these circumstances can be confident that it will be found in compliance with its obligation under Title VI regarding written translations.<sup>5</sup> However, the failure to provide written translations under these circumstances outlined in paragraphs (A) and (B) will not necessarily mean noncompliance with Title VI.

In such circumstances, OCR will review the totality of the circumstances to determine the precise nature of a recipient/covered entity's obligation to provide written materials in languages other than English. If written translation of a certain document or set of documents would be so financially burdensome as to defeat the legitimate objectives of its program, or if there is an alternative means of ensuring that LEP persons have meaningful access

<sup>5</sup> The "safe harbor" provisions in paragraphs (A) and (B) are not intended to establish numerical thresholds for when a recipient must translate documents. The numbers and percentages included in these provisions are based on the balancing of a number of factors, including OCR's experience in enforcing Title VI in the context of health and human services programs, and OCR's discussions with other department agencies about experiences of their grant recipient/covered entities with language access issues.

to the information provided in the document (such as timely, effective oral interpretation of vital documents), OCR will not find the translation of written materials necessary for compliance with Title VI.

OCR will consider a recipient/covered entity to be in compliance with its Title VI obligation to provide written materials in non-English languages if:

- (A) The recipient/covered entity provides translated written materials, including vital documents, for each eligible LEP language group that constitutes ten percent or 3,000, whichever is less, of the population of persons eligible to be served or likely to be directly affected by the recipient/covered entity's program.<sup>6</sup>
- (B) Regarding LEP language groups that do not fall within paragraph (A) above, but constitute five percent or 1,000, whichever is less, of the population of persons eligible to be served or likely to be directly affected, the recipient/covered entity ensures that, at a minimum, vital documents are translated into the appropriate non-English languages of such LEP persons. Translation of other documents, if needed, can be provided orally; and
- (C) Notwithstanding paragraphs (A) and (B) above, a recipient with fewer than 100 persons in a language group eligible to be served or likely to be directly affected by the recipient/covered entity's program, does not translate written materials but provides written notice in the primary language of the LEP language group of the right to receive competent oral translation of written materials.

The term "persons eligible to be served or likely to be directly affected" relates to the issue of what is the recipient/covered entity's service area for purposes of meeting its Title VI obligation. There is no "one size fits all" definition of what constitutes "persons eligible to be served or likely to be directly affected" and OCR will address this issue on a case by case basis.

Ordinarily, persons eligible to be served or likely to be directly affected by a recipient's program are those persons who are in the geographic area that has been approved by a Federal grant agency as the recipient/covered entity's service area, and who either are eligible for the recipient/covered entity's benefits or services, or otherwise might be directly affected by such an entity's conduct. For example, a parent who might seek services for a child would be seen as likely to be affected by a recipient/covered entity's

<sup>6</sup> As noted above, vital documents include applications, consent forms, letters containing information regarding eligibility or participation criteria, and notices pertaining to reduction, denial or termination of services or benefits, that require a response from beneficiaries, and/or that advise of free language assistance. Large documents, such as enrollment handbooks, may not need to be translated in their entirety. However, vital information contained in large documents must be translated.

policies and practices. Where no service area has been approved by a Federal grant agency, OCR will consider the relevant service area for determining persons eligible to be served as that designated and/or approved by state or local authorities or designated by the recipient/covered entity itself, provided that these designations do not themselves discriminatorily exclude certain populations. OCR may also determine the service area to be the geographic areas from which the recipient draws, or can be expected to draw, clients/patients. The following are examples of how OCR would determine the relevant service areas when assessing who is eligible to be served or likely to be affected:

- A complaint filed with OCR alleges that a private hospital discriminates against Hispanic and Chinese LEP patients by failing to provide such persons with language assistance, including written translations of consent forms. The hospital identifies its service area as the geographic area identified in its marketing plan. OCR determines that a substantial number of the hospital's patients are drawn from the area identified in the marketing plan and that no area with concentrations of racial, ethnic or other minorities is discriminatorily excluded from the plan. OCR is likely to accept the area identified in the marketing plan as the relevant service area.
- A state enters into a contract with a managed care plan for the provision of health services to Medicaid beneficiaries. The Medicaid managed care contract provides that the plan will serve beneficiaries in three counties. The contract is reviewed and approved by HHS. In determining the persons eligible to be served or likely to be affected, the relevant service area would be that designated in the contract.

As this guidance notes, Title VI provides that no person may be denied meaningful access to a recipient/covered entity's benefits and services, on the basis of national origin. To comply with the Title VI requirement, a recipient/covered entity must ensure that LEP persons have meaningful access to and can understand information contained in program-related written documents. Thus, for language groups that do not fall within paragraphs (A) and (B), above, a recipient can ensure such access by, at a minimum, providing notice, in writing, in the LEP person's primary language, of the right to receive free language assistance in a language other than English, including the right to competent oral translation of written materials, free of cost.

Recent technological advances have made it easier for recipient/covered entities to store translated documents readily. At the same time, OCR recognizes that recipient/covered entities in a number of areas, such as many large cities, regularly serve LEP persons from many different areas of the world who speak dozens and sometimes over 100 different languages. It

would be unduly burdensome to demand that recipient/covered entities in these circumstances translate all written materials into dozens, if not more than 100 languages. As a result, OCR will determine the extent of the recipient/covered entity's obligation to provide written translations of documents on a case by case basis, looking at the totality of the circumstances.<sup>7</sup>

It is also important to ensure that the person translating the materials is well qualified. In addition, it is important to note that in some circumstances verbatim translation of materials may not accurately or appropriately convey the substance of what is contained in the written materials. An effective way to address this potential problem is to reach out to community-based organizations to review translated materials to ensure that they are accurate and easily understood by LEP persons.

*(3) Methods for Providing Notice to LEP Persons*—A vital part of a well-functioning compliance program includes having effective methods for notifying LEP persons regarding their right to language assistance and the availability of such assistance free of charge. These methods include but are not limited to:

- ▶ use of language identification cards which allow LEP beneficiaries to identify their language needs to staff and for staff to identify the language needs of applicants and clients. To be effective, the cards (e.g., "I speak" cards) must invite the LEP person to identify the language he/she speaks. This identification must be recorded in the LEP person's file;
- ▶ posting and maintaining signs in regularly encountered languages other than English in waiting rooms, reception areas and other initial points of entry. In order to be effective, these signs must inform applicants and beneficiaries of their right to free language assistance services and invite them to identify themselves as persons needing such services; translation of application forms and instructional, informational and other written materials into appropriate non-English

<sup>7</sup> For instance, a Medicaid managed care program that regularly encounters, or potentially will encounter on a regular basis, LEP persons who speak dozens or perhaps over 100 different languages, would not be required to translate the lengthy program brochure into every regularly encountered language. Rather, the recipient/covered entity in these circumstances would likely be required to translate the written materials into the most frequently encountered languages. Regarding the remaining regularly encountered languages, the recipient/covered entity would be required to ensure that the LEP person receives written notification in the appropriate non-English language of the right to free oral translation of the written materials. In addition, the recipient/covered entity would frequently be required to provide written translations of vital documents that are short in length and pertain to important aspects of critical programs, such as a cover letter that outlines the terms and conditions of participation in a Medicaid managed care program, and/or contains time-sensitive information about enrollment or continued participation.

languages by competent translators. For LEP persons whose language does not exist in written form, assistance from an interpreter to explain the contents of the document;

- ▶ uniform procedures for timely and effective telephone communication between staff and LEP persons. This must include instructions for English-speaking employees to obtain assistance from interpreters or bilingual staff when receiving calls from or initiating calls to LEP persons; and
- ▶ inclusion of statements about the services available and the right to free language assistance services, in appropriate non-English languages, in brochures, booklets, outreach and recruitment information and other materials that are routinely disseminated to the public.

*(d) Training of Staff*

Another vital element in ensuring that its policies are followed is a recipient/covered entity's dissemination of its policy to all employees likely to have contact with LEP persons, and periodic training of these employees. Effective training ensures that employees are knowledgeable and aware of LEP policies and procedures, are trained to work effectively with in-person and telephone interpreters, and understand the dynamics of interpretation between clients, providers and interpreters. It is important that this training be part of the orientation for new employees and that all employees in client contact positions be properly trained. Given the high turnover rate among some employees, recipient/covered entities may find it useful to maintain a training registry that records the names and dates of employees' training. Over the years, OCR has observed that recipient/covered entities often develop effective language assistance policies and procedures but that employees are unaware of the policies, or do not know how to, or otherwise fail to, provide available assistance. Effective training is one means of ensuring that there is not a gap between a recipient/covered entity's written policies and procedures, and the actual practices of employees who are in the front lines interacting with LEP persons.

*(e) Monitoring*

It is also crucial for a recipient/covered entity to monitor its language assistance program at least annually to assess the current LEP makeup of its service area, the current communication needs of LEP applicants and clients, whether existing assistance is meeting the needs of such persons, whether staff is knowledgeable about policies and procedures and how to implement them, and whether sources of and arrangements for assistance are still current and viable. One element of such an assessment is for a recipient/covered entity to seek feedback from clients and advocates. OCR has found that compliance with the Title VI language assistance obligation is most likely



when a recipient/covered entity continuously monitors its program, makes modifications where necessary, and periodically trains employees in implementation of the policies and procedures.

#### **4. OCR's Assessment of Meaningful Access**

The failure to take all of the steps outlined in Section C.3 will not necessarily mean that a recipient/covered entity has failed to provide meaningful access to LEP clients. As noted above, OCR will make assessments on a case by case basis and will consider several factors in assessing whether the steps taken by a recipient/covered entity provide meaningful access. Those factors include the size of the recipient/covered entity and of the eligible LEP population, the nature of the program or service, the objectives of the program, the total resources available, the frequency with which particular languages are encountered, and the frequency with which LEP persons come into contact with the program. The following are examples of how meaningful access will be assessed by OCR:

- ▶ A physician, a sole practitioner, has about 50 LEP Hispanic patients. He has a staff of two nurses and a receptionist, derives a modest income from his practice, and receives Medicaid funds. He asserts that he cannot afford to hire bilingual staff, contract with a professional interpreter service, or translate written documents. To accommodate the language needs of his LEP patients, he has made arrangements with a Hispanic community organization for trained and competent volunteer interpreters, and with a telephone interpreter language line, to interpret during consultations and to orally translate written documents. There have been no client complaints of inordinate delays or other service related problems with respect to LEP clients. Given the physician's resources, the size of his staff, and the size of the LEP population, OCR would find the physician in compliance with Title VI.
- ▶ A county TANF program, with a large budget, serves 500,000 beneficiaries. Of the beneficiaries eligible for its services, 3,500 are LEP Chinese persons, 4,000 are LEP Hispanic persons, 2,000 are LEP Vietnamese persons and about 400 are LEP Laotian persons. The county has no policy regarding language assistance to LEP persons, and LEP clients are told to bring their own interpreters, are provided with application and consent forms in English and if unaccompanied by their own interpreters, must solicit the help of other clients or must return at a later date with an interpreter. Given the size of the county program, its resources, the size of the eligible LEP population, and the nature of the program, OCR would likely find the county in violation of Title VI and would likely require it to develop a comprehensive language assistance program that includes all of the options discussed in Section C.3.

- ▶ A large national corporation receives TANF funds from a local welfare agency to provide computer training to TANF beneficiaries. Of the 2000 clients that are trained by the corporation each month, approximately one-third are LEP Hispanic persons. The corporation has made no arrangements for language assistance and relies on bilingual Hispanic students in class to help LEP students understand the oral instructions and the written materials. Based on the size of the welfare agency and corporation, their budgets, the size of the LEP population, and the nature of the program, OCR would likely find both the welfare agency and the corporation in noncompliance with Title VI. The welfare agency would likely be found in noncompliance for failing to provide LEP clients meaningful access to its benefits and services through its contract with the corporation, and for failing to monitor the training program to ensure that it provided such access. OCR would likely also find the corporation in noncompliance for failing to provide meaningful access to LEP clients and would require it to provide them with both oral and written language assistance.

## 5. Interpreters

Two recurring issues in the area of interpreter services involve (a) the use of friends, family, or minor children as interpreters, and (b) the need to ensure that interpreters are competent, especially in the area of medical interpretation.

### *(a) Use of Friends, Family and Minor Children as Interpreters*

A recipient/covered entity may expose itself to liability under Title VI if it requires, suggests, or encourages an LEP person to use friends, minor children, or family members as interpreters, as this could compromise the effectiveness of the service. Use of such persons could result in a breach of confidentiality or reluctance on the part of individuals to reveal personal information critical to their situations. In a medical setting, this reluctance could have serious, even life threatening, consequences. In addition, family and friends usually are not competent to act as interpreters, since they are often insufficiently proficient in both languages, unskilled in interpretation, and unfamiliar with specialized terminology.

If after a recipient/covered entity informs an LEP person of the right to free interpreter services, the person declines such services and requests the use of a family member or friend, the recipient/covered entity may use the family member or friend, if the use of such a person would not compromise the effectiveness of services or violate the LEP person's confidentiality. The recipient/covered entity should document the offer and declination in the LEP person's file. Even if an LEP person elects to use a family member or friend, the recipient/covered entity should suggest that a trained interpreter sit in on the encounter to ensure accurate interpretation.

*(b) Competence of Interpreters*

In order to provide effective services to LEP persons, a recipient/covered entity must ensure that it uses persons who are competent to provide interpreter services. Competency does not necessarily mean formal certification as an interpreter, though certification is helpful. On the other hand, competency requires more than self-identification as bilingual. The competency requirement contemplates demonstrated proficiency in both English and the other language, orientation and training that includes the skills and ethics of interpreting (e.g. issues of confidentiality), fundamental knowledge in both languages of any specialized terms, or concepts peculiar to the recipient/covered entity's program or activity, sensitivity to the LEP person's culture and a demonstrated ability to convey information in both languages, accurately. A recipient/covered entity must ensure that those persons it provides as interpreters are trained and demonstrate competency as interpreters.

**6. Examples of Frequently Encountered Scenarios**

Over the course of the past 30 years enforcing Title VI in the LEP context, OCR has observed a number of recurring problems. The following are examples of frequently encountered policies and practices that are likely to violate Title VI:

- ▶ A woman is brought to the emergency room of a hospital by her brother. The hospital has no language assistance services and requires her brother to interpret for her. She is too embarrassed to discuss her condition through her brother and leaves without treatment. Alternatively, she is forced to use her brother as the interpreter, who is untrained in medical terminology and through whom she refuses to discuss sensitive information pertaining to her medical condition.
- ▶ A health clinic uses a Spanish-speaking security guard who has no training in interpreting skills and is unfamiliar with medical terminology as an interpreter for its Hispanic LEP patients. He frequently relays inaccurate information that results in inaccurate instructions to patients.
- ▶ A local welfare office uses a Vietnamese janitor to interpret whenever Vietnamese applicants or beneficiaries seek services or benefits. The janitor has been in America for six months, does not speak English well and is not familiar with the terminology that is used. He often relays inaccurate information that results in the denial of benefits to clients.
- ▶ A state welfare agency does not advise a mother of her right to free language assistance and encourages her to use her eleven-year-old daughter to interpret for her. The daughter does not understand the terminology being used and relays inaccurate information to her

mother whose benefits are jeopardized by the failure to obtain accurate information.

- ▶ A medical clinic uses a medical student as an interpreter based on her self-identification as bilingual. While in college, the student had spent a semester in Spain as an exchange student. The student speaks Spanish haltingly and must often ask patients to speak slowly and to repeat their statements. On several occasions, she has relayed inaccurate information that has resulted in misdiagnosis.
- ▶ A managed care plan calls the receptionist at an Ethiopian community organization whenever it or one of its providers needs the services of an interpreter for an Ethiopian patient. The plan instructs the receptionist to send anyone who is available as long as that person speaks English. Many of the interpreters sent to a provider either do not understand English well enough to interpret accurately or are unfamiliar with medical terminology. As a result, clients often misunderstand their rights and benefits.
- ▶ A local welfare office forces a Mandarin-speaking client seeking to apply for SCHIP benefits on behalf of her three-year-old child to wait for a number of hours (or tells the client to come back another day) to receive assistance because it cannot communicate effectively with her, and has no effective plan for ensuring meaningful communication. This results in a delay of benefits.
- ▶ An HMO that enrolls Medicaid beneficiaries instructs a non-English speaking client to provide his or her own interpreter services during all office visits.
- ▶ A health plan requires non-English speaking patients to pay for interpreter services.

#### **D. Promising Practices**

In meeting the needs of their LEP patients and clients, some recipient/covered entities have found unique ways of providing interpreter services and reaching out to the LEP community. As part of its technical assistance, OCR has frequently assisted, and will continue to assist, recipient/covered entities who are interested in learning about promising practices in the area of service to LEP populations. Examples of promising practices include the following:

**Simultaneous Translation**—One urban hospital is testing a state of the art medical interpretation system in which the provider and patient communicate using wireless remote headsets while a trained competent interpreter, located in a separate room, provides simultaneous interpreting services to the provider and patient. The interpreter can be miles away. This reduces delays in the delivery of language assistance, since the interpreter does not

have to travel to the recipient/covered entity's facility. In addition, a provider that operates more than one facility can deliver interpreter services to all facilities using this central bank of interpreters, as long as each facility is equipped with the proper technology.

**Language Banks**—In several parts of the country, both urban and rural, community organizations and providers have created community language banks that train, hire and dispatch competent interpreters to participating organizations, reducing the need to have on-staff interpreters for low demand languages. These language banks are frequently nonprofit and charge reasonable rates. This approach is particularly appropriate where there is a scarcity of language services, or where there is a large variety of language needs.

**Language Support Office**—A state social services agency has established an "Office for Language Interpreter Services and Translation." This office tests and certifies all in-house and contract interpreters, provides agency-wide support for translation of forms, client mailings, publications and other written materials into non-English languages, and monitors the policies of the agency and its vendors that affect LEP persons.

**Multicultural Delivery Project**—Another county agency has established a "Multicultural Delivery Project" that is designed to find interpreters to help immigrants and other LEP persons to navigate the county health and social service systems. The project uses community outreach workers to work with LEP clients and can be used by employees in solving cultural and language issues. A multicultural advisory committee helps to keep the county in touch with community needs.

**Pamphlets**—A hospital has created pamphlets in several languages, entitled "While Awaiting the Arrival of an Interpreter." The pamphlets are intended to facilitate basic communication between inpatients/outpatients and staff. They are not intended to replace interpreters but may aid in increasing the comfort level of LEP persons as they wait for services.

**Use of Technology**—Some recipient/covered entities use their internet and/or intranet capabilities to store translated documents online. These documents can be retrieved as needed.

**Telephone Information Lines**—Recipient/covered entities have established telephone information lines in languages spoken by frequently encountered language groups to instruct callers, in the non-English languages, on how to leave a recorded message that will be answered by someone who speaks the caller's language.

**Signage and Other Outreach**—Other recipient/covered entities have provided information about services, benefits, eligibility requirements, and the availability of free language assistance, in appropriate languages by (a) posting

signs and placards with this information in public places such as grocery stores, bus shelters and subway stations; (b) putting notices in newspapers, and on radio and television stations that serve LEP groups; (c) placing flyers and signs in the offices of community-based organizations that serve large populations of LEP persons; and (d) establishing information lines in appropriate languages.

## **E. Model Plan**

The following is an example of a model language assistance program that is potentially useful for all recipient/covered entities, but is particularly appropriate for entities such as hospitals or social service agencies that serve a significant and diverse LEP population. This model plan incorporates a variety of options and methods for providing meaningful access to LEP beneficiaries:

### **A formal written language assistance program**

- Identification and assessment of the languages that are likely to be encountered and estimating the number of LEP persons that are eligible for services and that are likely to be affected by its program through a review of census and client utilization data and data from school systems and community agencies and organizations;
- Posting of signs in lobbies and in other waiting areas, in several languages, informing applicants and clients of their right to free interpreter services and inviting them to identify themselves as persons needing language assistance;
- Use of “I speak” cards by intake workers and other patient contact personnel so that patients can identify their primary languages;
- Requiring intake workers to note the language of the LEP person in his/her record so that all staff can identify the language assistance needs of the client;
- Employment of a sufficient number of staff, bilingual in appropriate languages, in patient and client contact positions such as intake workers, caseworkers, nurses, doctors. These persons must be trained and competent as interpreters;
- Contracts with interpreting services that can provide competent interpreters in a wide variety of languages, in a timely manner;
- Formal arrangements with community groups for competent and timely interpreter services by community volunteers;
- An arrangement with a telephone language interpreter line;
- Translation of application forms, instructional, informational and other key documents into appropriate non-English languages. Provision of oral interpreter assistance with documents, for those persons whose language does not exist in written form;
- Procedures for effective telephone communication between staff and LEP persons, including instructions for English-speaking employees to

obtain assistance from bilingual staff or interpreters when initiating or receiving calls from LEP persons;

- Notice to and training of all staff, particularly patient and client contact staff, with respect to the recipient/covered entity's Title VI obligation to provide language assistance to LEP persons, and on the language assistance policies and the procedures to be followed in securing such assistance in a timely manner;
- Insertion of notices, in appropriate languages, about the right of LEP applicants and clients to free interpreters and other language assistance, in brochures, pamphlets, manuals, and other materials disseminated to the public and to staff;
- Notice to the public regarding the language assistance policies and procedures, and notice to and consultation with community organizations that represent LEP language groups, regarding problems and solutions, including standards and procedures for using their members as interpreters;
- Adoption of a procedure for the resolution of complaints regarding the provision of language assistance; and for notifying clients of their right to and how to file a complaint under Title VI with HHS;
- Appointment of a senior-level employee to coordinate the language assistance program, and ensure that there is regular monitoring of the program.

## F. Compliance and Enforcement

The recommendations outlined above are not intended to be exhaustive. Recipient/covered entities have considerable flexibility in determining how to comply with their legal obligation in the LEP setting, and are not required to use all of the suggested methods and options listed. However, recipient/covered entities must establish and implement policies and procedures for providing language assistance sufficient to fulfill their Title VI responsibilities and provide LEP persons with meaningful access to services.

OCR will enforce Title VI as it applies to recipient/covered entities' responsibilities to LEP persons through the procedures provided for in the Title VI regulations. These procedures include complaint investigations, compliance reviews, efforts to secure voluntary compliance, and technical assistance.

The Title VI regulations provide that OCR will investigate whenever it receives a complaint, report or other information that alleges or indicates possible noncompliance with Title VI. If the investigation results in a finding of compliance, OCR will inform the recipient/covered entity in writing of this determination, including the basis for the determination. If the investigation results in a finding of noncompliance, OCR must inform the recipient/covered entity of the noncompliance through a Letter of Findings that

sets out the areas of noncompliance and the steps that must be taken to correct the noncompliance, and must attempt to secure voluntary compliance through informal means. If the matter cannot be resolved informally, OCR must secure compliance through (a) the termination of Federal assistance after the recipient/covered entity has been given an opportunity for an administrative hearing, (b) referral to DOJ for injunctive relief or other enforcement proceedings, or (c) any other means authorized by law.

As the Title VI regulations set forth above indicate, OCR has a legal obligation to seek voluntary compliance in resolving cases and cannot seek the termination of funds until it has engaged in voluntary compliance efforts and has determined that compliance cannot be secured voluntarily. OCR will engage in voluntary compliance efforts, and will provide technical assistance to recipients at all stages of its investigation. During these efforts to secure voluntary compliance, OCR will propose reasonable timetables for achieving compliance and will consult with and assist recipient/covered entities in exploring cost effective ways of coming into compliance, by sharing information on potential community resources, by increasing awareness of emerging technologies, and by sharing information on how other recipient/covered entities have addressed the language needs of diverse populations.

OCR will focus its compliance review efforts primarily on larger recipient/covered entities such as hospitals, managed care organizations, state agencies, and social service organizations, that have a significant number or percentage of LEP persons eligible to be served, or likely to be directly affected, by the recipient/covered entity's program. Generally, it has been the experience of OCR that in order to ensure compliance with Title VI, these recipient/covered entities will be expected to utilize a wider range of the language assistance options outlined in section C.3.

The fact that OCR is focusing its investigative resources on larger recipient/covered entities with significant numbers or percentages of LEP persons likely to be served or directly affected does not mean that other recipient/covered entities are relieved of their obligation under Title VI, or will not be subject to review by OCR. In fact, OCR has a legal obligation under HHS regulations to promptly investigate all complaints alleging a violation of Title VI. All recipient/covered entities must take steps to overcome language differences that result in barriers and provide the language assistance needed to ensure that LEP persons have meaningful access to services and benefits. However, smaller recipient/covered entities—such as sole practitioners, those with more limited resources, and recipient/covered entities who serve small numbers of LEP persons on an infrequent basis—will have more flexibility in meeting their obligations to ensure meaningful access for LEP persons.

In determining a recipient/covered entity's compliance with Title VI, OCR's primary concern is to ensure that the recipient/covered entity's policies and



procedures overcome barriers resulting from language differences that would deny LEP persons a meaningful opportunity to participate in and access programs, services and benefits. A recipient/covered entity's appropriate use of the methods and options discussed in this policy guidance will be viewed by OCR as evidence of a recipient/covered entity's willingness to comply voluntarily with its Title VI obligations.

## G. Technical Assistance

Over the past 30 years, OCR has provided substantial technical assistance to recipient/covered entities, and will continue to be available to provide such assistance to any recipient/covered entity seeking to ensure that it operates an effective language assistance program. In addition, during its investigative process, OCR is available to provide technical assistance to enable recipient/covered entities to come into voluntary compliance.

## H. Attachments

Appendix A is a summary, in question and answer format, of a number of the critical elements of this guidance. The purpose of the summary is to assist recipient/covered entities further in understanding this guidance and their obligations under Title VI to ensure meaningful access to LEP persons. Appendix B is a list of numerous provisions, including but not limited to Federal and state laws and regulations, requiring the provision of language assistance to LEP persons in various circumstances. This list is not exhaustive, and is not limited to the health and human service context.

### Appendix A

*Questions and Answers Regarding the Office for Civil Rights Policy Guidance on the Title VI Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency*

**1. Q. What is the purpose of the guidance on language access released by the Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services (HHS)?**

A. The purpose of the Policy Guidance is two-fold: First, to clarify the responsibilities of providers of health and social services who receive Federal financial assistance from HHS, and assist them in fulfilling their responsibilities to Limited English Proficient (LEP) persons, pursuant to Title VI of the Civil Rights Act of 1964; and second, to clarify to members of the public that health and social service providers must ensure that LEP persons have meaningful access to their programs and services.

**2. Q. What does the policy guidance do?**

A. The policy guidance does the following:

- Reiterates the principles of Title VI with respect to LEP persons.
- Discusses the policies, procedures and other steps that recipients can take to ensure meaningful access to their program by LEP persons.

- Clarifies that failure to take one or more of these steps does not necessarily mean noncompliance with Title VI.
- Provides that OCR will determine compliance on a case by case basis, and that such assessments will take into account the size of the recipient, the size of the LEP population, the nature of the program, the resources available, and the frequency of use by LEP persons.
- Provides that small providers and recipient/covered entities with limited resources, will have a great deal of flexibility in achieving compliance.
- Provides that OCR will provide extensive technical assistance as needed by recipient/covered entities.

**3. Q. Does the guidance impose new requirements on recipient/covered entities?**

A. No. Since its enactment, Title VI of the Civil Rights Act of 1964 has prohibited discrimination on the basis of race, color or national origin in any program or activity that receives federal financial assistance. In order to avoid violating Title VI, recipient/covered entities must ensure that they provide LEP persons meaningful opportunity to participate in their programs, services and benefits. Over the past three decades, OCR has conducted thousands of investigations and reviews involving language differences that affect the access of LEP persons to medical care and social services. Where such language differences prevent meaningful access on the basis of national origin, the law requires that recipient/covered entities provide oral and written language assistance at no cost to the LEP person. This guidance synthesizes the legal requirements that have been on the books and that OCR has been enforcing for over three decades.

**4. Q. Who is covered by the guidance?**

A. Covered entities include any state or local agency, private institution or organization, or any public or private individual that (1) operates, provides or engages in health, or social service programs and activities, and (2) receives Federal financial assistance from HHS directly or through another recipient/covered entity. Examples of covered entities include but are not limited to hospitals, nursing homes, home health agencies, managed care organizations, universities and other entities with health or social service research programs; state, county and local health agencies; state Medicaid agencies; state, county and local welfare agencies; programs for families, youth and children; Head Start programs; public and private contractors, subcontractors and vendors; physicians; and other providers who receive Federal financial assistance from HHS.

**5. Q. How does the guidance affect small practitioners and providers?**

A. The key to providing meaningful access for LEP persons is to ensure that the relevant circumstances of the LEP person's situation can be effectively communicated to the service provider and the LEP person is

able to understand the services and benefits available and is able to receive those services and benefits for which he or she is eligible in a timely manner. Small practitioners and providers will have considerable flexibility in determining precisely how to fulfill their obligations to ensure meaningful access for persons with limited English proficiency. OCR will assess compliance on a case by case basis and will take into account the size of the recipient/covered entity, the size of the eligible LEP population it serves, the nature of the program or service, the objectives of the program, the total resources available to the recipient/covered entity, the frequency with which languages are encountered and the frequency with which LEP persons come into contact with the program. There is no “one size fits all” solution for Title VI compliance with respect to LEP persons.

In other words, OCR will focus on the end result, that is, whether the small practitioner or provider has taken steps, given the factors that will be considered by OCR, to ensure that the LEP persons have access to the programs and services provided by the physician. OCR will continue to be available to provide technical assistance to any physician seeking to ensure that s/he operates an effective language assistance program. For example: A physician, a sole practitioner, has about 50 LEP Hispanic patients. He has a staff of two nurses and a receptionist, derives a modest income from his practice, and receives Medicaid funds. He asserts that he cannot afford to hire bilingual staff, contract with a professional interpreter service, or translate written documents. To accommodate the language needs of his LEP patients he has made arrangements with a Hispanic community organization for trained and competent volunteer interpreters and with a telephone interpreter language line, to interpret during consultations and to orally translate written documents. There have been no client complaints of inordinate delays or other service related problems with respect to LEP clients. Given the physician’s resources, the size of his staff, and the size of the LEP population, OCR would find the physician in compliance with Title VI.

**6. Q. The guidance identifies some specific circumstances under which OCR will consider a program to be in compliance with its obligation under Title VI to provide written materials in languages other than English. Does this mean that a recipient/covered entity will be considered out of compliance with Title VI if its program does not fall within these circumstances?**

A. No. The circumstances outlined in the guidance are intended to provide a “safe harbor” for recipients who desire greater certainty with respect to their obligations to provide written translations. Thus, a recipient/covered entity whose policies and practices fall within these circumstances can be confident that, with respect to written translations, it will be found in compliance with Title VI. However, the failure to fall within the “safe harbors” outlined in the guidance does not

necessarily mean that a recipient/covered entity is not in compliance with Title VI. In such circumstances, OCR will review the totality of circumstances to determine the precise nature of a recipient/covered entity's obligation to provide written materials in languages other than English. If translation of a certain document or set of documents would be so financially burdensome as to defeat the legitimate objectives of its program, or if there is an alternative means of ensuring that LEP persons have meaningful access to the information provided in the document (such as timely, effective oral interpretation of vital documents), OCR will likely not find the translation necessary for compliance with Title VI.

**7. Q. The guidance makes reference to "vital documents" and notes that, in certain circumstances, a recipient/covered entity may have to translate such documents into other languages. What is a vital document?**

A. Given the wide array of programs and activities receiving HHS financial assistance, we do not attempt to identify vital documents and information with specificity in each program area. Rather, a document or information should be considered vital if it contains information that is critical for accessing the federal fund recipient's services and/or benefits, or is required by law. Thus, vital documents include, but are not limited to, applications, consent forms, letters and notices pertaining to the reduction, denial or termination of services or benefits, letters or notices that require a response from the beneficiary or client, and documents that advise of free language assistance. OCR will also collaborate with respective HHS agencies in determining which documents and information are deemed to be vital within a particular program.

**8. Q. Will recipient/covered entities have to translate large documents such as managed care enrollment handbooks?**

A. Not necessarily. As part of its overall language assistance program, a recipient must develop and implement a plan to provide written materials in languages other than English where a significant number or percentage of the population eligible to be served, or likely to be directly affected by the program, needs services or information in a language other than English to communicate effectively. OCR will assess the need for written translation of documents and vital information contained in larger documents on a case by case basis, taking into account all relevant circumstances, including the nature of the recipient/covered entity's services or benefits, the size of the recipient/covered entity, the number and size of the LEP language groups in its service area, the nature and length of the document, the objectives of the program, the total resources available to the recipient/covered entity, the frequency which particular languages are encountered and the frequency with which translated documents are needed and the cost of translation. Depending on these circumstances, large documents, such as enrollment handbooks, may not need to be translated or may not need to be trans-

lated in their entirety. For example, a recipient/covered entity may be required to provide written translations of vital information contained in larger documents, but may not have to translate the entire document, to meet its obligations under Title VI.

**9. Q. May a recipient/covered entity require an LEP person to use a family member or a friend as his or her interpreter?**

A. No. OCR's policy requires the recipient/covered entity to inform the LEP person of the right to receive free interpreter services first and permits the use of family and friends only after such offer of assistance has been declined and documented. Our policy regarding the use of family and friends as interpreters is based on over three decades of experience with Title VI. Although OCR recognizes that some individuals may be uncomfortable having a stranger serve as an interpreter, especially when the situation involves the discussion of very personal or private matters, it is our experience that family and friends frequently are not competent to act as interpreters, since they may be insufficiently proficient in both languages, untrained and unskilled as interpreters, and unfamiliar with specialized terminology. Use of such persons also may result in breaches of confidentiality or reluctance on the part of the individual to reveal personal information critical to their situations. These concerns are even more pronounced when the family member called upon to interpret is a minor. In other words, when family and friends are used, there is a grave risk that interpretation may not be accurate or complete. In medical settings, in particular, this can result in serious, even life threatening consequences.

**10. Q. How does low health literacy, non-literacy, non-written languages, blindness and deafness among LEP populations affect the responsibilities of federal fund recipients?**

A. Effective communication in any language requires an understanding of the literacy levels of the eligible populations. However, literacy generally is a program operations issue rather than a Title VI issue. Where a LEP individual has a limited understanding of health matters or cannot read, access to the program is complicated by factors not directly related to national origin or language. Under these circumstances, a recipient/covered entity should provide remedial health information to the same extent that it would provide such information to English-speakers. Similarly, a recipient/covered entity should assist LEP individuals who cannot read in understanding written materials as it would non-literate English-speakers. A non-written language precludes the translation of documents, but does not affect the responsibility of the recipient to communicate the vital information contained in the document or to provide notice of the availability of oral translation. Section 504 of the Rehabilitation Act of 1973 requires that federal fund recipients provide sign language and oral interpreters for people who have

hearing impairments and provide materials in alternative formats such as in large print, braille or on tape for individuals with impairments. The Americans with Disabilities Act imposes similar requirements on health and human service providers.

**11. Q. Can OCR provide help to recipient/covered entities who wish to come into compliance with Title VI?**

A. Absolutely. For over three decades, OCR has provided substantial technical assistance to recipient/covered entities who are seeking to ensure that LEP persons can meaningfully access their programs or services. Our regional staff is prepared to work with recipients to help them meet their obligations under Title VI. As part of its technical assistance services, OCR can help identify best practices and successful strategies used by other federal fund recipients, identify sources of federal reimbursement for translation services, and point providers to other resources.

**12. Q. How will OCR enforce compliance by recipient/covered entities with the LEP requirements of Title VI?**

A. OCR will enforce Title VI as it applies to recipient/covered entities through the procedures provided for in the Title VI regulations. The Title VI regulations provide that OCR will investigate whenever it receives a complaint, report, or other information that alleges or indicates possible noncompliance with Title VI. If the investigation results in a finding of compliance, OCR will inform the recipient/covered entity in writing of this determination, including the basis for the determination. If the investigation results in a finding of noncompliance, OCR must inform the recipient/covered entity of the noncompliance through a Letter of Findings that sets out the areas of noncompliance and the steps that must be taken to correct the noncompliance. By regulation, OCR must attempt to secure voluntary compliance through informal means. In practice, OCR has been quite successful in securing voluntary compliance and will continue these efforts. If the matter cannot be resolved informally, OCR must secure compliance through (a) the termination of Federal assistance after the recipient/covered entity has been given an opportunity for an administrative hearing, (b) referral to DOJ for injunctive relief or other enforcement proceedings, or (c) any other means authorized by law.

**13. Q. Does issuing this guidance mean that OCR will be changing how it enforces compliance with Title VI?**

A. No. How OCR enforces Title VI is governed by the Title VI implementing regulations. The methods and procedures used to investigate and resolve complaints, and conduct compliance reviews, have not changed.

**14. Q. What is HHS doing to ensure it is following the guidance it is giving to States and others?**

A. Although legally, federally conducted programs and activities are not subject to Title VI, HHS recognizes the importance of ensuring that its programs and services are accessible to LEP persons. To this end, HHS has established a working group to assess how HHS itself is providing language access. Currently, agencies across HHS have taken a number of important steps to ensure that their programs and services are accessible to LEP persons. For example, a number of agencies have translated important consumer materials into languages other than English. Also, several agencies have launched Spanish language Web sites. In order to ensure that all HHS federally conducted programs and activities are accessible to LEP persons, the Secretary has directed the working group to develop and implement a Department-wide plan for ensuring LEP persons meaningful access to HHS programs. This internal HHS initiative was begun prior to the President's August 11, 2000, Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency." The Executive Order requires Federal Agencies to develop and implement a system for ensuring LEP persons meaningful access to their federally-conducted programs. It also requires agencies to issue guidance to their recipients on the recipients' obligations to provide LEP persons meaningful access to their federally-assisted programs. HHS is a step ahead on each of the obligations outlined in the Executive Order.

**Appendix B**

*Selected Federal and State Laws and Regulations Requiring Language Assistance*

*Federal Laws and Regulations*

Federal laws that recognize the need for language assistance include:

- 1. The Voting Rights Act**, which bans English-only elections and prescribes other remedial devices to ensure nondiscrimination against language minorities;<sup>8</sup>
- 2. The Food Stamp Act of 1977**, which requires states to provide written and oral language assistance to LEP persons under certain circumstances;<sup>9</sup>
- 3. Judicial procedure laws** that require the use of certified or otherwise qualified interpreters for LEP parties and witnesses, at the government's expense, in certain proceedings;<sup>10</sup>

<sup>8</sup> 42 U.S.C. Section 1973b(f)(1).

<sup>9</sup> 7 U.S.C. Section 2020(e)(1) and (2)(A).

<sup>10</sup> 28 U.S.C. Section 1827(d)(1)(A).

4. **The Older Americans Act**, which requires state planning agencies to use outreach workers who are fluent in the languages of older LEP persons, where there is a substantial number of such persons in a planning area;<sup>11</sup>
5. **The Substance Abuse and Mental Health Administration Reorganization Act**, which requires services provided with funds under the statute to be bilingual if appropriate;<sup>12</sup>
6. **The Disadvantaged Minority Health Improvement Act**, which requires the Office of Minority Health (OMH) to enter into contracts to increase the access of LEP persons to health care by developing programs to provide bilingual or interpreter services;<sup>13</sup>
7. **The Equal Educational Opportunities Act of 1974**, which requires educational agencies to take appropriate action to accommodate the language differences that impede equal participation by students in instructional programs;<sup>14</sup>
8. **Regulations issued by the Centers for Medicare and Medicaid (CMA)** which require that evaluations for the mentally ill and mentally retarded be adapted to the cultural background, language, ethnic origin and means of communication of the person being evaluated.<sup>15</sup>
9. **State Laws and Regulations.** Many states have recognized the seriousness of the language access challenge and have enacted laws that require providers to offer language assistance to LEP persons in many service settings.<sup>16</sup> States that require language assistance include:
  1. California, which provides that intermediate care facilities must use interpreters and other methods to ensure adequate communication between staff and patients;<sup>17</sup> California has a wide array of other laws and regulations that require language assistance, including those that require: (a) intermediate nursing facilities to use interpreters and

<sup>11</sup> 42 U.S.C. Section 3027(a)(20)(A).

<sup>12</sup> 42 U.S.C. Section 290aa(d)(14).

<sup>13</sup> 42 U.S.C. Section 300u-6(b)(7)

<sup>14</sup> 20 U.S.C. Section 1703(f).

<sup>15</sup> 42 CFR section 483.128(b).

<sup>16</sup> At least twenty-six (26) states and the District of Columbia have enacted legislation requiring language assistance, such as interpreters and/or translated forms and other written materials, for LEP persons.

<sup>17</sup> 22 California Code of Regulations, Section 73501. California has a wide array of other laws and regulations that require language assistance, including those that require: (a) intermediate nursing facilities to use interpreters and other methods to ensure adequate communication with patients, (b) adult day care centers to employ ethnic and linguistic staff as indicated by participant characteristics, (c) certified interpreters for non-English speaking persons at administrative hearings, and (d) health licensing agencies to translate patients rights information into every language spoken by 1% or more of the nursing home population.



- other methods to ensure adequate communication with patients, (b) adult day care centers to employ ethnic and linguistic staff as indicated by participant characteristics, (c) certified interpreters for non-English speaking persons at administrative hearings, and (d) health licensing agencies to translate patients rights information into every language spoken by 1% or more of the nursing home population.
2. New Jersey, which provides that drug and alcohol treatment facilities must provide interpreter services if their patient population in non-English speaking.<sup>18</sup>
  3. Pennsylvania, which provides that a patient who does not speak English should have access, where possible, to an interpreter;<sup>19</sup> and
  4. Massachusetts, which in April 2000, enacted legislation that requires every acute care hospital to provide competent interpreter services to LEP patients in connection with all emergency room services.<sup>20</sup>

## Medical Accreditation Organizations

1. **The Joint Committee on Accreditation of Healthcare Organizations (JCAHO)**, which accredits hospitals and other health care institutions, requires language assistance in a number of situations. For example, its accreditation manual for hospitals provides that written notice of patients' rights must be appropriate to the patient's age, understanding and language.<sup>21</sup>
2. **The National Committee for Quality Assurance (NCQA)**, which provides accreditation for managed care organizations, also requires language assistance in a variety of settings. As part of its evaluation process, the NCQA assesses managed care member materials to determine whether they are available in languages, other than English, spoken by major population groups.<sup>22</sup>

<sup>18</sup> New Jersey Administrative Code Section 42A-6.7.

<sup>19</sup> 28 Pennsylvania Administrative Code Section 103.22(b)(14).

<sup>20</sup> M.G.L.A. 111, Section 25J

<sup>21</sup> JCAHO, 1997 Accreditation Manual for Hospitals, Section R1.1.4.

<sup>22</sup> NCQA, 1997 Accreditation Standards, RR 6.2.



# National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care

**65 Fed. Reg. 80865-79 (Dec. 22, 2000)**

## **Department of Health and Human Services Office of Minority Health**

**AGENCY:** HHS/OS/Office of Public Health and Science, Office of Minority Health, DHHS.

**ACTION:** Final report.

**SUMMARY:** The HHS Office of Minority Health announces the publication of final national standards on culturally and linguistically appropriate services (CLAS) in health care, following a 120-day comment period on draft standards in 2000 and revisions to the standards. The CLAS standards, with a brief background summary of the development and comment process, are printed below.

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The standards, the public comments from the regional meetings, and a complete report on the project can be found online at [www.omhrc.gov/CLAS](http://www.omhrc.gov/CLAS).

### **SUPPLEMENTARY INFORMATION:**

#### **Table of Contents**

- Background
- Public Comment Period and Regional Informational Meetings
- National Project Advisory Committee (NPAC)
- Analysis and Response to Public Comments on the CLAS Standards
- National Standards for Culturally and Linguistically Appropriate Services in Health Care

## Background

Cultural and linguistic competence is the ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by patients to the health care encounter. As health providers begin to treat a more diverse clientele as a result of demographic shifts and changes in insurance program participation, interest is increasing in culturally and linguistically appropriate services that lead to improved outcomes, efficiency, and satisfaction. The provision of culturally and linguistically appropriate services is in the interest of providers, policy-makers, accreditation and credentialing agencies, purchasers, patients, advocates, educators and the general health care community.

Many health care providers do not have clear guidance on how to prepare for, or respond to, culturally sensitive situations. Until now, no comprehensive nationally recognized standards of cultural and linguistic competence in health care service delivery have been developed. Instead, Federal health agencies, State policymakers, and national organizations have independently developed their own standards and practices. Some have developed definitions of cultural competence while others mandate providing language services to limited English proficient (LEP) speakers. Some specify collection of language, race, and ethnicity data. Many approaches attempt to be comprehensive, while others target only a specific issue, geographic area, or subfield of health care, such as mental health. The result is a wide spectrum of ideas about what constitutes culturally appropriate health services, including significant differences with respect to target population, scope, and quality of services. Although limited in their jurisdiction, many excellent policies do exist, and the increasing numbers of model programs and practices demonstrate that culturally competent health services are viable, beneficial, and important to health care consumers.

In 1997, the U.S. Department of Health and Human Services' (HHS) Office of Minority Health (OMH) asked Resources for Cross Cultural Health Care and the Center for the Advancement of Health to review and compare existing cultural and linguistic competence standards and measures in a national context, propose draft national standard language where appropriate, assess the information or research needed to relate these guidelines to outcomes, and develop an agenda for future work in this area. *Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda* was the result of this request, with a two-part report submitted to OMH in May 1999.

The first part of the 1999 report contained draft national standards for culturally and linguistically appropriate services in health care. Based on an analytical review of key laws, regulations, contracts, and standards currently in use by Federal and State agencies and other national organizations, these draft standards were developed with input from a national project

advisory committee of policymakers, health care providers, and researchers. Each standard was accompanied by a discussion that addressed the proposed guideline's relationship to existing laws and standards, and offered recommendations for implementation and oversight to providers, policymakers, and advocates.

### **Public Comment Period and Regional Informational Meetings**

The Office of Minority Health determined that the appropriate next step for the draft CLAS standards was to undergo a national process of public comment that would result in a broader awareness of HHS interest in CLAS in health care, significant input from stakeholder groups on the draft standards, and a final revision of the standards and accompanying commentary supported by the expertise of a National Project Advisory Committee.

The draft CLAS standards were published in the *Federal Register* on December 15, 1999 (Volume 64, Number 240, pages 70042–70044), and the full report was made available for review online at [www.omhrc.gov/CLAS](http://www.omhrc.gov/CLAS). Individuals and organizations desiring to comment on the standards were encouraged to read the standards and full report, and to send comments during the public comment period, which ran from January 1 to April 30, 2000. During this period, written comments sent by email and regular mail were received from 104 individuals and organizations.

Individuals also had the opportunity to participate in one of three regional meetings on the CLAS standards. The purpose of these one-day meetings was to present information on the standards' development process, and for participants to discuss and provide feedback on issues related to the standards themselves or their implementation. Meetings were publicized in the *Federal Register* notice, on the Web site, and in letters mailed to more than 3,000 stakeholders. The meetings were held on January 21, 2000, in San Francisco, California; March 10, 2000, in Baltimore, Maryland; and April 7, 2000, in Chicago, Illinois. More than 309 individuals, representing themselves or their organizations, participated in the three meetings. All sessions of each meeting were audiotaped and transcribed for inclusion in the analysis of public comments.

Following the closure of the public comment period on April 30, 2000, the project team (consisting of staff members of OMH, IQ Solutions, Inc., and its subcontractor Resources for Cross Cultural Health Care) implemented the following steps to analyze the public comments on the CLAS standards received through the three regional meetings, mail, and email.

The public comments received from all sources were organized according to the following categories (the numbers used to identify the standards pertain to the numbering system of the draft standards. The standards have been reordered in the final revision):

- General Comments (made on the overall report)
- Diverse and Culturally Competent Staff (Standards 1, 4, and 5)
- Consumer and Community Input (Standard 3)
- Bilingual/Interpreter Services (Standards 6, 7, and 9)
- Translated Written Materials (Standard 8)
- The Culturally Competent Organization (Standards 2 and 13)
- Data Collection and Performance Evaluation (Standards 10, 11, 12, and 14)

Within these categories, comments were organized by individual standards and within standards by major identified themes. Staff reviewed the compilations of comments to identify issues and controversies for each standard, and the original comments were organized topically for each standard and for the General Comments. The project team then conducted a series of meetings to discuss comments on topically grouped sets of standards. Deliberations on the CLAS Standards addressed the following set of questions:

- Is there a powerful consensus from public comments to change the standard in any way? If so, what are the issues?
- Are there any meaningful secondary issues that are so compelling or sensible that they need to be considered in terms of changes to the standard?
- Are there any other issues that should be addressed (e.g., controversies raised by the standard) by the CLAS Standards National Project Advisory Committee (NPAC)?

Deliberations on the general comments addressed the following set of questions:

- What are the major themes or issues related to the previous process of developing the standards, and how should these issues be addressed in the final CLAS standards report?
- What are major themes related to contextual issues, and how should these themes be addressed in the final CLAS standards report?
- What are major issues related to the subsequent standards development process, and how should these themes be addressed?

### **National Project Advisory Committee**

Based on the discussions related to these questions, the project team prepared a deliberation report for the NPAC that included an analysis of comments on the general comments and each standard. Each analysis:

- Makes recommendations for changes to the standards when clearly indicated by a consensus in either public comments or project team deliberations;

- Identifies key themes, issues, and controversies; and
- Provides rationales for changes or controversies that the NPAC is being asked to consider.

The CLAS Standards National Project Advisory Committee was composed of 27 individuals representing State and Federal agencies, health care organizations, health care professionals, consumers, unions, and health care accrediting agencies. A complete list of NPAC members is available at [www.omhrc.gov/CLAS](http://www.omhrc.gov/CLAS). The NPAC met with the project team in Washington, DC, on July 21–22, 2000. Together, the group:

- Considered the recommendations proposed in the deliberation report and either concurred on the suggested changes to the standard or offered an alternative approach to responding to public comments on the issues;
- Examined key issues for which recommendations were not presented in analysis (due to a lack of clear consensus) and, when possible, recommended changes to the standards that were responsive to public comments;
- Identified and addressed other issues not raised in the deliberation report; and
- Made recommendations for next steps.

Following the meeting the project team revised the standards based on the public comments and the deliberations of the NPAC, whose members were given the opportunity to review and comment on subsequent revisions. No formal consensus was obtained from the NPAC after the meeting, although most comments were integrated into the final standards by the project team, and the NPAC was given the opportunity to review and comment on the final revisions. The final revisions are now being published in the *Federal Register* as recommended national standards for adoption or adaptation by stakeholder organizations and agencies.

The project team will also produce a comprehensive final report documenting all phases of the project and discussing issues related to the standards in depth. This report will be available in early January 2000 online at [www.omhrc.gov/CLAS](http://www.omhrc.gov/CLAS) and in hard copy by request to: Guadalupe Pacheco, Office of Minority Health, 5515 Security Lane, Suite 1000, Rockville, MD 20852, Attn: CLAS; Office: Telephone 301-443-5084, Fax: 301-594-0767, Email: [gpacheco@osophs.dhhs.gov](mailto:gpacheco@osophs.dhhs.gov).

### **Analysis and Response to Public Comments on the CLAS Standards**

In response to publication in the *Federal Register* of the CLAS Standards on December 15, 1999, OMH received public comments from 413 individuals or organizations, along with comments from the NPAC. Comments were

received from a broad range of stakeholders, including hospitals, community-based clinics, managed care organizations, home health agencies, and other types of health care organizations; physicians, nurses, and other providers; professional associations; state health departments; government and other purchasers of health care; accreditation and credentialing agencies; patient advocates and advocacy groups; policymakers; and educators. We present comments and responses generally in the order in which the issues appeared in the recommended CLAS Standards.

### **General Comments**

The comments called for more specificity regarding terms such as culture and competence. Two comments affirmed the choice of definition used by the report; there were other votes for and against culturally sensitive/effective/appropriate/competent. Culturally and linguistically appropriate services (CLAS) was retained as the overall descriptor for the package of activities described by standards. Cultural competence remains the mainstream term for this area, and will be used within standards and defined in the glossary. The NPAC generally agreed with the continued use of the definition of cultural and linguistic competence from the original report.

Comments suggested that the scope of the project include other consumer groups/issues such as the poor, homeless, disabled, gender, socioeconomic status, HIV, gay, bisexual, transgender, immigrants, American Indians, different ages, countercultures, cultures within cultures, individuals within cultures. In the discussion for this section, the final report on the CLAS standards will articulate an inclusive definition of culture that promotes a broad understanding of the whole person. The report will note that every aspect of culture does not need to be addressed in each standard in order for them to apply to different groups, although we will emphasize the original focus on racial, ethnic, and linguistic issues.

Comments asked that the standards be more precise and directive and include more discussion in the standards themselves. To provide added details without encumbering the language of the standards, the format for presenting the revised CLAS standard was revised to continue using concise language for the standard itself and incorporate wordsmithing changes that enhance the clarity of each standard. Additional clarification of key issues or requirements are provided in a brief commentary accompanying the standard. It is our intent that the commentary will not be separated from the standard in executive summaries or other abbreviations of the full report. We also moved many important points from the discussion section of each standard in the original report into the commentary and will include more examples of models and implementation practices in the discussion section of the final report. However, much of the research on and verification of this information should be conducted within the context of the anticipated



pilot tests of the standards by health care organizations. Suggestions also were made for reorganizing the standards by topic area; the revised standards reflect this reorganization, with three main categories (culturally competent care, language assistance, and organizational supports for cultural competence).

Comments raised concerns about too much emphasis on foreign language issues, and it was suggested that they be broadened to include other communication issues. The policies from which the standards were derived are much more specific on the issue of language than culture, and this reflects the current abstract nature of cultural competence and the clear mandates that exist on language issues. We have tried to strengthen the commentary and discussions on cultural competence generally, separate the general cultural competence and language issues into different categories, and call for more work on developing national standards for cultural competence training and other aspects of cultural competence.

Comments raised questions about several implementation issues, including the cost burden and the applicability of the CLAS standards to different kinds of health care organizations (e.g., community clinics/community-based organizations (CBOs), mono-ethnic or “already” culturally competent providers, with extensive ethnic diversity/little diversity, rural providers, home health care agencies). Although the comments raise valid issues, we cannot address cost implications and the implementation nuances according to organization type within the scope of this project. Follow-up projects to pilot test implementation of the CLAS standards and address such issues are planned.

Commenters suggested that additional groups might have participated in the development and comment process, including: health care providers, practicing clinicians, CBOs, community health centers, consumer groups, ethnic organizations, grassroots advocacy groups, Indian reservations, tribal organizations, primary consumers, direct service personnel, Native Americans, Asians, and people who don't speak English. They also suggested that the outreach/public comment process could have been more inclusive by using more participatory approaches to getting information, offering interpreters, doing a better job of informing people about the process, and targeting certain audiences. The final report will detail the public comment process used and its limitations. For example, alternative methods to get input, such as focus groups, ethnic media advertising, were constrained by resource limitations. We used recommendations from public meetings and developed a matrix to assist with our analysis and inclusion of different stakeholder groups in the NPAC. We attempted to recruit representatives from key groups and added additional stakeholders to the NPAC who provided community- and patient-based perspectives.

Comments indicated that many people are not aware of existing laws that addressed issues raised by the CLAS standards, and some standards can be strengthened on the basis of Federal legislation. The commentary of the revised standards identifies the relationship between each standard and any existing Federal laws or regulations. Input from the NPAC was used to identify relevant Federal requirements.

Comments raised concerns about whether the recommended CLAS standards should be guidelines, standards, or mandates. Overall, there was a broad continuum of support for and opposition to different conceptualizations of the standards. Fifty comments supported the standards as mandates, with another thirty-seven expressing endorsement, support for their adoption, agreement with the intent, and other general expressions of praise. Thirty-four comments expressed some level of concern about seeing the standards as national standards or requirements. Some prefer the standards as guidelines, and others disliked them in any format. Among the reasons for their concern or opposition include: The potential costs/burden of implementation; the standards are too broad, too narrow, or too prescriptive; and the lack of research evidence to support the CLAS activities. These issues were raised in the pre-NPAC analytical report and discussed by the committee. The NPAC offered up a consensus on three types of standards of varying stringency: mandates, guidelines, and recommendations. The revised CLAS standards are identified according to these types.

Several comments were raised about elevating the issues of racism, bias, discrimination, and the issues of gender, social class, and socioeconomic status more directly into the standards. Unconscious and conscious referral bias and its impact on health disparities was emphasized, as well as a tension between recognizing the needs of newcomers vs. English-speaking individuals who may still not be respectfully treated in health care. The revised preamble highlights bias and discrimination issues, and the final report will further discuss these issues.

### **Preamble**

Public comments offered a variety of suggestions on how to revise the preamble to the CLAS standards. The principal themes focused on describing the purpose and desired outcomes of the standards, elucidating the standards' overarching principles, and providing definitions to key terms. Other comments suggested that the preamble should include a list of stakeholders and specifically address issues such as bias, ethics and confidentiality, and access. We have revised the preamble to provide both a visionary and practical foundation for understanding the CLAS standards while focusing on a principal theme rather than the array of issues identified. We also have added explanations of the three types of standards (mandates, guidelines, and recommendations), definitions of key concepts used in the standards, and a list of intended stakeholders.

**Standard 1**

Public comments took issue with the overall language of the standard, questioning whether its vague language will render it difficult to implement and enforce. Various comments cited the lack of operationally defined and measurable requirements, recommended that the standard be moved to the preamble or combined with Standard 5, and suggested ways that the standard could be strengthened. The revised standard, along with the accompanying Commentary, is intended to encompass the spirit and overall purpose of the CLAS standards as well as the details that can help organizations “actualize” and “operationalize” the requirements of Standard 1. As suggested in public comments and by the NPAC, portions of the discussion in the CLAS standards report have been incorporated into the standard’s Commentary, including actions organizations can take to support culturally competent encounters. The intent of the standard is more fully explicated in the discussion section of the final report.

Public comments focused on the term “attitudes” or the phrase “attitudes, behaviors, knowledge, and skills” of staff. The lack of definitions and measures for these terms was cited as an obstacle to implementing Standard 1. The revised standard deletes this phrase and focuses instead on concrete actions as reflected in the commentary.

Comments requested that the CLAS standards address the issue of traditional health practices. The response to these comments was to include a reference to traditional health practices in the Commentary to Standard 1. The Commentary cites “being familiar with and respectful of various traditional healing systems and beliefs and, where appropriate, integrating these approaches into treatment plans.” The discussion section for this standard in the final report will include additional information and examples.

NPAC members emphasized the need to define “respectful,” “effective,” “understandable,” and “culturally competent” care. The revised standard calls more explicitly for “care that is provided in a manner compatible with (patients’/consumers’) cultural health beliefs and practices and preferred language” rather than merely culturally competent care. This language was recommended by a NPAC member and supported by the committee. The definition and assessment of cultural competence are discussed more fully in the final report. Further explanation of the other terms provided in the Commentary as well as the discussion section of the final report.

**Standard 2**

One comment pointed out that “diverse staff” and “culturally competent staff” are two distinct concepts that have been combined in a single standard. The conceptual issues raised by combining in one standard two distinct notions about the staff of a culturally competent organization were addressed by separating the two different notions. With the deletion of “culturally

competent,” Standard 2 now focuses on the need for a diverse staff that reflects the racial/ethnic and cultural profile of the communities being served and is primarily concerned with strategies for staff recruitment and retention. Standard 3 now focuses on the need for cultural competence in that staff and addresses issues related to education and training.

Comments raised concerns about the definition of diverse staff in Standard 2. With additional input from the NPAC, the standard now defines a diverse staff within the standard as one that is “representative of the demographic characteristics of the service area.” The standard’s accompanying Commentary provides numerous examples of the types of staff members who should reflect the communities’ diversity.

Comments criticized the use of the phrase “administrative, clinical, and support staff” in the original draft standard. Although comments differ in their suggested approach, they expressed a consensus that the standard needs to be inclusive of all position levels in an organization. The revised standard substitutes “at all levels of the organization” for “administrative, clinical, and support staff.” The commentary accompanying the standard provides more detailed information about the various position levels and types of staff members that are included in this specification.

Public comments recommended making Standard 2 more inclusive by deleting the words “racial and ethnic.” The phrase was considered too limiting a descriptor of communities and not synonymous with culture or diversity. The term was deleted to encompass all cultural groups in the communities being served.

Public comments indicate that use of the term “qualified” staff within Standard 3 is controversial. Another issue is that the term “qualified” raises questions about its definition, including the different levels of qualification that might be required for various types of staff. NPAC input was sought on whether the term “qualified” should be included within the standard and, if it was to be included, how it should be defined in the Commentary. However, no consensus among the group was reached. One member urged that the issue be addressed in the final report if not in the commentary.

### **Standard 3**

Public comments focused on the nature of the organization’s responsibility in arranging for ongoing education and training. Interpretations differed on whether the original terminology, “arrange for,” implies that the organization itself should conduct in-service training or should be responsible merely for making arrangements and paying for the training to be offered (possibly outside of the organization) to staff members. Substitution of the term “ensure,” along with an explanation in the Commentary of the intent of the standard, clarifies the role of the health care organization.

Comments questioned whether specific types of staff members should be specified in Standard 3. Comments addressed the need to define who should be included in the various staff categories and to include all position levels in an organization. Similar comments were made about Standard 2, and a similar approach was used to revise Standard 3 with the substitution of “staff at all levels and across all disciplines” for “administrative, clinical, and support staff.”

More than 50 public comments on Standard 3 dealt with ways to offer more explicit guidance on cultural competency education and training. Comments emphasized the need to develop a standard or measures for cultural competency training; offered recommendations on the process of cultural competency education and training as well as specific topics that should be included in cultural competency trainings. Despite the preponderance of comments related to providing greater specificity about the conduct and evaluation of cultural competency education and training, the fact remains that there is no consensus on the definition of cultural competency or what constitutes a culturally competent health professional. Moreover, there are no standard curricula or universally accepted certification or credentialing for cultural competence and no standardized measures for evaluating the effectiveness of cultural competency trainings. Given the lack of certainty or consensus in this area, we sought NPAC advice on whether Standard 3 or its accompanying Commentary should be more prescriptive about the content and process of cultural competency education and training. The Commentary reflects suggestions by NPAC members.

#### **Standards 4 and 5**

Comments raised questions about the relationship between Standards 4, 5, and 6. The project team originally decided to combine Standards 4 and 5 as a complete articulation of the health care organization’s responsibility to advertise, offer, and provide language services as stipulated in Title VI of the Civil Rights Act of 1964. However, the NPAC thought that the obligation to provide verbal and written notices was sufficiently important to warrant its own standard. Thus, Standard 4 now addresses the organization’s obligation to offer and provide language assistance services, and Standard 5 addresses the obligation to provide verbal and written notices of patients’/consumers’ rights to such services.

Public comments emphasized the need to clarify the link between Standards 4 and 5 and Title VI of the Civil Rights Act of 1964. The link between these standards and Title VI and VII is explicitly highlighted in the Commentary, and organizations are referred to the August 30, 2000 Office for Civil Rights (OCR) guidance on Title VI with respect to LEP individuals [www.hhs.gov/ocr/lep](http://www.hhs.gov/ocr/lep). Because of this reference, language in the standard and commentary for Standards 4–7 was changed to reflect requirements of terminology in the guidance. For example, the term “language assistance

services,” taken from the OCR guidance, was chosen as a generic term for bilingual interpreter services, and written materials in other languages.

A reference to the needs of patients/consumers speaking American Sign Language (ASL) was made in the commentary in response to public comments.

#### **Standard 6**

Comments indicated confusion related to the abilities and responsibilities of bilingual staff who do not function as interpreters. Abilities and responsibilities of bilingual staff who communicate directly with patients/consumers are now specified in a paragraph in the commentary. NPAC comments were incorporated into descriptions of what constitutes the competence of these staff members as well as of interpreters. The abilities and responsibilities of interpreter staff are similarly addressed. The commentary now also addresses the need for assuring competence, and the requirements of Title VI with respect to assuring competence.

Numerous public comments and the NPAC raised issues related to the use of family and friends as interpreters. The wording in the standard about family and friends was revised, and additional details are provided in the commentary.

#### **Standard 7**

Comments suggested the deletion of the term “translated” and raised concerns about the advisability of merely translating materials versus creating original documents in non-English languages. The new standard no longer uses the term “translated.”

The term “signage” was cited in comments for being too vague and needing clarification. Public comments were addressed by including guidance in the commentary on the types of signage that should be translated. The NPAC suggested that signage in Standard 7 should not include the posted notices already addressed in Standard 5. The language of the standard was further refined to reflect NPAC input, and in the commentary, other types of notices (e.g., regarding patients rights) have been added to examples of way-finding signage.

Comments cited the term “commonly used” as being too “broad” or “unclear.” One concern is that the term could be interpreted as requiring translation of every document, however insignificant or large. Other comments raised questions about what constituted “patient education materials and other materials.” These comments have been addressed by deleting the term “commonly used” and using the broader term “patient-related materials” instead of patient education materials. “Patient-related materials” encompasses alternative formats (see below) as well as various forms, notifications, and health prevention and promotion materials. The standard’s

commentary refers organizations to the OCR guidance for examples of the types of documents that may be important to translate.

The term “predominant language groups” was commonly cited in public comments, many of which were concerned about the vagueness of the term. However, suggestions for defining the term varied. Public comments have been addressed by revising the language of the standard and including the clarification of requirements in the accompanying commentary. The term “commonly encountered,” as suggested in one comment, addresses the need for organizations and providers to assess needs in their particular service areas. It also is consistent with language in OCR Title VI policy guidance, which refers to “regularly encountered” language groups. Because there is existing policy guidance on the Federal mandate for translated materials, the standard’s commentary refers to that document for guidance in determining for which language groups materials should be translated.

There was a general consensus among commenters that materials should be consistent with a patient’s culture and literacy level. Comments emphasized that literal translation of patient information is not sufficient. Signage and materials also must use culturally appropriate images and take into account people’s acculturation levels, medical beliefs, and practice systems. The inappropriately high reading level for forms and health education materials in English was cited often, and this problem is compounded when materials with inappropriate reading levels are translated. The need for consistency with a patient’s culture and literacy levels was addressed in the discussion section of the original CLAS standards report. In response to public comments, the wording of the standard itself has been revised to include “easily understood.” The new terminology mirrors that used in the first article in the Consumer Bill of Rights and Responsibilities, which states that “Consumers have the right to receive accurate, *easily understood* information . . .” The term is intended to emphasize the need to help ensure the patient’s comprehension of information, a requirement that goes beyond mere literal translation. For further emphasis on this issue, the accompanying commentary for the standard specifies that signage and patient information should be responsive not only to language differences but also to patients’ cultures and literacy levels.

Comments called attention to the need for alternative formats to address the needs of people with sensory, developmental, and/or cognitive impairments and persons whose languages lack a written version. Public comments have been addressed by including in the standard’s commentary a reference to the need to develop alternative materials as a detail of the standard’s requirements. Deletion of the word “written” also addresses the issue raised in comments of providing information for people who are illiterate or whose language has no written form.

Public comments addressed issues concerning the appropriate translation process. In response to such comments, the commentary accompanying the standard now specifies three important aspects of the translation process: use of a trained translator, back translation and/or review by a target audience group, and periodic updates.

Comments expressed concern that Standard 7 could be interpreted as a way to replace oral interpretation with translated written materials. Rather than address this important concern by complicating the language of the standard itself, specific reference to the continued importance of oral interpretation is contained in the commentary accompanying the standard.

### **Standard 8**

Comments suggested that a rationale for the standard should be provided. Language from comments and the original report articulate the central nature of this standard, which is now stated in the first paragraph of the commentary.

Comments observed that the word “have” in the original standard lacked the power to convey the critical importance of the activities described in this standard. The response to these comments was to replace “have” with “develop, implement, and promote.”

Many comments spoke to the need for integrating CLAS into the mission and activities of the organization. This concept is now articulated in the commentary.

Nearly half of the comments on Standard 8 addressed the issue of internal and external accountability for cultural competence in an organization. Some comments identified a bottom-up or line-staff approach to initiating cultural competence activities, although most comments recognized the need for top management support for cultural competence to assure accountability and longevity, and shared responsibility for implementation throughout the organization. This issue is now raised in the commentary.

One comment directly addressed the need to involve communities and patient/consumers in the development of an organization’s management strategy on cultural competence. This issue is now mentioned in the commentary, with a reference to Standard 12, which more fully explores the role of community involvement.

In accordance with suggestions from the NPAC, “management strategy” has been changed to “strategic plan.”

### **Standard 9**

Comments pointed out the need to identify the purpose and use of the data collection activities called for in the CLAS standards. These comments have been addressed by describing the purpose of organizational self-assessment



at the beginning of the standard's commentary. The role of initial and ongoing organizational self-assessment is described in more detail in the discussion section of the final report.

The NPAC was divided on whether to classify Standard 9 as a guideline or recommendation. The two aspects of the standard—conducting an initial and ongoing self-assessment and integrating measures of cultural and linguistic competence into existing quality improvement activities—were supported by different levels of evidence. Self-assessment was considered by some committee members to be a prerequisite for developing the strategic plan called for in Standard 8. Consequently, this aspect of the standard has been identified as a guideline. Many public comments and NPAC members emphasized the importance of taking organizational self-assessment to another level by assessing the impact of CLAS services on patient care, access, satisfaction, and health outcomes. Because the current evidence base does not support a guideline to link organizational self-assessment with the impact of CLAS on patients, building such links is a recommendation of this standard.

Comments raised issues about the use of patient surveys in organizational self-assessments. Concerns were expressed about the need for the surveys to be culturally and linguistically appropriate, to be suitable for measuring patient acceptance or compliance, and to be jointly designed with the appropriate patient population. Comments also pointed out the difficulties in identifying valid patient surveys that can be used across cultures and the possibility that a qualitative approach might be more appropriate than patient surveys for finding out how serious organizations are about implementing the CLAS standards. The response to these comments is to include in the commentary a statement that patient/consumer and other community surveys are an important component of organizational self-assessment of cultural and linguistic competence, but they should not constitute the only self-assessment tool. The commentary also notes that these surveys should be culturally and linguistically appropriate. The final report will contain a discussion on patient satisfaction surveys.

Organizational self-assessment appears to be an issue for which many commenters sought clarification. Comments called for more specificity in Standard 9, made suggestions about the processes and components of self-assessment, addressed self-assessment tools, and discussed the need for and appropriateness of indicators and measures of organizational competence in CLAS. Although the general consensus of these comments was that the standard should be more prescriptive regarding the organizational self-assessment, no preferred process, tool, or measures emerged. This situation is mirrored in the field, where there also is a lack of consensus about what constitutes valid tools and measures for organizational cultural competence. Given the lack of information and consensus, we requested NPAC input on

what specific details, if any, should be provided to help organizations implement the standard. Input from NPAC members and other experts contributed to a discussion in the final report that will provide examples of ways that some organizations are linking self-assessment with CLAS impact.

#### **Standard 10**

Public comments focused on how the standard should describe the data collected on language. Clarification was requested on what was meant by “primary spoken language,” and several comments cited the need to address both written and spoken languages. Comments suggested using the term “preferred” language. The term “preferred” has the advantage of implying that the patient/consumer, rather than the organization’s staff, makes the decision about which language is noted in the management information system (MIS) and patient record. The response to the public comments is to use the term “preferred language” as well as both spoken and written languages in the standard. The commentary describes what is meant by “preferred” and “written” language.

One public comment raised the important issue of the potential for variations in data, depending on when they are collected. This comment recognizes that there may be multiple points of entry (e.g., physician’s office, pharmacy, and enrollment office) into a health care organization and that information may not be routinely shared across the various service components. To address this issue, the commentary calls for data to be collected at the patient’s/consumer’s first point of contact with the health care organization and be collected in health records and integrated into the organization’s MIS. This requirement is designed to ensure consistency and continuity of information across appropriate service components of the organization.

Public comments emphasized the importance of explaining the purpose of data collection, particularly to populations that may fear negative reprisals for providing personal information. To respond to this important concern, the commentary accompanying the standard lists five purposes for the collection of data on race/ethnicity and language.

More public comments addressed the issue of race/ethnicity data than any other topic related to this standard. Comments focused on how these data should be collected, including the need to collect information on subpopulations and to standardize race/ethnicity data, recommended systems for classifying race and ethnicity, and the importance of self-identified race/ethnicity. To respond to these concerns, the standard’s commentary recommends using the standard procedures and racial/ethnic categories specified in the Office of Management and Budget (OMB) standards for maintaining, collecting, and presenting Federal data on race and ethnicity (revision to OMB directive #15) and adapted in the U.S. Census 2000. In keeping with the OMB requirements and Census 2000, the commentary calls for organiza-

tions to allow individuals to select more than one race/ethnic category. The commentary also encourages organizations to enhance their information on subpopulations by collecting additional identifiers such as country of origin.

Comments and NPAC members suggested that data on language be inclusive of diverse dialects or languages such as American Sign Language (ASL). The response to these comments is to specify in the commentary that data collected on language should include dialects and ASL.

Public comments raised the issue of special data collection considerations that should be made in certain cases involving minor children. The response to these comments is to include in the commentary a statement calling for the collection and documentation of information about the preferred language and interpretation needs of non-English-speaking parents of an English-speaking minor child. NPAC input helped modify this statement.

Comments raised concerns about the confidentiality and privacy of individual data collected on language and race/ethnicity. In addition to clarifying the purpose of such data collection, the commentary for Standard 10 requires that health care organizations maintain all patient data according to the highest standard of confidentiality and privacy. In response to NPAC concerns, organizations also are asked to inform patients/consumers about the purposes of data collection and to emphasize that the data will not be used for discriminatory purposes. Additionally, the commentary states that no patient/consumer should be required to provide data on race, ethnicity, or language or be denied care or services if he or she chooses not to provide such information.

#### **Standard 11**

Comments cited a lack of clarity in the draft of Standard 11, but no consensus emerged on how to reframe the standard. Our deliberations on how to rewrite Standard 11 centered first on its purpose, which is now stated at the beginning of the commentary. Based on this identified goal, we have honed the focus of the standard on the maintenance of two tools for helping organizations understand their communities (i.e., a demographic, cultural, and epidemiological profile of the community, and a needs assessment) and on the use to which this information should be put (i.e., to plan for and implement responsive services). Additional details provided in the commentary are intended to further clarify the language of the standard.

Public comments suggested that the aggregate data collected under the terms of Standard 11 should be updated regularly. Two comments specifically suggested annual updates. Because many characteristics of a community change over time, it is important that health care organizations ensure that information on their community is up to date. However, some organizations might consider an annual update too burdensome. To address this issue without being too prescriptive, the revised standard requires organizations

to maintain a current profile of the community and needs assessment, and the commentary calls for organizations to obtain baseline data and update it regularly.

Comments and the NPAC discussed various methods and information sources that could be used to maintain the profile and the needs assessment. To respond to these comments, the commentary calls for health care organizations to use a variety of methods and information sources and presents examples of each.

Comments suggested that both qualitative and quantitative methods should be used to collect information on the community. These comments have been addressed by calling for the use of qualitative and quantitative methods in the standard's commentary.

Comments emphasized the need to involve the community in data collection efforts. This issue is addressed by including in the standard's commentary the reminder that health care organizations should involve the community in the design and implementation of the community profile and needs assessment in accordance with Standard 12.

At the request of the NPAC, the commentary includes a statement that organizations should not use the collected data for discriminatory purposes.

### **Standard 12**

Many comments focused on wordsmithing changes to the language of the draft standard. The standard has been streamlined, although the major thrust is the same. As rewritten, the standard is intended to be directive, but not prescriptive. The commentary provides a rationale for the standard, examples that elucidate key words, and examples of the types of activities in which communities might become involved.

Comments suggested that both informal and formal mechanisms should be used to facilitate community and patient/consumer involvement. This language has been added to the standard, along with examples of such mechanisms in the commentary.

Comments suggested using a stronger term than "involvement." At the suggestion of the NPAC, the standard was revised to recommend "participatory, collaborative partnerships" to strengthen the standard.

The NPAC did not achieve consensus on whether Standard 12 should be a guideline or recommendation. Although a summary chart developed by the NPAC at the committee meeting listed Standard 12 under guidelines, some individual members voiced a minority opinion that it should be a recommendation. Given the overwhelming number of public comments about the critical role of community in CLAS, in the final report, this standard is listed as a guideline.

**Standard 13**

Comments noted the ambiguity of certain terms used in the standard. The standard was rewritten based on several suggestions provided by commenters. “Develop structures and procedures to address” was replaced with “provide a process to identify, prevent, and resolve,” and additional details of staff and patient complaints were included in the commentary.

In response to public comments, language was included in the commentary that recognizes that many existing legal requirements cover some of the issues raised in the standard.

NPAC members recommended that staff issues be separated from patient/consumer issues because there are many mechanisms (e.g., EEO, labor grievance processes) within organizations to work with staff-staff problems. The revised standard focuses on conflict and grievance resolution processes for patients/consumers and does not refer to staff issues.

NPAC members expressed concerns that the draft standard did not provide a sufficient link with existing organizational mechanisms for patient complaint/grievance processes. Although it was suggested that complaint processes for cross-cultural issues should be integrated with existing mechanisms rather than be separate parallel systems, it was agreed that the key was that the process be culturally competent and include culturally competent staff. The revised standard calls for organizations to ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers, rather than develop structures and procedures to address cross-cultural issues.

**Standard 14**

The requirement in Standard 14 did not appear in any of the source documents for the original CLAS standards report. However, its inclusion as a CLAS standard was recommended and approved by the National Advisory Committee that met in July 1998. The original intent of the standard was to address the accountability of health care organizations to their patients/consumers and communities by calling for organizations to publish an annual report. However, opinions expressed in the public comments differed on the need for this standard as well as on the nature of the report and the extent to which its preparation should involve the community. A major issue was believed to be the fear that the standard would become a mandated process that would be used by Federal agencies as a monitoring tool. The general consensus of comments is that the standard must be more specific if it is to have any meaning.

Given the level of uncertainty about the report’s intended purpose and lack of specificity in the draft standard, the NPAC was requested to provide input

on the purpose of the annual report and on any details that should be added to the standard or commentary to help organizations implement this standard. The revised standard reflects the NPAC's consensus that the standard should be a recommendation rather than a guideline and that organizations should be encouraged not to make an annual report but rather to regularly make available to the public information about their progress in implementing the CLAS standards. The commentary explains the potential purposes of the standard and provides examples of ways that organizations could report this information.

After consideration of the comments received and further analysis of specific issues, the revised CLAS Standards are presented below.

## **National Standards for Culturally and Linguistically Appropriate Services in Health Care**

### **Preamble**

The following national standards issued by the U.S. Department of Health and Human Services' (HHS) Office of Minority Health (OMH) respond to the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner. These standards for culturally and linguistically appropriate services (CLAS) are proposed as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers. The standards are intended to be inclusive of all cultures and not limited to any particular population group or sets of groups; however, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services. Ultimately, the aim of the standards is to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.

The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1–3), Language Access Services (Standards 4–7), and Organizational Supports for Cultural Competence (Standards 8–14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

CLAS mandates are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7).

CLAS guidelines are activities recommended by OMH for adoption mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).

CLAS recommendations are suggested by OMH for voluntary adoption by health care organizations (Standard 14).

The standards are also intended for use by:

- *Policymakers*, to draft consistent and comprehensive laws, regulations, and contract language. This audience would include Federal, State and legislators, administrative and oversight staff, and program managers.
- *Accreditation and credentialing agencies*, to assess and compare providers who say they offer culturally competent services and to assure quality for diverse populations. This audience would include the Joint Commission on Accreditation of Organizations, the National Committee for Quality Assurance, professional organizations such as the American Medical Association and American Nurses Association, and quality review organizations such as peer review organizations.
- *Purchasers*, to advocate for the needs of ethnic consumers of health benefits, and leverage responses from insurers and health plans. This audience would include government and employer purchasers of health benefits, including labor unions.
- *Patients*, to understand their right to receive accessible and appropriate care services, and to evaluate whether providers can offer them.
- *Advocates*, to promote quality health care for diverse populations and to assess and monitor care being delivered by providers. The potential is wide, including legal services and consumer education/protection agencies; local and national ethnic, immigrant, and other community-focused organizations; and local and national nonprofit organizations that address health care issues.
- *Educators*, to incorporate cultural and linguistic competence into their curricula and to raise awareness about the impact of culture and language on health care delivery. This audience would include educators from health care professions and training institutions, as well as educators from legal and social services professions.
- *The health care community in general*, to debate and assess the applicability and adoption of culturally and linguistically appropriate health services into standard health care practice.

The CLAS standards employ key concepts that are defined as follows:

*CLAS standards:* The collective set of CLAS mandates, guidelines, and recommendations issued by the HHS Office of Minority Health intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services.

*Culture:* “The thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Culture defines how health care information is received, how rights and protections are exercised, what is considered to be a health problem, how symptoms and concerns about the problem are expressed, who should provide treatment for the problem, and what type of treatment should be given. In sum, because health care is a cultural construct, arising from beliefs about the nature of disease and the human body, cultural issues are actually central in the delivery of health services treatment and preventive interventions. By understanding, valuing, and incorporating the cultural differences of America’s diverse population and examining one’s own health-related values and beliefs, health care organizations, practitioners, and others can support a health care system that responds appropriately to, and directly serves the unique needs of populations whose cultures may be different from the prevailing culture” (Katz, Michael. Personal communication, November 1998).

*Cultural and linguistic competence:* “Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities” (Based on Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). *Towards A Culturally Competent System of Care Volume I*. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center).

*Culturally and linguistically appropriate services:* Health care services that are respectful of and responsive to cultural and linguistic needs.

*Health care organizations:* Any public or private institution involved in any aspect of delivering health care services.

*Patients/consumers:* Individuals, including accompanying family members, guardians, or companions, seeking physical or mental health care services, or other health-related services.

*Staff:* Individuals employed directly by a health care organization, as well as those subcontracted or affiliated with the organization.



**1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.**

This standard constitutes the fundamental requirement on which all activities specified in the other CLAS standards are based. Its intent is to ensure that all patients/consumers receiving health care services experience culturally and linguistically competent encounters with an organization's staff. The standard is relevant not only to staff, who ultimately are responsible for the kinds of interactions they have with patients, but also to their organizations, which must provide the managers, policies, and systems that support the realities of culturally competent encounters.

Respectful care includes taking into consideration the values, preferences, and expressed needs of the patient/consumer. Understandable care involves communicating in the preferred language of patients/consumers and ensuring that they understand all clinical and administrative information. Effective care results in positive outcomes for patients/consumers, including satisfaction; appropriate preventive services, diagnosis, and treatment; adherence; and improved health status.

Cultural competence includes being able to recognize and respond to health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy. Examples of culturally competent care include striving to overcome cultural, language, and communications barriers; providing an environment in which patients/consumers from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices in the context of negotiating treatment options; using community workers as a check on the effectiveness of communication and care; encouraging patients/consumers to express their spiritual beliefs and cultural practices; and being familiar with and respectful of various traditional healing systems and beliefs and, where appropriate, integrating these approaches into treatment plans. When individuals need additional assistance, it may be appropriate to involve a patient advocate, case manager, or ombudsperson with special expertise in cross-cultural issues.

Ways to operationalize this standard include implementing all the other CLAS standards. For example, in accordance with Standard 3, ensure that staff and other personnel receive cross-cultural education and training, and that their skills in providing culturally competent care are assessed through testing, direct observation, and monitoring of patient/consumer satisfaction with individual staff/personnel encounters. Assessment of staff and other personnel could also be done in the context of regular staff performance reviews or other evaluations that could be included in the organizational self-assessment called for in Standard 9. Health care organizations should provide patients/consumers with information regarding existing laws and

policies prohibiting disrespectful or discriminatory treatment or marketing/enrollment practices.

**2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.**

The diversity of an organization's staff is a necessary, but not sufficient, condition for providing culturally and linguistically appropriate health care services. Although hiring bilingual and individuals from different cultures does not in itself ensure that the staff is culturally competent and sensitive, this practice is a critical component to the delivery of relevant and effective services for all patients/consumers. Diverse staff is defined in the standard as being representative of the diverse demographic population of the service area and includes the leadership of the organization as well as its governing boards, clinicians, and administrative personnel. Building staff that adequately mirrors the diversity of the patient/consumer population should be based on continual assessment of staff demographics (collected as part of organizational self-assessment in accordance with Standard 9) as well as demographic data from the community maintained in accordance with Standard 11. Staff refers not only to personnel employed by the health care organization but also its subcontracted and affiliated personnel.

Staff diversity at all levels of an organization can play an important role in considering the needs of patients/consumers from various cultural and linguistic backgrounds in the decisions and structures of the organization. Examples of the types of staff members whose backgrounds should reflect the community's diversity include clinical staff such as doctors, nurses, and allied health professionals; support staff such as receptionists; administrative staff such as individuals in the billing department; clergy and lay volunteers; and high-level decisionmakers such as senior managers, corporate executives, and governing bodies such as boards of directors.

Acknowledging the practical difficulties in achieving full racial, ethnic, and cultural parity within the workforce, this standard emphasizes commitment and a good-faith effort rather than specific outcomes. It focuses not on numerical goals or quotas, but rather on the continuing efforts of an organization to design, implement, and evaluate strategies for recruiting and retaining a diverse staff as well as continual quality evaluation of improvements in this area. The goal of staff diversity should be incorporated into organizations' mission statements, strategic plans, and goals. Organizations should use proactive strategies, such as incentives, mentoring programs, and partnerships with local schools and employment programs, to build diverse workforce capacity. Organizations should encourage the retention of diverse staff by fostering a culture of responsiveness toward the ideas and challenges that a culturally diverse staff offers.

**3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.**

Hiring a diverse staff does not automatically guarantee the provision of culturally competent care. Staff education and training are also crucial to ensuring CLAS delivery because all staff will interact with patients/consumers representing different countries of origin, acculturation levels, and social and economic standing. Staff refers not only to personnel employed by the health care organization but also its subcontracted and affiliated personnel.

Health care organizations should either verify that staff at all levels and in all disciplines participate in ongoing CME- or CEU-accredited education or other training in CLAS delivery, or arrange for such education and training to be made available to staff. This training should be based on sound educational (i.e., adult learning) principles, include pre- and post-training assessments, and be conducted by appropriately qualified individuals. Training objectives should be tailored for relevance to the particular functions of the trainees and the needs of the specific populations served, and over time should include the following topics:

- Effects of differences in the cultures of staff and patients/consumers on clinical and other workforce encounters, including effects of the culture of American medicine and clinical training;
- Elements of effective communication among staff and patients/consumers of different cultures and different languages, including how to work with interpreters and telephone language services;
- Strategies and techniques for the resolution of racial, ethnic, or cultural conflicts between staff and patients/consumers;
- Health care organizations' written language access policies and procedures, including how to access interpreters and translated written materials;
- The applicable provisions of: (1) Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d, 45 C.F.R. 80.1 et seq. (including Office for Civil Rights Guidance on Title VI of the Civil Rights Act of 1964, with respect to services for (LEP) individuals (65 FR 52762–52774, August 30, 2000);
- Health care organizations' complaint/grievance procedures;
- Effects of cultural differences on health promotion and disease prevention, diagnosis and treatment, and supportive, rehabilitative, and end-of-life care;
- Impact of poverty and socioeconomic status, race and racism, ethnicity, and sociocultural factors on access to care, service utilization, quality of care, and health outcomes;

- Differences in the clinical management of preventable and chronic diseases and conditions indicated by differences in the race or ethnicity of patients/consumers; and
- Effects of cultural differences among patients/consumers and staff upon health outcomes, patient satisfaction, and clinical management of preventable and chronic diseases and conditions.

Organizations that conduct the trainings should involve community representatives in the development of CLAS education and training programs, in accordance with Standard 12.

**4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.**

Standards 4, 5, 6, and 7 are based on Title VI of the Civil Rights Act of 1964 (Title VI) with respect to services for limited English proficient (LEP) individuals. Title VI requires all entities receiving Federal financial assistance, including health care organizations, take steps to ensure that LEP persons have meaningful access to the health services that they provide. The key to providing meaningful access for LEP persons is to ensure effective communication between the entity and the LEP person. For complete details on compliance with these requirements, consult the HHS guidance on Title VI with respect to services for (LEP) individuals (65 FR 52762–52774, August 30, 2000) at [www.hhs.gov/ocr/lep](http://www.hhs.gov/ocr/lep).

Language services, as described below, must be made available to each individual with limited English proficiency who seeks services, regardless of the size of the individual's language group in that community. Such an individual cannot speak, read, or understand the English language at a level that permits him or her to interact effectively with clinical or nonclinical staff at a health care organization. (Patients needing services in American Sign Language would also be covered by this standard, although other Federal laws and regulations apply and should be consulted separately.)

Language services include, as a first preference, the availability of bilingual staff who can communicate directly with patients/consumers in their preferred language. When such staff members are not available, face-to-face interpretation provided by trained staff, or contract or volunteer interpreters, is the next preference. Telephone interpreter services should be used as a supplemental system when an interpreter is needed instantly, or when services are needed in an unusual or infrequently encountered language. The competence and qualifications of individuals providing language services are discussed in Standard 6.

**5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.**

LEP individuals should be informed—in a language they can understand—that they have the right to free language services and that such services are readily available. At all points of contact, health care organizations should also distribute written notices with this information and post translated signage. Health care organizations should explicitly inquire about the preferred language of each patient/consumer and record this information in all records. The preferred language of each patient/consumer is the language in which he or she feels most comfortable in a clinical or nonclinical encounter.

Some successful methods of informing patients/consumers about language assistance services include: (a) using language identification or “I speak . . .” cards; (b) posting and maintaining signs in regularly encountered languages at all points of entry; (c) creating uniform procedures for timely and effective telephone communication between staff and LEP persons; and (d) including statements about the services available and the right to free language assistance services in appropriate non-English languages in brochures, booklets, outreach materials, and other materials that are routinely distributed to the public.

**6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).**

Accurate and effective communication between patients/consumers and clinicians is the most essential component of the health care encounter. Patients/consumers cannot fully utilize or negotiate other important services if they cannot communicate with the nonclinical staff of health care organizations. When language barriers exist, relying on staff who are not fully bilingual or lack interpreter training frequently leads to misunderstanding, dissatisfaction, omission of vital information, misdiagnoses, inappropriate treatment, and lack of compliance. It is insufficient for health care organizations to use any apparently bilingual—person for delivering language services they must assess and ensure the training and competency of individuals who deliver such services.

Bilingual clinicians and other staff who communicate directly with patients/consumers in their preferred language must demonstrate a command of both English and the target language that includes knowledge and facility with the terms and concepts relevant to the type of encounter. Ideally, this should be verified by formal testing. Research has shown that individuals with exposure to a second language, even those raised in bilingual homes, frequently overestimate their ability to communicate in that language, and

make errors that could affect complete and accurate communication and comprehension.

Prospective and working interpreters must demonstrate a similar level of bilingual proficiency. Health care organizations should verify the completion of, or arrange for, formal training in the techniques, ethics, and cross-cultural issues related to medical interpreting (a minimum of 40 hours is recommended by the National Council on Interpretation in Health Care). Interpreters must be assessed for their ability to convey information accurately in both languages before they are allowed to interpret in a health care setting.

In order to ensure complete, accurate, impartial, and confidential communication, family, friends or other individuals, should not be required, suggested, or used as interpreters. However, a patient/consumer may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services unless the effectiveness of services is compromised or the LEP person's confidentiality is violated. The health care organization's staff should suggest that a trained interpreter be present during the encounter to ensure accurate interpretation and should document the offer and declination in the LEP person's file. Minor children should never be used as interpreters, nor be allowed to interpret for their parents when they are the patients/consumers.

**7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.**

An effective language assistance program ensures that written materials routinely provided in English to applicants, patients/consumers, and the public are available in commonly encountered languages other than English. It is important to translate materials that are essential to patients/consumers accessing and making educated decisions about health care. Examples of relevant patient-related materials include applications, consent forms, and medical or treatment instructions; however, health care organizations should consult OCR guidance on Title VI for more information on what the Office considers to be "vital" documents that are particularly important to ensure translation (65 FR 52762–52774, August 30, 2000) at [www.hhs.gov/ocr/lep](http://www.hhs.gov/ocr/lep).

Commonly encountered languages are languages that are used by a significant number or percentage of the population in the service area. Consult the OCR guidance for guidelines regarding the LEP language groups for which translated written materials should be provided. Persons in language groups that do not fall within these guidelines should be notified of their right to receive oral translation of written materials.

Signage in commonly encountered languages should provide notices of a variety of patient rights, the availability of conflict and grievance resolution processes, and directions to facility services. Way-finding signage should identify or label the location of specific services (e.g., admissions, pediatrics, emergency room). Written notices about patient/consumer rights to receive language assistance services are discussed in Standard 5.

Materials in commonly encountered languages should be responsive to the cultures as well as the levels of literacy of patients/consumers. Organizations should provide notice of the availability of oral translation of written materials to LEP individuals who cannot read or who speak nonwritten languages. Materials in alternative formats should be developed for these individuals as well as for people with sensory, developmental, and/or cognitive impairments.

The obligation to provide meaningful access is not limited to written translations. Oral communication often is a necessary part of the exchange of information, and written materials should never be used as substitutes for oral interpreters. A health care organization that limits its language services to the provision of written materials may not be allowing LEP persons equal access to programs and services available to persons who speak English.

Organizations should develop policies and procedures to ensure development of quality non-English signage and patient-related materials that are appropriate for their target audiences. At a minimum, the translation process should include translation by a trained individual, back translation and/or review by target audience groups, and periodic updates.

It is important to note that in some circumstances verbatim translation may not accurately or appropriately convey the substance of what is contained in materials written in English. Additionally, health care organizations should be aware of and comply with existing State or local nondiscrimination laws that are not superseded by Federal requirements.

**8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.**

Successful implementation of the CLAS standards depends on an organization's ability to target attention and resources on the needs of culturally diverse populations. The purpose of strategic planning is to help the organization define and structure activities, policy development, and goal setting relevant to culturally and linguistically appropriate services. It also allows the agency to identify, monitor, and evaluate system features that may warrant implementing new policies or programs consistent with the overall mission.

The attainment of cultural competence depends on the willingness of the organization to learn and adapt values that are explicitly articulated in its guiding mission. A sound strategic plan for CLAS is integrally tied to the organization's mission, operating principles, and service focus. Accountability for CLAS activities must reside at the highest levels of leadership including the governing body of the organization. Without the strategic plan, the organization may be at a disadvantage to identify and prioritize patient/consumer service need priorities.

Designated personnel or departments should have authority to implement CLAS-specific activities as well as to monitor the responsiveness of the whole organization to the cultural and linguistic needs of patients/consumers.

Consistent with Standard 12, the strategic plan should be developed with the participation of consumers, community, and staff who can convey the needs and concerns of all communities and all parts of the organization affected by the strategy. And, consistent with Standards 9, 10, and 11, the results of data gathering and self-assessment processes should inform the development and refinement of goals, plans, and policies.

**9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.**

Ideally, these self-assessments should address all the activities called for in the 14 CLAS standards. Initial self-assessment, including an inventory of organizational policies, practices, and procedures, is a prerequisite to developing and implementing the strategic plan called for in Standard 8. Ongoing self-assessment is necessary to determine the degree to which the organization has made progress in implementing all the CLAS standards. The purpose of ongoing organizational self-assessment is to obtain baseline and updated information that can be used to define service needs, identify opportunities for improvement, develop action plans, and design programs and activities. The self-assessment should focus on the capacities, strengths, and weaknesses of the organization in meeting the CLAS standards.

Integrating cultural and linguistic competence-related measures into existing quality improvement activities will also help institutionalize a focus on CLAS within the organization. Linking CLAS-related measures with routine quality and outcome efforts may help build the evidence base regarding the impact of CLAS interventions on access, patient satisfaction, quality, and clinical outcomes.

Patient/consumer and community surveys and other methods of obtaining input are important components of organizational quality improvement



activities. But they should not constitute the only method of assessing quality with respect to CLAS. When used, such surveys should be culturally and linguistically appropriate.

**10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.**

The purposes of collecting information on race, ethnicity, and language are to:

- Adequately identify population groups within a service area;
- Ensure appropriate monitoring of patient/consumer needs, utilization, quality of care, and outcome patterns;
- Prioritize allocation of organizational resources;
- Improve service planning to enhance access and coordination of care; and
- Assure that health care services are provided equitably.

Collection of data on self-identified race/ethnicity should adhere to the standard procedures and racial and ethnic categories specified in the Office of Management and Budget's most current policy directive and adapted in the U.S. Census 2000. To improve the accuracy and reliability of race and ethnic identifier data, health care organizations should adapt intake and registration procedures to facilitate patient/consumer self-identification and avoid use of observational/visual assessment methods whenever possible. Individuals should be allowed to indicate all racial and ethnic categories that apply. Health care organizations can enhance their information on subpopulation differences by collecting additional identifiers such as self-identified country of origin, which provides information relevant to patient/consumer care that is unobtainable from other identifiers.

The purpose of collecting information on language is to enable staff to identify the preferred mode of spoken and written communication that a patient/consumer is most comfortable using in a health care encounter. Language data also can help organizations develop language services that facilitate LEP patients/consumers receiving care in a timely manner. To improve the accuracy and reliability of language data, health care organizations should adapt procedures to document patient/consumer preferred spoken and written language. Written language refers to the patient/consumer preference for receiving health-related materials. Data collected on language should include dialects and American Sign Language.

For health encounters that involve or require the presence of a legal parent or guardian who does not speak English (e.g., when the patient/consumer is a minor or severely disabled), the management information system record

and chart should document the language not only of the patient/consumer but also of the accompanying adult(s).

Health care organizations should collect data from patients/consumers at the first point of contact using personnel who are trained to be culturally competent in the data collection process. Health care organizations should inform patients/consumers about the purposes (as stated above) of collecting data on race, ethnicity, and language, and should emphasize that such data are confidential and will not be used for discriminatory purposes. No patient/consumer should be required to provide race, ethnicity, or language information, nor be denied care or services if he or she chooses not to provide such information. All patient/consumer data should be maintained according to the highest standards of ethics, confidentiality, and privacy, and should not be used for discriminatory purposes.

**11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.**

The purpose of this standard is to ensure that health care organizations obtain a variety of baseline data and update the data regularly to better understand their communities, and to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Health care organizations should regularly use a variety of methods and information sources to maintain data on racial and ethnic groups in the service area. It is important that health care organizations go beyond their own data, such as marketing, enrollment, and termination figures, which may provide an incomplete portrait of the potential patient/consumer population, many of whom may not be aware of or use the organization's services. A more useful and in-depth approach would use data sources such as census figures and/or adjustments, voter registration data, school enrollment profiles, county and State health status reports, and data from community agencies and organizations. Both quantitative and qualitative methods should be used to determine cultural factors related to patient/consumer needs, attitudes, behaviors, health practices, and concerns about using health care services as well as the surrounding community's resources, assets, and needs related to CLAS. Methods could include epidemiological and ethnographic profiles as well as focus groups, interviews, and surveys conducted in the appropriate languages spoken by the patient/consumer population. Health care organizations should not use the collected data for discriminatory purposes.

In accordance with Standard 12, health care organizations should involve the community in the design and implementation of the community profile and needs assessment.

**12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.**

The culturally competent organization views responsive service delivery to a community as a collaborative process that is informed and influenced by community interests, expertise, and needs. Services that are designed and improved with attention to community needs and desires are more likely to be used by patients/consumers, thus leading to more acceptable, responsive, efficient, and effective care. As described below, this standard addresses two levels of consumer/patient and community involvement that are not token in nature, but involve working with the community in a mutual exchange of expertise that will help shape the direction and practices of the health care organization.

Patients/consumers and community representatives should be actively consulted and involved in a broad range of service design and delivery activities. In addition to providing input on the planning and implementation of CLAS activities, they should be solicited for input on broad organizational policies, evaluation mechanisms, marketing and communication strategies, staff training programs, and so forth. There are many formal and informal mechanisms available for this, including participation in governing boards, community advisory committees, ad hoc advisory groups, and community meetings as well as informal conversations, interviews, and focus groups.

Health care organizations should also collaborate and consult with community-based organizations, providers, and leaders for the purposes of partnering on outreach, building provider networks, providing service referrals, and enhancing public relations with the community being served.

Related to Standard 11, health care organizations should involve relevant community groups and patients/consumers in the implementation of the community profile and needs assessment.

**13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.**

This standard requires health care organizations to anticipate and be responsive to the inevitable cross-cultural differences that arise between patients/consumers and the organization and its staff. Ideally, this responsiveness may be achieved by integrating cultural sensitivity and staff diversity into existing complaint and grievance procedures as well as into policies, programs, offices or committees charged with responsibility for patient relations, and legal or ethical issues. When these existing structures are inadequate, new approaches may need to be developed. Patients/consumers who bring racial, cultural, religious, or linguistic differences to the health care

setting are particularly vulnerable to experiencing situations where those differences are not accommodated or respected by the health care institution or its staff. These situations may range from differences related to informed consent and advanced directives, to difficulty in accessing services or denial of services, to outright discriminatory treatment. Health care organizations should ensure that all staff members are trained to recognize and prevent these potential conflicts, and that patients are informed about and have access to complaint and grievance procedures that cover all aspects of their interaction with the organization. In anticipation of patients/consumers who are not comfortable with expressing or acting on their own concerns, the organization should have informal and formal procedures such as focus groups, staff-peer observation, and medical record review to identify and address potential conflicts.

Among the steps health care organizations can take to fulfill this standard are: providing cultural competence training to staff who handle complaints and grievances or other legal or ethical conflict issues; providing notice in other languages about the right of each patient/consumer to file a complaint or grievance; providing the contact name and number of the individual responsible for disposition of a grievance; and offering ombudsperson services. Health care organizations should include oversight and monitoring of these culturally or linguistically related complaints/grievances as part of the overall quality assurance program for the institution.

**14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.**

Sharing information with the public about a health care organization's efforts to implement the CLAS standards can serve many purposes. It is a way for the organization to communicate to communities and patients/consumers about its efforts and accomplishments in meeting the CLAS standards. It can help institutionalize the CLAS standards by prompting the organization to regularly focus on the extent to which it has implemented each standard. It also can be a mechanism for organizations to learn from each other about new ideas and successful approaches to implementing CLAS.

Health care organizations can exercise considerable latitude in both the information they make available and the means by which they report it to the public. For example, organizations can describe specific organizational changes or new programs that have been instituted in response to the standards, CLAS-related interventions or initiatives undertaken, and/or accomplishments made in meeting the needs of diverse populations. Organizations that wish to provide more in-depth information can report on the data collected about the populations and communities served in accordance with

Standard 11 and the self-assessment results gathered from Standard 9. Organizations should not report scores or use data from self-assessment tools that have not been validated. However, as standard self-assessment instruments and performance measures are developed and validated, additional information gathered by using these tools could be made available to the public.

Health care organizations can use a variety of methods to communicate or report information about progress in implementing the CLAS standards, including publication of stand-alone documents focused specifically on cultural and linguistic competence or inclusion of CLAS components within existing organizational reports and documents. Other channels for sharing this information include the organization's member publications; newsletters targeting the communities being served; presentations at conferences; newspaper articles; television, radio, and other broadcast media; and postings on Web sites.

The complete report, along with supporting material, is available online at [www.OMHRC.gov/clas](http://www.OMHRC.gov/clas).

**DATED:** December 15, 2000.

**Nathan Stinson, Jr.**, Deputy Assistant Secretary for Minority Health



# Glossary

**Affidavits of Support (New):** A legally enforceable agreement between the federal government and an immigrant's sponsor to provide sufficient support to maintain an immigrant at 125 percent of the federal poverty level. Nearly all family-based and some employment-based immigrant visa applicants have to submit the new affidavit of support, Form I-864, which became effective December 19, 1997. For anyone not required to use the new form, the traditional affidavit of support, Form I-143, and the rules governing its use remain in effect.

**Affidavit of Support (Old):** (Form I-143) A non-binding statement by an immigrant's sponsor to provide financial support to the immigrant.

**Amerasian:** A child fathered by a U.S. citizen in certain Southeast Asian countries during the years of U.S. conflict in that region. Amerasians are "qualified" immigrants because they were given Legal Permanent Resident (LPR) status under special provisions of the immigration law.

**American Indian born in Canada, and certain other tribal members born outside the United States:** People who possess at least 50 percent of the blood of the American Indian race who were born in Canada or outside the United States (8 U.S.C. Section 1359 & 25 U.S.C. Section 450b(e)).

**Asylee:** An immigrant who flees his or her country in fear of persecution or with a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group and who is already present in the United States at the time he/she obtained asylum.

**Battered immigrant spouse or child:** A qualified immigrant who: (1) is a victim of domestic violence, (2) has a pending or approved visa petition filed by a U.S. citizen or LPR spouse/parent, a self-petition pursuant to VAWA, or an application for cancellation of a removal/suspension of deportation under VAWA, and (3) whose need for benefits have a substantial connection to the battery or cruelty. Also includes the parent of a battered child and the child of a battered spouse.

**BBA:** Balanced Budget Act of 1997.

**Border crossing identification card:** A document of identity bearing the designation issued to an immigrant who is lawfully admitted for permanent residence, or to an immigrant who is a resident in foreign contiguous territory, by a counselor or officer or immigration officer for the purpose of crossing over the borders between the United States and foreign contiguous territory (8 U.S.C. Section 1101(6)).

**Categorically needy:** Individuals who either qualify automatically for Medicaid because they are eligible for another form of assistance (i.e., Supplemental Security Income), or they fit into specified groups of low-income families and children, or low-income aged, blind, or disabled individuals.

**Centers for Medicare and Medicaid Services (CMS):** The federal agency in charge of Medicare and Medicaid. (This agency was formerly called Health Care Financing Administration [HCFA].)

**Cuban and Haitian entrant:** A person paroled into the United States as a Cuban or Haitian entrant or any other national from Cuba or Haiti who is the subject of exclusion or removal proceedings or who has an application for asylum pending. Cuban and Haitian entrants are “qualified” immigrants (Refugee Education Assistance Act of 1980, Section 501(e)).

**Deeming:** The act of adding the income and resources of another person to the income and resources of an applicant to determine eligibility for federal or state public benefits.

**Diversity immigrant:** An immigrant who has obtained a visa through the diversity visa process. That is a program that makes available 55,000 visas yearly to applicants who: (1) are natives of countries that provided fewer than 50,000 immigrants to the United States over the preceding five years; and (2) have at least a high school education or its equivalent, or have worked for at least two years in an occupation that requires two years of training or experience.

**Emergency Medicaid:** A form of Medicaid that pays only for the treatment of an emergency medical condition for any immigrant, regardless of immigration status.

**Emergency medical condition:** The sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

**Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA):** The federal anti-dumping statute that requires all hospitals receiving Medicare to examine and provide stabilizing treatment to all patients seeking care for emergency conditions, regardless of their ability to pay and regardless of their eligibility to Medicare (42 U.S.C. Section 1395dd).



**Federal means-tested public benefits:** Defined as Supplemental Security Income (SSI), Medicaid, Temporary Assistance to Needy Families (TANF), Food Stamps and the State Children’s Health Insurance Program (SCHIP). Unless specifically exempted by law, qualified immigrants who enter the United States after August 22, 1996, are ineligible for any federal means-tested public benefit for their first five years in the country.

**Federal poverty level (FPL):** The amount of income established by the federal government below which a person is considered to lack adequate support for subsistence. FPL is used to establish eligibility for various federal and state benefit programs. It is also known as the Federal Income Guideline.

**Federal public benefit:** Described in PRWORA as: retirement, welfare, health, disability, assisted housing, post-secondary education, food assistance, unemployment benefits, or “any other similar benefit” for which payments/assistance are provided to an individual/household by a U.S. agency or with U.S. funds. Federal public benefits also include any government grant, contract, loan, or professional or commercial license.

**Five-year bar:** The period of time during which most qualified immigrants who enter the United States on or after August 22, 1996, are barred from receipt of Medicaid and other federal means-tested public benefits.

**Forty credited quarters:** The term that refers to Social Security credits earned. A person earns Social Security credits by working at a job or as a self-employed individual. For 1978 and later, the number of credits that can be earned is based solely on the person’s total yearly earnings. A maximum of four credits can be earned each year. The amount of earnings needed to earn a credit increases and is different for each year. Generally, a person with forty credited quarters would have to have a 10-year work history. To meet the 40 quarters threshold, immigrants may receive credit for work performed: (1) by their parents when the immigrant is under 18, and (2) by a spouse during the marriage (unless the marriage ended in divorce or annulment); however, no credit is given for a quarter worked after December 31, 1996, if a federal means-tested benefit is received in that quarter.

**Health Care Financing Administration (HCFA):** This agency was renamed Centers for Medicare and Medicaid (CMS).

**Hill-Burton Act:** A federal law that provided grants to states to build hospitals and other health care facilities. Hospitals and health care facilities built with Hill-Burton funds assume obligations to provide community services and, to a more limited degree, free care.

**Immigrant:** A person who is not a U.S. citizen or national who enters the United States with the intent to remain for an indefinite period of time.

**Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA):** Federal statute that imposes restrictions on immigrants’ access to benefits.

**Immigration and Naturalization Service of the United States (INS):** An agency within the Department of Justice which oversees the implementation of the federal immigration and naturalization laws, including the immigration, exclusion, deportation, expulsion, or removal of immigrants (\* U.S.C. §1101(17) & (34)).

**Immigration status:** The legal or illegal character or condition under which an immigrant has entered the United States.

**Lawfully present:** A person who has entered or remains in the United States with legal immigration status.

**Legal (or lawful) permanent resident (LPR):** An immigrant who has been granted lawful permanent residence status, i.e., who is a green card holder, and is entitled to remain in the United States indefinitely.

**Limited English proficiency (LEP):** A term used to describe a person whose primary language is other than English and whose written and oral skill level with English is limited.

**Mandatory state supplement:** Cash payments that states are required to make to aged, blind, or disabled individuals in order to provide them with the same amount of cash assistance they were receiving before the SSI program was established.

**Medicaid:** A joint federal/state entitlement program that provides health insurance coverage for low-income people meeting minimum income and other eligibility standards.

**Medically needy:** Individuals who fit into federal Medicaid program eligibility categories, but whose income and resources are above the categorically needy levels. States that opt to provide Medicaid for the medically needy allow applicants to “spend down” to eligibility by incurring medical expenses.

**Noncitizen:** Any person who is not a U.S. citizen or national.

**Nonexempt federal means-tested public benefits:** SSI, TANF, Food Stamps, nonemergency Medicaid and SCHIP benefits.

**Nonprofit, charitable organization:** An organization that is: (1) created and operated for purposes other than making gains or profits for the organization, its member, or its shareholders, and that is precluded from distributing any gains or profits to its members or shareholders, and (2) organized and operated for charitable purposes such as relief to the poor, distressed, or underprivileged, as well as religiously affiliated and educational institutions.

**Not-qualified immigrants:** Immigrants who do not fall within the “qualified” immigrant categories, including persons residing under color of law, such as applicants for asylum and family unity and applicants for adjustment of status, undocumented immigrants, and non-immigrants such as students and foreign visitors.

**Parolee for more than one year:** A qualified immigrant who has been paroled into the United States for at least one year.

**Persons residing under color of law (PRUCOL):** This includes the following immigrants: (1) granted indefinite voluntary departure, (2) residing in the United States under orders of supervision, (3) continuously living in the United States since January 1, 1972, (4) granted stays or suspension of deportation, or (5) whose departure the INS does not contemplate enforcing.

**Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA):** This is the welfare reform statute that replaced the Aid to Dependent Children (AFDC) entitlement with block grants to the states for temporary assistance for needy families (TANF); imposed new restrictions on immigrants' access to public benefits, and made it more difficult for children with disabilities to obtain Supplemental Security Income.

**"Pickle people":** Individuals who are ineligible for Supplemental Security Income or State Supplemental Payments because they have received Social Security cost-of-living increases that place their incomes above eligibility guidelines. Pickle people are categorically eligible for Medicaid. (The name Pickle refers to Congressman Jake Pickle who worked on changing the law to provide eligibility for these people under Medicaid.)

**Presumptive Eligibility:** At state option, a temporary Medicaid eligibility status that allows pregnant women and children to obtain Medicaid coverage without completing the formal Medicaid application process and waiting for an eligibility determination.

**Public charge:** Determination by the INS or the State Department that an immigrant is likely to become primarily dependent on government public benefits for subsistence.

**Qualified immigrant:** A lawful permanent resident, a refugee; an asylee; an immigrant who had deportation withheld; an immigrant granted parole for at least one year; an immigrant granted conditional entry; a battered immigrant and her child/children; and immigrants born in Canada who possess at least 50 percent blood of the American Indian race, or are members of certain Indian tribes.

**Refugee:** An immigrant who flees his or her country due to persecution or a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group and who obtains the status while abroad.

**Retroactive Medicaid:** The three-month period of time before the date of a Medicaid application during which the state must pay for Medicaid-reimbursable medical services received by the recipient. The recipient is eligible for retroactive Medicaid only if he/she would have been eligible had he/she applied for Medicaid at the time services were received.

**Section 1931:** A section in the Personal Responsibility and Work Opportunity Reconciliation Act that is intended to ensure that low-income families remain eligible for Medicaid after repeal of the AFDC program. Under Section 1931, low-income families with dependent children are eligible for Medicaid if they meet the income and resource standards of the Aid to Families with Dependent Children Program in effect in the state as of July 14, 1996.

**Sponsor:** A person who signs an affidavit of support for a person who is applying to immigrate to the United States as a resident. A sponsor must be a U.S. citizen, national, or Legal Permanent Resident, 18 years or older, domiciled in the United States, and must meet income/assets requirements.

**Sponsor-deeming of income:** For any federal means-tested public benefits program, such as TANF, SSI, Food Stamps, CHIP, and Medicaid, the income and resources of a sponsor are added to those of the immigrant when determining eligibility for, and amount of, benefits available under each of the programs

**State Children's Health Insurance Program (SCHIP):** Federally funded program to enable the states to provide health insurance to uninsured, "targeted low-income" children under the age of 19 and whose family income meets state-specified guidelines.

**Totality of circumstances test:** In making public charge determinations, the INS and State Department must look at the immigrant's total circumstances including his/her: (1) age, (2) health, (3) family status, (4) financial status, and (5) education and skills.

**Transitional Medical Assistance (TMA):** Time-limited Medicaid coverage that is provided to families with children who are no longer eligible for Medicaid because of increased earnings. Families are entitled to receive the first six months of TMA, regardless of their income. They may be eligible for another six months of TMA depending on their income and compliance with certain reporting requirements.

**"209(b) state":** A state that has opted to provide Medicaid using more restrictive definitions of blindness or disability, or using more restrictive financial eligibility standards then are used in the SSI program.

**Undocumented immigrant:** A person who is not a U.S. citizen or national, who has entered the United States (or has remained in the United States) without proper documentation and who does not have legal status for immigration purposes.

**Withholding of removal (formerly withholding of deportation):** A person who has been granted withholding of removal and is eligible for the refugee exemption, even if he/she has subsequently adjusted to LPR status.

## About the Author

Claudia Schlosberg currently serves as a Senior Civil Rights Analyst at the Office for Civil Rights for the U.S. Department of Health and Human Services. She was the staff attorney for the Washington, D.C. office of the National Health Law Program (NHeLP) when she prepared this manual. She was responsible for federal legislative and administrative advocacy on health issues affecting low-income people and for providing technical assistance and information to attorneys and advocates nationwide while at NHeLP.

Before joining the National Health Law Program in September 1996, Claudia was a senior staff attorney at the Judge David L. Bazelon Center for Mental Health Law. While there she was involved in advocacy and system change litigation to improve institutional and community-based services for adults and seniors with serious mental illness. Claudia also worked extensively with consumer groups and on Medicaid “restructuring” issues, i.e., managed care, for people with disabilities.

Since 1988, Claudia has served as legal adviser to the D.C. Long-Term Care Ombudsman Program. As legal adviser, she has represented the Ombudsman and residents in administrative and judicial proceedings and provided legal advice and assistance regarding nursing home and long-term care quality issues and residents’ rights.

Claudia has also served as a training consultant for the National Training Project of the American Association of Retired Persons/Legal Counsel for the Elderly and has trained Ombudsman staff and attorneys regarding nursing home law and advocacy throughout the United States.

Prior to 1988, Claudia directed Advocacy for the Elderly, a legal clinic of the Columbus School of Law at Catholic University, where she taught and supervised evening division law students who were providing legal services to homebound and institutionalized elderly residents of the District of Columbia. She was also in private practice for four years handling criminal, juvenile, domestic relations, and general civil litigation.

Claudia received her law degree from Antioch School of Law in 1981 and graduated from Union College with a B.A. in history in 1976.

