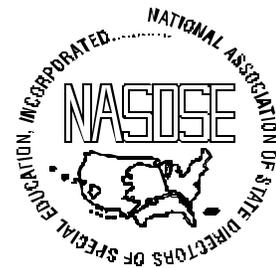


# *Opportunities for Collaboration Across Human Services Programs*

A Joint Project of





## Table of Contents

<b>Transmittal Letter.....</b>	<b>5</b>
<b>Introduction.....</b>	<b>7</b>
<b>Participating Organizations.....</b>	<b>10</b>
<b>Program Descriptions.....</b>	<b>13</b>
Child Care .....	15
Child Support.....	19
Child Welfare.....	23
Community Services.....	29
Developmental Disabilities Services.....	35
Food Stamps.....	41
Medicaid.....	47
Mental Health Agencies.....	51
Special Education.....	55
Substance Abuse.....	59
Temporary Assistance for Needy Families.....	63
Vocational Rehabilitation.....	67
Workforce Development.....	73
Workforce Investment Boards.....	77



## **Opportunities for Collaboration Across Human Services Programs**

Dear Colleague:

Most human service programs share the common goal of working to improve the social and economic well-being of the individuals and families they serve. While our programs may serve different clients and offer different services, our clients often have multiple problems, and many of them seek services from a number of agencies. Moreover, as we develop programs and services for our own clients we must often supplement them with services and programs from other agencies. Often we deal with the same employers, providers, and community organizations. We are increasingly interdependent and can learn much from learning more about the opportunities to work together more closely.

The good news is that it is possible to develop and deliver the comprehensive and coordinated services that are called for. The bad news is that it is often challenging and difficult to do so.

Unfortunately the world in which you operate is not a simple one. Government services are funded through a variety of programs and agencies. Eligibility and reporting requirements often make collaboration difficult, and the constant competition for limited funds often creates barriers to cooperation and further categorization.

While efforts will certainly continue to address some of these issues at the federal level, the playing field is likely to remain complex for the foreseeable future. As a result, you and your colleagues at the state and local levels will have to look increasingly to building the relationships yourselves.

In order to encourage and support your efforts, our organizations have undertaken a project to provide human service administrators and other state policy makers with a series of short papers that will provide a brief overview of the major human service programs we represent at the national level and that will highlight the current levels of interdependence and provide an understanding of future opportunities to work together.

We hope that you will find these papers a useful tool in helping you and your staffs to better understand the range of complex programs that address human service needs, and that they will provide the information and examples you need to begin and maintain a dialogue at the state level.

We are each available to work with our own members, and with CEOs from other programs who are beginning to address these issues.

In addition, over the next several months we will continue to consult with our members and work with each other to develop additional tools that can support innovative state efforts to promote collaboration.

Please call us if you have any questions.

Sincerely,

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## **Introduction**

### **Purpose of this Paper**

The importance of collaboration and cooperation in the development and implementation of human service programs at the state and local level is increasing dramatically both from the perspective of effective services to families and that of efficiently stewarding resources in a time of fiscal pressure.

This paper provides agency and program leaders, governors' staff, and legislative staff with a concise overview of some of the major human service programs administered at the state and local level. It also discusses the interdependence of those programs, their common goals, and the way in which those programs might work together. While directed largely at individuals new to these responsibilities it can also prove of value to more experienced staff as well.

### **Background**

The leaders of state human services agencies and programs face an extraordinary series of challenges in the years ahead. These challenges are exacerbated by a combination of factors, including a slower than expected economic recovery, the extremely tight fiscal situation of government at all levels, and a continuing change in the underlying structure of federal programs as they go through the reauthorization process.

Increasingly, political leaders, advocates, researchers and public administrators are recognizing that social problems cannot always be solved within the constraints of individual programs and funding silos. Many families and individuals face multiple problems. And, many problems cannot be solved within the confines of a single program. As a result, there is a growing recognition that success will, in many cases, depend upon the ability of government to work with nonprofits and the private sector to create ready access to the comprehensive services needed.

While there are, and will be, many attempts to achieve comprehensive services through statutory changes and formal requirements for the integration of services, these efforts will probably fall short of the mark. As a result, both short- and long-term improvements will probably depend on efforts at the state and local levels to improve cooperation and coordination among existing programs and organizations.

Such efforts are difficult at best and are often hampered by a lack of information on the roles and responsibilities of other program and agencies. Efforts often fail because they begin with a demand for what one agency needs, rather than with the recognition of common goals and objectives or with a willingness to bring a resource to the table that can be shared with others.

In an effort to encourage greater dialogue at the national level, The Finance Project's Welfare Information Network invited leadership from ten organizations that represent state officials that administer fourteen human service programs to come together to discuss their individual organizations and to examine areas where they might work

together. At its first meeting, this group identified the importance of collaboration at the service delivery level. It also noted the lack of information and tools that could assist their members in exploring opportunities for collaboration. Following an intensive discussion, the organizations agreed to explore a number of joint activities. This publication represents the first of those activities.

### **Areas of Interdependence**

As noted above, many seek services from a variety of agencies and many agencies need support from their colleagues if their own treatment plans or program goals are to be met. Moreover, in at least some cases, funds in one program can be an important component of the funding for the programs of others. A few examples may help to underscore this point:

- The placement of welfare recipients into work may require the supports and services of alcohol and substance abuse treatment programs or of mental health services.
- The ability to participate in an alcohol or substance abuse program may require short-term income support or the availability of temporary living arrangements for the children of those who need treatment.
- Federal entitlement programs can provide critical funding as in the case of Medicaid and community-based care or in the case of TANF which is providing funding for child care and other programs for the working poor.

### **The Opportunities for Cooperation and Collaboration**

While barriers abound, opportunities are even more plentiful. Agency and program administrators at the state and local level have great flexibility in the use of the resources that are made available to them. For example:

- Application processes can be simplified and coordinated.
- Information can be centralized and shared.
- One-stop and no wrong door approaches can be developed and implemented.
- Agencies can engage in joint planning.
- Agencies can supplement federal outcome measures with accountability systems that can recognize and reward cooperation and shared outcomes.
- Localities can be given increased flexibility in the operation of programs.

### **Potential Solutions**

States cannot wait for the federal government. They need to lead.

There is no single approach to collaboration and no single solution. Collaboration can be initiated at any point in the process. Responsibility rests in no single agency. It can be as broad or as limited as the participants' desire. It can be project specific or extend to a broad array of relationships. It can be transparent as in the case of sharing information, or it can have an immediate and direct impact on the client, as in the case of co-location.

### **You Can Lead**

The primary message is that collaboration is in the best interest of all of our programs and organizations. And, that collaboration will only take place if you each are willing to come to the table in a number of roles, both as initiators and as collaborators.

### **Our Role**

Our organizations are committed to help. We are committed to working with you to identify opportunities; highlight promising practices; provide access to tools and technical assistance; and to work at the federal level to remove barriers.

### **An Introductory Tool To Assist You**

This paper provides an overview of major human service programs including:

- Child Care
- Child Support
- Child Welfare
- Community Services
- Developmental Disabilities Services
- Food Stamps
- Medicaid
- Mental Health Agencies
- Special Education
- Substance Abuse
- Temporary Assistance for Needy Families
- Vocational Rehabilitation
- Workforce Development
- Workforce Investment Boards

For each of these programs you will find a description of the program; the program goals; the population served; constituencies and critical partners; major funding sources and administering agencies; the need for collaboration and current program interdependence; future opportunities for and examples of collaboration; and tools, resources, and contacts for more information.

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# **PROGRAM DESCRIPTIONS**



## **Child Care**

### **Program Description**

The Child Care Development Block Grant (CCDBG) was first authorized as an amendment to the Omnibus Budget Reconciliation Act of 1990 and was reauthorized by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (PL 104-193) to assist low-income families, families receiving temporary public assistance, and those transitioning from public assistance in obtaining child care, so they can work or attend educational and training programs. Under reauthorization, the program was renamed the Child Care Development Fund (CCDF). Today, both CCDBG and CCDF are used to refer to the program.

### **Program Goals**

There are five goals within the CCDF. They are to provide states with maximum flexibility in developing child care programs and policies; to promote parental choice so that working parents can make decisions that best suit their family needs; to encourage states to provide consumer education to parents on child care; to assist states in the provision of child care to parents trying to achieve independence from public assistance; and to assist states in implementing health, safety, licensing and registration standards.<sup>1</sup>

### **Populations Served**

Children whose family income does not exceed 85 percent of the state median income for a family of the same size are eligible to receive subsidized child care under the CCDF program.<sup>2</sup> However, this is not an entitlement program. States are not required to provide a subsidy to the children, even if they are eligible. States are required to give priority to children of families with very low family income and children with special needs.<sup>3</sup> Children must also be under 13 years of age, reside with parents who are either working or attending a job training or educational program, or be in need of protective services to be eligible.<sup>4</sup> States must use at least 70 percent of their subsidy funds for child care to assist families trying to become independent of TANF either by work activities, job training, or attendance at educational programs. A few states have limited their subsidy to program to only eligible children from such families.

### **Constituencies and Critical Community Partners**

- TANF and low-income families with children below age 13
- State and local human service agencies
- State and local education agencies
- Head Start state collaboration officers
- Center based child care providers
- Home based child care providers
- School-age child care providers

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<sup>1</sup> Sec. 658A(b) of the Child Care and Development Block Grant Act of 1990.

<sup>2</sup> 45 CFR 98.20(a)(2).

<sup>3</sup> 45 CFR 98.44.

<sup>4</sup> 45 CFR 98.20.

- Child care accreditation agencies
- Child care resource and referral agencies

### **Overview of Major Funding Sources and Supervising Agencies**

The CCDF is a consolidation of three federal funding sources (discretionary, mandatory and matching) and two state funds (maintenance of effort and matching).

Funding for the CCDF expired on September 30, 2002. It has been extended through December 31, 2003. Legislation is expected extend for the program for another one to five years.

Discretionary funding is authorized by the CCDBG and appropriated by Congress annually. For Fiscal Year 2002 (FY02), \$1 billion was authorized and appropriations surpassed the authorized amount as it has since 1999, with \$2.1 billion for 2002. This represents an increase of \$100 million from FY01. The Administration has requested the same amount for FY03. States are not required to match discretionary funds.

Discretionary funds must be obligated in the year they are received or in the subsequent fiscal year. If they are not, the secretary may reallocate unused funds.

Mandatory and matching funds amounted to 2.7 billion in FY02. Mandatory funds are funds states are entitled to under the CCDBG. While no matching funds are required, states do have a maintenance of effort (MOE) requirement to maintain at least 80 percent of their previous welfare expenditures, including expenditures for welfare-related child care in FY94, to receive their full TANF allotment. There is no fiscal year limitation on the expenditure of mandatory funds, and they can be carried over from year to year.

Matching funds were created under PRWORA and are remainder funds (the difference between the amount appropriated by Congress for a given year and the amount of mandatory funds distributed to states). To be eligible to receive matching funds, states must provide matching funds at the current Medicaid match rate; obligate the federal and state share of matching funds in the year in which the matching funds are awarded; obligate all of its mandatory funds in the fiscal year in which the mandatory funds are awarded; and obligate and expend its MOE funds in the year in which the matching funds are awarded.

States must set aside 4 percent of their overall federal funding for child care to be used for activities that improve the quality of child care. Administrative costs under the CCDBG are capped at 5 percent of the funds received.

The CCDBG also contains several earmarks. For FY02, these included \$18.12 million for child care resource and referral and school-age care, \$1 million for the Child Care Aware Hotline, \$172 million of quality improvement activities, \$100 million for infant and toddler care, and \$10 million for research, demonstration and evaluation activities. Additionally, the Administration for Children and Families reserves \$12 million for technical assistance. There are three tribal set-asides. In FY02, the tribal mandatory fund

was \$54 million, tribal discretionary was \$10.5 million and the territories discretionary was \$10.5 million.

States may also use TANF funds for child care. States may transfer up to 30 percent of their TANF funds into the CCDBG. These funds must be spent according to the CCDBG rules. In FY01, 42 states transferred \$1.99 billion from TANF to CCDBG. This was a decrease in the transfer of TANF funds from FY00, when 43 states transferred \$2.31 billion from TANF to the CCDBG.<sup>5</sup>

States can also directly spend TANF funds on child care without transferring them to the CCDBG. In FY01, 32 states directly spent \$1.66 billion of TANF on child care. This was an increase from FY00 when 33 states directly spent \$1.46 billion of TANF on child care.<sup>6</sup>

The Child Care Bureau administers the CCDF to states, territories, and tribes. The Child Care Bureau is located within the Administration on Children, Youth and Families, which is part of the U.S. Department of Health and Human Services' Administration for Children and Families.

### **The Need for Collaboration**

- **TANF:** States may transfer up to 30 percent of their TANF funds into the CCDBG and can also directly spend TANF funds on child care without transferring them to the CCDBG.
- **Head Start:** Memorandums of understanding (MOU) have been initiated by Head Start State Collaboration Offices between Head Start and child care providers.
- **CACFP:** Nonprofit center based, family and school-age child care providers supply nutritious meals and snacks through Child and Adult Care Food Program (CACFP). To be eligible for participation in CACFP, a sponsor must be a licensed or approved child care provider or a public or nonprofit private school which provides organized child care programs for school children during off-school hours.
- **Pre-K:** A majority of states have begun funding pre-kindergarten programs and several have initiated universal access to pre-kindergarten. States may use public pre-K funds for up to 20 percent of its MOE or state matching funds and the federal government is considering increasing the amount to 30 percent.

### **Future Opportunities for Collaboration and Examples of Collaboration**

- Early Reading First
- Even Start
- Title I preschool programs
- Ready to Learn Television
- IDEA preschool programs

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<sup>5</sup> Schumacher, Rachel, "States Have Slowed Their Use of TANF Funds for Child Care in the Last Year," CLASP, September 2002.

<sup>6</sup> Ibid.

## **Tools, Resources and Contacts**

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- *Child Care Bureau*

The Child Care Bureau (CCB) has its own website at

<http://www.acf.dhhs.gov/programs/ccb/geninfo/index.htm>. The site contains information on policy, funding, grantee reporting, research, data and technical assistance. An online resource notebook is available at

<http://www.acf.dhhs.gov/programs/ccb/1stateadm/nbookc.htm>.

- *National Child Care Information Center*

The National Child Care Information Center (NCCIC) a project of the Child Care Bureau, Administration for Children and Families, links information and people to complement, enhance, and promote the child care delivery system, working to ensure that all children and families have access to high-quality comprehensive services. Their Website is at [www.nccic.org](http://www.nccic.org).

- *Good Start, Grow Smart*

The Bush Administration has proposed a new early childhood initiative *Good Start, Grow Smart* to help states and local communities strengthen early learning for young children. The information about the initiative can be accessed online at <http://www.whitehouse.gov/infocus/earlychildhood/earlychildhood.html>.

- *Head Start Bureau*

The Head Start Bureau has its own Website at

<http://www.acf.hhs.gov/programs/hsb/index.htm>. The site provides information on programs and services, grant opportunities, research and statistics, publications and resources, budget and policy, conferences and events, frequently asked questions and contacts.

## **Child Support**

### **Program Description**

The nation's public sector child support program was established in 1975 under Title IV-D of the Social Security Act. Each state runs a child support program – usually located in its Human Services Department, Department of Revenue or Attorneys General's Office – often with the help of prosecuting attorneys, other law enforcement offices and officials of family or domestic relations courts. Child support enforcement services provided by public sector agencies are available automatically at no cost to families receiving assistance under the Temporary Assistance for Needy Families (TANF) program and to families not receiving TANF who apply. For these families, states must charge an application fee of up to \$25, but may pay this fee from state funds. Some states may also charge for the cost of services rendered. Services include:

### **Locating Noncustodial Parents**

Identifying and verifying the location of the noncustodial parent is the first step in the child support enforcement process. A variety of location techniques ranging from automated database matches to skip tracing are employed.

### **Establishing Paternity**

In cases involving children of unmarried parents, paternity must be legally determined prior to establishing an order for child support. Paternity can be established by an administrative order of a child support agency in some states; through a court in all states; or by both parents signing a voluntary paternity acknowledgment form.

### **Establishing Child Support Orders**

An order for child support can be established either through a court-based, judicial process or an administrative process handled by the child support agency. Either way, the amount a parent should pay is based on mandatory child support guidelines set by each state's legislature and court statutes. Health insurance coverage can also be ordered.

### **Enforcing Child Support Orders**

A variety of enforcement tools are available and include:

- **Income withholding** – deducting the support obligation from wages; more than 60 percent of child support collected across the country is a result of income withholding.
- **Court Action** – bringing contempt of court actions against parents who do not comply with their child support order.
- **Seizing Tax Refunds** – intercepting federal and state tax refunds to pay child support arrears.
- **Credit Bureau Reporting** – reporting parents owing past-due child support to credit bureaus.
- **License Suspension** – suspending driver's, professional, business, occupational and recreational licenses of parents owing past-due support unless they come into compliance.

- **Denying Passports** – certifying cases with past-due support exceeding \$5,000 to the U.S. State Department for passport denial.
- **Booting Cars** – immobilizing vehicles owned by delinquent parents until arrangements for compliance are made.
- **Criminal Non-Support/Project Save Our Children** – referring chronic delinquent, large arrears cases for federal prosecution.
- **Financial Institution Data Matching** – identifying accounts of delinquent parents and using existing state laws to place a lien on and seize all or part of the accounts to pay child support arrears.
- **Lottery Intercept** – intercepting lottery winnings of delinquent parents.
- **Unemployment Benefit Intercept** - intercepting unemployment benefits, in the absence of voluntary deduction, for child support.

### **Processing and Distributing Child Support Payments**

States are required to process child support payments through centralized State Disbursement Units (SDUs). The primary purpose of SDUs is to provide employers with a single location in each state to send income withholding payments and to make payment processing and distribution more efficient and economical.

### **Child Support Enforcement - Public/Private Partnerships**

Before the advent of the child support enforcement program under Title IV-D of the Social Security Act, much of the enforcement of child support obligations was accomplished in the private sector through civil actions using private attorneys. Since that time, state government programs have assumed the primary responsibility for child support enforcement. However, public/private partnerships on behalf of child support are nothing new. Public sector child support programs have relied on the private sector for certain services needed in the process of enforcing child support. Services such as genetic testing for paternity establishment have been supplied nearly exclusively by the private sector. More recently, comprehensive automated system development; centralized state collection and disbursement units; full-service program operation; location; employer new hire reporting; legal services; voice information response systems and customer service call centers are principal areas which state government programs have contracted out to private sector firms.

### **Child Support Enforcement - Private Sector**

Private sector resources devoted to child support enforcement are also available. Private attorneys continue to play an important role in enforcing child support obligations on behalf of individual clients. Private firms specializing in child support collection are increasingly being employed by custodial parents to obtain past-due support. Operating on a contingency basis, private firms locate noncustodial parents and their assets, file liens on assets, file income withholding orders with employers of noncustodial parents and initiate legal action when necessary.

### **Program Goals**

To ensure that children receive the financial and emotional support they need from both of their parents.

### **Populations Served By Public Sector Agencies and Public/Private Partnerships**

- Families receiving assistance under the Temporary Assistance for Needy Families (TANF) Program
- Families not receiving TANF

Child support enforcement services provided by public sector agencies or through public/private partnerships are available automatically at no cost to families receiving assistance under the TANF program and to families not receiving TANF who apply. The majority of the program's 17 million cases are not currently receiving cash public assistance through the TANF program. At present, the child support collected for TANF recipients reimburses the state and federal governments for cash assistance payments made to the family. Collections above that amount go directly to the family. The Bush Administration's proposal for welfare reform reauthorization gives states incentives to pass more of the child support collected for families that receive TANF cash assistance directly to the family in need. Child support payments that are collected on behalf of non-TANF families are sent to the family.

### **Populations Served By Private Sector Attorneys and Collection Firms**

- Families not receiving TANF.

### **Populations Served By Tribal and Alaskan Native Village Organizations**

- Tribal and Alaskan Native families whose organizations have applied for and received approval from the U.S. Department of Health and Human Services (HHS) to establish child support enforcement programs.

### **Constituencies and Critical Community Partners**

- Key influencers in local/state/federal government
- Judiciary/court personnel
- Custodial and noncustodial parents who are consumers of child support services
- Custodial and noncustodial parents who are potential consumers of child support services
- Employer community
- IRS and state tax agencies
- Financial institutions
- Birthing hospitals
- Public policy and research communities
- Custodial parents and program advocacy organizations
- Fatherhood organizations
- Faith-based, community-based organizations
- Workforce development and manpower demonstration centers
- Family independence/investment administrations/TANF agencies
- Child care/Head Start/child welfare agencies
- Alcohol and substance abuse treatment facilities/programs
- Educational community
- Genetic testing agencies
- Credit bureaus/credit reporting agencies

- Government agencies, i.e. Motor Vehicles/Vital Records/Labor/Transportation

### **Major Funding Sources and Supervising Agencies**

At the federal level, the U.S. Department of Health and Human Services (HHS) provides technical assistance and funding to states through its Office of Child Support Enforcement. The HHS budget for FY02 includes \$3.9 billion to state child support enforcement programs. HHS directly supports tribes, tribal organizations and Alaskan Native village child support programs for those groups that have applied to establish the programs and have shown that they are able to meet the programs' objectives.

### **Areas of Current Interdependence (The Need for Collaboration)**

Some examples include:

- Employer community: wage withholding/new hire reporting
- Financial institutions: financial institution data matching
- Birthing hospitals: in-hospital paternity acknowledgment/paternity opportunity programs
- Department of Motor Vehicles: driver's license suspension
- Workforce development and manpower demonstration centers: job training; welfare-to-work initiatives
- Family and fatherhood initiatives: fragile family demonstration projects in ten states (CA, CO, IL, IN, MD, MA, MN, NY, PA, WI)
- Educational community: Dads Make a Difference programs
- Access and visitation programs
- Child support/child care/Head Start collaboration

### **Future Opportunities for Collaboration and Examples of Collaboration**

- Increased collaboration with tribal child support organizations
- Increased collaboration with international child support organizations/agencies
- Increased collaboration with faith-based community organizations in support of fatherhood and marriage initiatives

### **Tools, Resources and Contacts**

Based in Washington, DC, the National Child Support Enforcement Association (NCSEA) is the non-profit, membership organization representing the child support community – a workforce of over 60,000. NCSEA's diverse membership includes individual child support professionals, state/local/tribal/international child support agencies, affiliated governmental agencies, nonprofit organizations and corporate associates. Active on Capitol hill and well-known for its training events, NCSEA provides a forum for multiple constituencies to collaborate and partner in areas of common interest. NCSEA's website ([www.ncsea.org](http://www.ncsea.org)) includes links to all state child support agencies, federal government, private and nonprofit sites, as well as current child support-related public policy and research.

For more information on NCSEA, call or e-mail James Hollan, NCSEA's Executive Director, at 202-624-8180 or [jhollan@sso.org](mailto:jhollan@sso.org).

## **Child Welfare**

### **Program Description**

The child welfare system serves some of our nation's most vulnerable and troubled families in crisis, -- children who have been abused and neglected, children who have special medical or mental health needs, or in some cases, children who are delinquent. Parents have the responsibility for meeting the physical needs of their children as well as their intellectual and emotional development. While society presumes parents will act in the best interest of their children and provide at least a minimum standard of care, society may intervene when that standard goes unmet. Every state has a mechanism for legal intervention in cases of child abuse and neglect and a public child welfare agency mandated to carry out the intervention. In 2000, three million referrals concerning the welfare of approximately five million children were made nationally. Approximately 879,000 children were found to be victims of child maltreatment. On September 30, 1999, there were 568,000 children in foster care.

Public child welfare agencies and staff provide a broad array of core services to children and families:

- Prevention/Family Support – services to keep children and families from entering the child welfare system and to promote children remaining with their families in safe and stable homes whenever possible.
- Early Intervention/Family Preservation – services to address the needs of families at risk or in crisis, which are designed to strengthen and stabilize families and prevent entry into the child welfare system.
- Child Protective Services – investigation of cases of suspected abuse and neglect, as well as provision of treatment services for children and families.
- Foster Care – placement of children in out-of-home care (e.g. foster care, kinship care, etc.) with services designed to meet the child's need for safety and well-being.
- Permanency – determining a permanent home for a child whether it be reunification with the biological family, placement with an adoptive family or guardianship.
- Post-Permanency Services/After-Care – services to support a permanent placement for a child, such as reunification services, post-adoption or guardianship services, or services to children and families in kinship care arrangements.
- Independent Living – services to prepare older youths or those who are aging out of the foster care system for self-sufficiency.

### **Program Goals**

As established by the Adoption and Safe Families Act (ASFA) in 1997, the three primary goals for public child welfare are:

- Child Safety – children should be protected from abuse and neglect and maintained in their homes whenever possible and appropriate.

- Permanency for Children – agencies should promote stability in children’s living situations and maintain continuity of family relationships and connections.
- Child and Family Well-Being – agencies should enhance family’s capacity to provide for their children, and ensure that children receive appropriate services to meet their educational, and physical and mental health needs.

**Populations Served**

Maltreated children and children at risk of maltreatment and their families are served by the public child welfare system. Professionals and others in contact with children report situations to the child welfare system when they are concerned about a child.

**Constituencies and Critical Community Partners**

- Key decision makers in local/state/federal government
- Families and children at risk of child maltreatment or children who have been maltreated
- Other relatives of maltreated children
- Family/juvenile courts
- Education/school/child care personnel
- Medical/mental health/hospital personnel
- Mandated child maltreatment reporters
- Alcohol and substance abuse treatment facilities/programs
- Domestic violence treatment facilities/programs
- Law enforcement
- Juvenile justice programs
- Private/nonprofit assessment and treatment agencies
- Community/grassroots agencies
- Family support providers
- Churches
- Housing agencies/programs

**Major Funding Sources and Supervising Agencies**

The major federal funding stream is Title IV-E of the Social Security Act, established in 1980. Title IV-E Foster Care and Adoption Assistance provides funds to states to reimburse a portion of the cost of room and board for foster care, subsidize adoptions of children with special needs; train public agency staff and foster and adoptive parents’ administer the program; and provide the statutory protections assured for all children (case planning and permanency hearings). These funds are available only for the cost of care for low-income children (based on the former AFDC eligibility standard in effect on July 16, 1996). The state is responsible for the remaining costs for eligible children and 100 percent of costs for children who are not Title IV-E eligible. Proposed funding for Title IV-E for FY03 is \$4.85 billion, based on an estimate of approximately 250,000 eligible children.

Comparatively smaller federal funding sources are also used to finance child welfare:

- Title IV-B, Subpart 1, provides discretionary funding for child welfare services. FY02 funding was \$292 million; proposed funding for FY03 is also \$292 million;
- Title IV-B, Subpart 2 (Promoting Safe and Stable Families) provides funding for family preservation, family support, reunification and adoption. FY2002 funding was \$375 million (\$305 in mandatory funding and \$70 million in discretionary funding); proposed funding for FY03 is \$505 million (\$305 in mandatory funding and \$200 in discretionary funding).
- The Child Abuse Prevention and Treatment Act (CAPTA) State Grant Program provides minimal funding for state agencies to improve prevention, investigation and treatment of child abuse and neglect. FY02 funding was approximately \$22 million; proposed funding for FY03 remains approximately is \$22 million.
- The Chaffee Foster Care Independence Program provides funding for support services, job training, housing, and other skills needed for older youth moving from foster care. FY02 funding was \$140 million; proposed funding for FY03 is \$200 million (\$140 million in mandatory funds and \$60 million in discretionary funds).
- The Social Services Block Grant (Title XX) provides funding used by many states to support child welfare. It is estimated that, in 1999, states used over \$800 million of their total SSBG allocation on child welfare services such as child protection, adoption, foster care, independent and transitional living services, residential treatment services and special services for youth at risk.
- Temporary Assistance for Needy Families (TANF) funds programs in most states that support families so that children may be care for in their own homes or in the homes of relatives.
- Title XIX (Medicaid) has increasingly become an important source of funding for child welfare services, particularly under the targeted case management and the “rehab option.”

### **Areas of Current Interdependence (The Need for Collaboration)**

Families coming to public child welfare have increasingly presented with multiple issues caused by a wide range of problems, including mental health, substance abuse, domestic violence, delinquency, education, special needs, and poverty. With public child welfare accountability focused on meeting the outcomes of safety, permanency and well-being, child welfare must work with its professional and community partners to address the needs of families within specific timeframes.

As one example, the impact of substance abuse has changed the way that child welfare agencies work with families. Substance abuse, estimated as a problem for as many as 80 percent of families involved in child welfare in some states, is one of the most pervasive problems confronting child welfare. Substance abuse makes it more difficult to control for safety and increases the likelihood that children will be removed to foster care. Treatment of substance abuse for adults has generally been a long-term process and requires change if it is to remain relevant to families in the child welfare system. Under ASFA requirements, states are required to make time-limited permanency decisions for children, i.e. states must file for the termination of parental rights of a child who has been in care for 17 of the most recent 24 month period. The need for collaboration between

child welfare and substance abuse is clear. Similar situations exist for mental health, domestic violence, education (especially related to behavior and special needs of children) and juvenile justice.

### **Future Opportunities for Collaboration and Examples of Collaboration**

- **Substance Abuse**: Connecticut child welfare and substance abuse agencies created a joint strategic plan to address substance abuse in child welfare – Project SAFE (Substance Abuse Family Evaluation). Each agency employs specialists from the other discipline, uses joint evaluation and a standardized release of information to address confidentiality concerns. Project SAFE, with client input, developed a comprehensive array of community-based services to promote wraparound services for families, with recovery support services like transportation and child care. Each system blends state and federal funds to support assessment and treatment of their mutual clients.
- **Domestic Violence**: Massachusetts successfully developed and implemented collaborative domestic violence programs; see resources for additional information.
- **Mental Health**: In Riverside County, California, the Assessment and Consultation Team (ACT) was created by interagency agreement between the Department of Mental Health (DMH) and the Department of Public Social Services (DPSS). Mental health clinicians are stationed at DPSS offices so that children and families served have direct and quick access to an expanded range of mental health assessment and treatment services. Services are matched to child and family needs and access is timely. Mental health and child welfare staff work together as a team.
- **Juvenile Justice**: In Lucas County, Ohio, the *Safe Kids Safe Streets* project coordinates improved comprehensive services and support for families already in the child protection and juvenile court system with community-wide primary prevention programs of individualized family assessment and intensive home visitation support services for at-risk families. The project is a coalition of 18 agencies providing health, welfare and advocacy for children.

### **Tools, Resources and Contacts**

- American Public Human Services Association: <http://www.aphsa.org>
- Legislative information: <http://thomas.loc.gov/>
- Children’s Bureau (CB), Department of Health and Human Services (HHS): <http://www.acf.hhs.gov/programs/cb/>
- National Clearinghouse on Child Abuse and Neglect: <http://www.calib.com/nccanch/>
- National Indian Child Welfare Association: <http://www.nicwa.org/>
- Substance Abuse and Mental Health Services Administration, Department of Health and Human Services (SAMHSA): <http://www.hhs.gov/asl/testify/t000314b.html>

- Substance Abuse: “*Connecting Child Protective Services and Substance Abuse Treatment in Communities, A Resource Guide*,” APHSA, October 2001, APHSA Website or on request to [pubs@aphsa.org](mailto:pubs@aphsa.org).
- Domestic Violence, Child Welfare, Court Collaboration Project: The National Association of Public Child Welfare Administrators, contact Dena Huff, Domestic Violence Project Coordinator, 202-682-0100, [dhuff@aphsa.org](mailto:dhuff@aphsa.org).
  - Guidelines for Public Child Welfare Agencies Servicing Children and Families Experiencing Domestic Violence
  - Toolkit of Resource: Improving Outcomes for Children and Families Affected by Domestic Violence
- The Georgetown University Center for Child and Human Development: <http://gucdc.georgetown.edu/foster.html>
- Department of Justice (DOJ) Program Resource Guide, Third Edition, [www.ojp.gov:80/resguide/resguide.txt](http://www.ojp.gov:80/resguide/resguide.txt)
- Office of Juvenile Justice Delinquency Prevention (OJJDP), Grants and Funding, <http://ojjdp.ncjrs.org/>



## Community Services

### Program Description

The Community Services Block Grant (CSBG) is a federal, anti-poverty block grant, which funds the operations of a state-administered network of local agencies. The federal agency, which oversees the block grant, is the Office of Community Services within the Administration for Children and Families at the U.S. Department of Health and Human Services.

Once state CSBG administrators are allocated the CSBG, they must then pass through 90 percent of the monies to the local agencies. The remaining 10 percent can be used as follows. Up to five percent is deemed a state administration allotment that can be used to cover the administration of the program. The last five percent is deemed discretionary dollars and can be used to build the capacity of the network, demonstrate new initiatives and/or provide training and technical assistance. The CSBG network consists of more than 1,100 agencies that create, coordinate and deliver programs and services to low-income Americans in 96 percent of the nation's counties. In FY00 the CSBG network served nearly 10 million low-income people.

Most agencies in the CSBG network are Community Action Agencies (CAAs) created through the Economic Opportunity Act, a predecessor of the CSBG. Community representation and accountability are hallmarks of the CSBG network, where agencies are governed by tri-partite boards. This board structure consists of elected public officials, representatives of the low-income community, and appointed leaders from the private sector.

Because the CSBG designates an agency as *the* anti-poverty agency for its jurisdiction and funds the central management and core activities of these agencies, the network is able to mobilize additional resources to combat the central causes of poverty.

### Program Goals

The CSBG network is charged with “mobilizing the resources of the community to eradicate causes of poverty and move low-income persons to self-sufficiency.” This mobilization effort means engaging local institutions, the public and private sectors, and ordinary citizens to create economic opportunity, attack racism, build low-income housing, and increase community capacity in other ways. As outlined in the CSBG legislation, the network operates programs in, but not limited to, the following areas: housing, nutrition, healthcare, alcohol/substance abuse, employment, income management, education, transportation, childcare, and family relationships.

The overall missions of the CSBG network’s activities are driven by six national goals. The goals are:

GOAL 1. (Self-sufficiency) Low-income people become more self-sufficient

GOAL 2. (Community Revitalization)The conditions in which low-income people live are improved

GOAL 3. (Community Revitalization) Low-income people own a stake in their community

GOAL 4. Partnerships among supporters and providers of services to low-income people are achieved

GOAL 5. Agencies increase their capacity to achieve results

GOAL 6. (Family stability) Low-income people, especially vulnerable population, achieve their potential by strengthening family and other supportive systems

### **Populations Served**

In FY00, the CSBG network served nearly 10 million clients who are members of over 4 million families. Overall, the CSBG network's clientele was ethnically diverse. The ethnicity of almost 7.1 million individual clients was as follows: half were white and non-Hispanic, 27 percent were African American, and 18 percent were of Hispanic origin.

Although, it should be noted that the data indicated this network continued to serve a heterogeneous group of low-income Americans.

The typical client:

- lived in a family with children,
- was white and non-Hispanic,
- was very poor, and
- had family members currently working or with work experience.

In addition, nearly three-fifths of the client families include children less than 18 years of age. While more than a third of these had both parents present, more than half were headed by single mothers; single fathers headed yet another six percent of families. Children made up about 39 percent of all local agency clients.

### **Constituencies and Critical Community Partners**

The CSBG network's programmatic initiatives begin with an environmental assessment of the local community to ascertain unmet needs of low-income persons, identification of resources to address those needs and a survey of the effects of public policy and legislation on low-income persons. This assessment helps to identify the most critical areas of need within a local community.

CSBG designees then partner with other community and faith-based organizations, federal agencies, state government, and private institutions in a mission to address the issues identified by the needs assessment.

### **Overview of Major Funding Sources and Supervising Agencies**

In FY00, the CSBG network leveraged nearly \$7 billion in federal, state, local and private resources to provide support, services, facilities and improvements in low-income communities.

### **Areas of Current Interdependence (The Need for Collaboration)**

The CSBG network is most successful when working in collaboration with federal, state, and local government agencies as well as other community and faith-based organizations, and private institutions. Each state and agency collaborates with other entities and organizations based on the resources and needs of the local community.

### **Future Opportunities for Collaboration**

The designation of a CSBG eligible entity as the anti-poverty agency in its jurisdiction provides a CSBG eligible entity the opportunity to assess a variety of federal, state and private funding streams. In many cases, behind the scenes, CSBG eligible entities meld these various funding streams and provide a comprehensive intake which determines a client's eligibility for supports such as food stamps, Low Income Home Energy Assistance Program (LIHEAP), housing or rental assistance, job training, employment, transportation, counseling and other needed services to aid an individual in their journey toward self-sufficiency. As more CSBG eligible entities move toward results oriented management, there becomes more of an opportunity to creatively combine funding sources and provide "wrap around" services to low-income people.

### **Examples of Collaboration:**

Below you will find two current examples of collaboration, which have led to truly making an impact on the lives of low-income people.

#### **Working with TANF clients**

The CSBG network, which is mostly made up of Community Action Agencies (CAAs), uses CSBG-paid staff and a CSBG-funded agency infrastructure to organize a much larger set of low-income community resources. CAAs usually draw upon many categories of programs to combat a single cause of poverty. When CAAs design services for clients, they typically organize a variety of interventions to support the multiple changes a client pursues to improve his or her life. CAAs fill in gaps in community resources for the poor and coordinate existing facilities and services by bringing together not only material resources, but also the many elements of the community and public sector that are represented by their partners and board members.

For example, CAAs meld various funding streams to provide comprehensive services such as food stamps, LIHEAP, housing or rental assistance, job training, employment, transportation, counseling and other needed services to aid an individual in the journey toward self-sufficiency.

The states of Michigan, Pennsylvania, and Texas have taken this "way of doing business" one step farther and used the five percent discretionary allotment to build and nurture the case management capacity of the CSBG network in their respective states. The case management systems have embodied the outcome-driven goals of the CSBG and therefore have been so successful that, in these three states, Temporary Assistance for Needy Families (TANF) offices have contacted the CSBG network to serve as the vehicle to provide services.

In Texas, actual awards range from \$1,000 to \$20,000 and are distributed to local agencies. The rewards are distributed based on the number of people achieving the outcome of “moving out of poverty toward self-sufficiency.” The criteria for such an award is complex and specific. If you would like further information on this initiative in Texas, please contact: Eddie Fariss, Director of Community Affairs, at Texas Department of Housing and Community Affairs, Administration and Community Affairs Divisions by phone at 512-475-3897, or by email at [efariss@tdhca.state.tx.us](mailto:efariss@tdhca.state.tx.us).

For information on the initiative in Michigan, please contact, Ms. Janet Strope, Director, Office of Financial Assistance Program, Michigan Family Independence Agency by phone at 517-373-2535, or by email at [stropej@michigan.gov](mailto:stropej@michigan.gov).

### **Agency Level Example:**

In the case of Fayette County Community Action Agency (FCCAA) in Pennsylvania, case management means many things, including the necessity that all staff are cross-trained in every aspect of the support services available at the CAA. Typically when a client enters FCCAA, they begin with a general intake session where family composition and income data are entered into a system called Family Access Management System (FAMS). Paper copies of the intake form are then generated for the client’s signature. At intake, the system automatically determines client and household eligibility for all agency services and the intake worker can generate information sheets on any of the programs for the clients’ further information as well as discuss the merits of the program or support.

Information is also shared via a wide-area network with local agencies, such as children and youth, juvenile justice, public assistance and others, through a consumer-choice feature. Clients must authorize an agency to share information over the database and they may pick and choose among those agencies they wish to coordinate. This allows clients to instantly obtain all supports they are eligible for and ultimately helps them on their journey toward self-sufficiency. If you would like further information on the initiative in Pennsylvania, please contact Dennis Darling, Director, Office of Community Services, Pennsylvania Dept. of Community and Economic Development, by phone at 717-787-1984, or by email at [ddarling@state.pa.us](mailto:ddarling@state.pa.us).

### **Working with Homeless Veterans**

In central New Jersey, Middlesex County Economic Opportunity Corporation (MCEOC), a community action agency, partnered with the New Jersey Department of Veteran Affairs to develop a creative comprehensive program to address the needs of homeless veterans in Middlesex County. The program, Moving American Veterans into Employment and Residences in Communities (MAVERIC), works comprehensively to provide housing, job training, employment, transportation, counseling and other needed services to restore homeless veterans to full productive lives.

Due to the fact that both organizations are mandated to provide needed services to the poor and in this instance, homeless veterans, the partnership came quite naturally. In pursuit of their respective missions, MCEOC and the Department of Veteran Affairs (VA) work collaboratively to provide outreach services, case management, treatment and

rehabilitation, work training and employment, housing and a full continuum of care for homeless veterans.

For more information on this initiative, please contact Carroll Thomas, Executive Director of MCEOC by phone at 732-846-6600 or by email at [cht1004ct@aol.com](mailto:cht1004ct@aol.com).

**Tools, Resources, and Contacts**

Margaret Washnitzer, Director  
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Office of Community Services  
Administration for Children and Families  
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Phone: 202-401-9343 Fax: 202-401-5718  
Email: [mwashnitzer@acf.dhhs.gov](mailto:mwashnitzer@acf.dhhs.gov)  
Website: <http://www.acf.dhhs.gov/programs/ocs/csbj/index.htm>

Timothy R. Warfield, Executive Director  
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Website: <http://www.nascsp.org/default.htm>



## Developmental Disabilities Services

### Program Description

State governments provide a wide range of residential and daytime services for individuals with developmental disabilities. These disabling conditions result from mental retardation and a wide-range of other disabilities that occur during the developmental period between ages 0 and 21 and include conditions such as cerebral palsy, epilepsy, autism and many other, related neurological disorders (see additional discussion below under “Description of the Population”). Developmental disabilities programs must address a broad spectrum of medical, social, psychological, and educational needs throughout an individual’s lifespan, and, in recent years, have been characterized by:

- An emphasis on the most integrated setting. During the first three-quarters of the Twentieth Century, services were restricted primarily to large, publicly operated institutions. New approaches to community support and a series of landmark court rulings resulted in a dramatic shift from institutions to community programs. Between 1977 and 2000, states closed over 120 public mental retardation facilities. The aggregate census of state facilities declined by two-thirds over the 23-year period. During the past ten years, twelve states have closed all of their institutions in favor of community-based services. Overall, the number of persons served in community-based residential settings has grown from 63,073 in 1982 to 310,299 in 2001. Currently, states support approximately 900,000 individuals with developmental disabilities, about 400,000 of who reside in state-financed out-of-home living arrangements of various sorts.
- Increased reliance on private providers of services. As states have closed and downsized public residential treatment centers, they have relied increasingly on the private sector to furnish publicly funded services to people with developmental disabilities. According to one study, 97.7 percent of the 122,260 residential sites where persons with developmental disabilities were receiving services in 2001 were operated by private agencies.
- A growing emphasis on self-directed, individually tailored services and supports. The increasing advocacy of individuals with disabilities has helped to fuel the shift from specialized, congregate services to individually designed networks of self-directed supports in which the consumer has a direct voice in determining the mix of supports he or she receives and the authority to oversee the delivery of such supports.
- The decentralization of decision-making authority. In response to the growth in community services, a growing number of states have vested day-to-day management responsibilities in local governmental units, specially-constituted area/region-wide nonprofit agencies, or district/regional/area offices of the state administering agency.

### **Program Goals**

In contrast to past efforts to remove people with developmental disabilities from society, the contemporary goal is to assist persons receiving support to take their rightful place as valued and contributing members of the community. This transformation in societal goals and expectations has been influenced by several factors. First, people receiving support are taking on greater responsibilities for meeting their own needs and developing the skills to organize and manage their own supports. Traditional provider agencies have to compete with new flexible organizations based on informal, family managed support networks. Although service capacity has grown substantially over the past ten years, increasing demands for publicly funded supports coupled with state budget constraints has resulted in a widening gap between service need and service availability. Estimates of the total number of individuals waiting for out-of-home residential supports range between 40,000 to 100,000.

### **Description of the Population Served**

In comparison to people with other major categories of chronic mental, physical, or sensory disabilities and illnesses, individuals with mental retardation/developmental disabilities have a greater probability of experiencing significant limitations in life's activities and a heightened likelihood of requiring comprehensive long-term services. Furthermore, due to the nature and longevity of these disabilities, people with developmental disabilities, as a class, are more costly to serve.

Before the mid-to-late 1970s, state-funded services were restricted primarily to persons with mental retardation. Following the passage of the federal Developmental Disabilities Act in 1970, many state legislatures expanded eligibility to include individuals with developmental disabilities who did not have mental retardation. While specific eligibility criteria still vary considerably from state to state, the trend is toward the adoption of functional eligibility criteria, rather than basing eligibility on the existence of specific etiological conditions. Studies of U.S. Census data suggest that approximately 4.1 million Americans, or 1.58 percent of the population, were diagnosed as having developmental disabilities in 1995. Of this number, roughly 1.1 million had diagnoses of both mental retardation and developmental disabilities; and 945,000 were diagnosed mentally retarded but not developmentally disabled. The remaining 1.9 million had developmental disabilities only.

### **Constituencies and Critical Community Partners**

For many years, parents and other family members of individuals with developmental disabilities have worked closely with state officials to improve service opportunities. The growing emphasis on community-based supports over the past two decades, however, has led to the emergence of other important constituencies, as summarized below:

- Private service provider agencies and their staff. The number and size of private agencies that contract with the state to provide developmental disabilities services has mushroomed over the past decade into a multi-billion dollar industry, with strong connections to local communities, businesses and government.

- Families. Far more persons with developmental disabilities are supported by family members than are served by all of the components of the public/private service delivery system combined. In many states, the developmental disability system was built upon the advocacy, persistence, and innovation of families who convinced state policy makers and legislators of the need for expanded publicly funded service alternatives.
- Self Advocates. Individuals with disabilities in recent years have become vocal advocates for the services they need and an influential voice in the public policy arena.
- Educators. Developmental state/local disabilities agencies have formed alliances with neighborhood schools to ensure that young people with disabilities continue to receive necessary support as adults.
- Local Healthcare Systems. The rapid growth in community developmental disability service systems has created a broad and stable base of employment for a wide range of professionals and paraprofessionals. These individuals frequently derive a significant part of their income from the services and supports they provide to people with developmental disabilities living in the community.

**Major Funding Sources and Supervising Agencies.** Over the past two decades, the federal-state Medicaid program has emerged as the principal source of funding for long-term services to individuals with developmental disabilities. The two primary Medicaid funding avenues available to the states are: (a) payments on behalf of residents of public and private intermediate care facilities for persons with mental retardation (ICFs/MR); and (b) payments on behalf of participants in home and community-based services (HCBS) waiver programs. Some highlights related to financing developmental disabilities services are:

- Public spending on developmental disabilities services in the United States increased from \$3.5 billion in 1977 to \$29.3 billion in 2000. This increase is attributable mainly to the growth in spending on community services, which increased at an inflation-adjusted rate of 845 percent over the period.
- States collectively spent \$22.1 billion, or 72 percent of their total outlays, on people with developmental disabilities residing in community settings. The remaining expenditures (\$7.2 billion) were devoted to supporting individuals living in public and privately-operated institutions and other large congregate care settings.
- Revenue sources for community developmental disabilities services were almost equally divided between the federal government (48%) and the states (49%), with the balance (3%) furnished by local governments.
- The federal government paid approximately 55 percent of the cost of institutional services, with the balance of funding (45%) derived almost entirely from state general revenue funds.

- States, in aggregate, received \$5.6 billion in federal Medicaid payments on behalf of ICF/MR residents and \$5.5 billion on behalf of participants in HCBS waiver programs. States also received a total of \$1.3 billion in Medicaid reimbursements for other state plan services provided to Title XIX-eligible individuals with developmental disabilities.
- States received a total of \$1.3 billion in Medicaid reimbursements for other state plan services provided to Title XIX-eligible individuals with developmental disabilities (targeted case management; personal care; rehabilitative services; etc.), bringing total Medicaid reimbursements from all sources to \$12.4 billion, according to one analysis.
- Another significant source of federal revenue includes Title XX, Social Services Block Grant Program (\$318 million in FY00).
- Supplemental Security Income (SSI) and Social Security Old Age, Survivors and Disability Insurance (OASDI) benefits are individual entitlements. In 1998, 325,000 children and slightly over 1 million adults with a diagnosis of mental retardation were receiving SSI payments. Of this number, approximately one-third were either residing in an ICF/MR-certified facility or participating in a HCBS waiver program.

### **Areas of Current Interdependence**

Due to the chronic, often lifelong nature of developmental disabilities and the profound impact that the disability can and often does have on an individual's capacity to function successfully in society, state and local developmental disability agencies need to develop close working relations with a wide range of other human services agencies, including agencies involved in:

- Early intervention services for infants and toddlers with disabilities and developmental delays.
- Child welfare or foster care services to children with disabilities, or youngsters living in households that receive TANF benefits.
- School-to-work (adult life) transition services to adolescents and young adults with developmental disabilities.
- Services to individuals requiring a combination of developmental and mental health services.
- Acute and preventive health and dental services to persons with developmental disabilities.
- Assisting individuals involved with the criminal justice system.
- Meeting the needs of older individuals with developmental disabilities.

### **Future Opportunities for Collaboration**

There are a number of opportunities for productive cross-system collaborations that hold promise for improving the efficiency and effectiveness of public services to the developmentally disabled population. Among these opportunities are:

- Creating family-centered strategies for organizing and delivering early interventions services to infants and toddlers with disabilities and developmental delays.

- Developing targeted initiatives under the 1996 welfare reform legislation to reach TANF families supporting individuals with developmental disabilities in their households.
- Initiating joint foster-to-adopt pilot programs for difficult-to-place children with disabilities.
- Establishing local school-to-work collaboratives involving state/local special education, vocational rehabilitation, developmental disabilities (DD), and mental health agencies.
- Creating joint task forces composed of state/local DD program administrators and officials from other, overlapping state/local human services agencies to:
  - Improve services for people with developmental and mental health diagnoses;
  - Assure that individuals with disabilities who are victims or perpetrators of crimes gain access to specialized supports while part of the criminal justice system; and
  - Develop and implement plans for serving older individuals with developmental disabilities.

### **Tools, Resources and Contacts**

Additional information on the topics discussed in this paper can be accessed through the following websites: the University of Minnesota Institute on Community Integration (<http://ici.umn.edu>); The State of the States, The University of Colorado Coleman Institute on Cognitive Disabilities. (<http://www.cusys.edu/ColemanInstitute/stateofthestates/home.htm>); and the National Association of State Directors of Developmental Disabilities Services (<http://www.nasdds.org>).



## Food Stamps

### Program Description

The Food Stamp Program (FSP) is one of the most fundamental safety nets for low-income families. The FSP is the nation's largest food assistance program, and in FY02, over 19 million people received FSP assistance each month. The FSP provided over \$18.25 billion in benefits during FY02, or an average of \$79.55 per participant per month. FSP benefits, which are usable in retail outlets for food purchases, are nearly all now issued via electronic benefit transfer (EBT) rather than the traditional "stamp" coupons. Eligible households may have no more than \$2,000 in countable resources (\$3,000 if at least one person in the household is age 60 or older, or is disabled). The gross monthly income of most households must be 130 percent or less of the federal poverty level. Net monthly income (gross income less certain approved deductions for child care, some shelter costs, and other expenses) must be 100 percent or less of the poverty level. Households with an elderly or disabled member are subject only to the net income test. Most able-bodied adult applicants must meet certain work requirements.

In May 2002, the farm bill (the Agriculture, Conservation, and Rural Enhancement Act of 2002, P.L. 107-171) reauthorized the FSP. It was the first substantial change in program law since 1977, although there have been many modifications over the years. Beginning in the latter half of the 1990s, there was a significant decline in the FSP caseload, which fell by 35 percent between 1993 and 2000. Many observers blamed complexities in the program as a major factor in this decline. Families are asked to follow a detailed list of procedures while applying for FSP, and states are required to follow an even more complex list of rules for administering the program. The farm bill reforms, which were strongly supported by states, helped to simplify many of these complex policies.

*Program performance measures* – FSP law includes a rigid quality control (QC) system that calculates the accuracy of the states' eligibility determinations and tracks certain other related factors. The system rewards or sanctions states based on their error rates each year; in general, states that fall well below the national average in errors are provided with additional administrative funds, while those above are assessed a penalty. The national average is calculated through random samples of cases. Through use of a regression formula, a statewide error rate is determined each fiscal year for overpayments and underpayments of benefits. The "combined payment error rate" represents the sum of the over- and under-payments for the year.

From the states' perspective, the QC system often hampers their ability to develop the most effective nutrition assistance program. By forcing states to remain compliant with a rigid, narrowly focused measurement and sanction system, QC has often worked to hinder much of the creativity and flexibility that might let states better serve families. For example, the QC system effectively penalizes state efforts to move families into the workforce, since the fluctuations and uncertainties typical of entry-level jobs are exactly the factors that cause payment "errors." Yet neither recipients nor caseworkers can predict these fluctuations with any certainty. Attempting to track and report them, at least with the degree of precision necessary to avoid sanctions, is burdensome to recipients and employers and adds greatly to the states' administrative workload and costs.

The farm bill legislation made important improvements in the QC system effective for FY03, although states had strongly urged even more far-reaching reforms. The changes include a higher tolerance level (105 percent of the national average compared to simply the national average in prior law); a one-year grace period before states must begin paying sanctions; and a new 95 percent confidence level test that error rate calculations must meet to be considered valid. The changes should substantially lower the number of states subject to sanction each year. In addition, the prior enhanced funding system was replaced with a new outcome-based bonus incentive system providing payments for high performance in reducing errors and improving service delivery.

*Policy options* – By design, the FSP is for the most part a nationally uniform program. In recent years a few administrative options have been extended to states via both legislation and regulations, such as certain details of change reporting and the calculation of countable resources. The farm bill expanded the list of available options. The major new ones include simplified and conformed definitions of income and resources; simplified determinations of utility costs, housing costs, and deductions; reduced reporting requirements; and a five-month transitional benefit for those leaving TANF. States strongly supported these options and believe they can simplify the program, reduce administrative costs, and make it more accessible to recipients. However, in the current state budget crisis, many states may have difficulty taking some of these options as quickly as desirable since, like all changes, implementing them will have an impact on staff and automation resources.

Examples of promising state programs – Prior to the farm bill’s changes, the only “official” measure of high state performance in the FSP has been the QC system and the resulting error rate “score” each state achieves annually. The pre-farm bill sanction and enhanced funding payment system provided several states with payments each year for achieving very low error rates. For FY01, ten jurisdictions (Arkansas, Louisiana, Minnesota, Mississippi, Rhode Island, South Carolina, South Dakota, Texas, the Virgin Islands, and Wyoming) received a total of \$51.76 million in enhanced funding. The first year for payments under the farm bill’s new bonus payment system for high performance in payment accuracy and customer service measures will be FY03. Other ways in which state performance has been measured include various rankings by anti-hunger groups. For example, in January 2002 the Food Research and Action Center issued “Rates of Household Hunger and Food Insecurity, 1997-1999,” based on census surveys. States having the best ratings were Iowa, Massachusetts, Minnesota, New Hampshire, North Dakota, Pennsylvania, and South Dakota.

*Program outlook* – The farm bill’s administrative simplifications and benefit increases went far toward reducing the burden on states of this complex program and toward restoring the eligibility cutbacks of the 1990s. However, there remain areas of the program where APHSA will continue to work for legislative change; for example, states still seek automatic eligibility for those receiving Supplemental Security Income benefits, and the QC system still does not provide the necessary balance between process measures and outcome incentives. It is unclear when the next opportunity may occur for FSP

legislative changes, although there have been few years in the past when some type of FSP legislation was not enacted.

The House TANF reauthorization bill, H.R. 4737, contains two sections that could substantially affect the FSP. Sec. 701 would authorize “superwaiver” demonstration projects in which states could coordinate a variety of public assistance programs under waivers granted by the respective agencies of jurisdiction. Programs eligible would include Title I of the Workforce Investment Act, the CCDBG, most programs under the Housing Act, the FSP, and others. Section 702 of the bill would authorize optional food assistance block grants for up to five states. States electing to take the block grant could operate only a block-granted program, would have to offer it throughout the entire state, and could reverse their election only once. Prospects for TANF reauthorization are uncertain at this writing.

In the meantime, states face considerable work to implement the farm bill changes passed last May. Although relatively few of the changes were mandatory, one of the most labor-intensive changes – the benefit restorations to legal immigrants – are in the mandatory category, and must be implemented in stages between October 1, 2002, and October 1, 2003. The largest group of legal immigrants to be restored, qualified aliens who have been in the United States for five years or more, will become eligible on April 1, 2003.

### **Program Goals**

According to the Food Stamp Act, Section 2 (Declaration of Policy), the FSP was created to “alleviate ... hunger and malnutrition” by permitting “low-income households to obtain a more nutritious diet through normal channels of trade by increasing food purchasing power ...” for those eligible.

### **Description of the Populations Served**

According to a survey of FY01 data on the composition of FSP households, the majority of households contained children, over two-thirds were single parent households, and 14.4 percent were headed by married parents. One-fifth of all FSP households contained an elderly individual, and 27.6 percent contained disabled individuals. Over half of all FSP recipients were children. Among adult participants, 70.3 percent were women, one-quarter was disabled, and 3.9 percent were noncitizens. The survey also included household benefit and income levels; the average monthly benefit was \$163 per household, and over three-fourths of these benefits went to households with children. The household average monthly gross income was \$624, and the average total of all deductions claimed was \$310 per household. Over time, the participation rate in the FSP declined steadily from 1994 through July 2000 but increased again through 2001. The percentage of households with disabled individuals and/or elderly individuals has increased steadily over time. The percentage of households with children in the FSP has declined but the percentage of participants who are children has remained essentially unchanged. A full report on FSP caseload characteristics is available at [www.fns.usda.gov](http://www.fns.usda.gov).

### **Constituencies and Critical Community Partners**

State and local public human service agencies (administration of the program at the local level)

- Anti-hunger and other advocacy groups:
  - Food Research and Action Center and their state/local members
  - America's Second Harvest and their state/local members
  - Center on Budget and Policy Priorities
- United States Department of Agriculture (USDA), Food and Nutrition Service (national policy oversight)
- House and Senate Agriculture Committees
- Organizations with retail and wholesale food sales interests, such as Food Marketing Institute
- Vendors that sell automation services and equipment, such as Citibank and Lockheed-IMS

### **Overview of Major Funding Sources and Supervising Agencies**

Unlike benefits in most other entitlement programs, FSP benefits are 100 percent funded by the federal government. States share in the administrative costs of determining eligibility and providing related services to families. This share is nominally 50 percent; however, cost allocation rules enacted in 1998, and renewed through 2007 in the farm bill, reduce the federal funds reimbursed to many states below 50 percent. The reductions are based on amounts of FSP administrative cost claims charged to the Aid to Families with Dependent Children program prior to the 1996 enactment of TANF. The premise of the law is that since these charges (which the federal government encouraged for accounting simplicity) led to larger TANF grants, the FSP reductions merely "balance the books" and do not take federal funds away from states. However, since TANF funds cannot be used for FSP purposes, the law did in fact reduce funds available to states for FSP administration.

The program's administrative costs are extremely high; in FY01, the federal and state governments together paid out administrative costs of over \$3 billion, compared to \$15.547 billion in benefits for that year.

USDA exercises federal oversight of the FSP through the Food and Nutrition Service (FNS), while state human service agencies administer it. State staff determines eligibility, set the household's benefit rate, and establish a certification period. Households are generally required to report any changes that might alter their eligibility during the certification period. FSP law and regulations provide states flexibility in some areas in change reporting requirements, particularly with changes achieved in the farm bill.

### **Areas of Current Interdependence**

The FSP serves as the major nationally uniform "safety net" program for low-income individuals and families. It is a critical supplement to the budgets of those on other types of assistance, particularly TANF and Medicaid. FSP benefits often make the difference in an individual's efforts to transition to the workforce. State and local agencies assure that those eligible for FSP are made aware of these programs plus others such as child

support, and vice-versa. The FSP is often the gateway for other nutrition assistance programs such as the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).

### **Future Opportunities for Collaboration**

As state TANF programs become more focused on moving recipient into the workforce and maintaining their attachment, the FSP has become more closely associated with Medicaid than with cash assistance. There is a slowly growing closer alignment between FSP and the Supplemental Security Income (SSI) program; those eligible for SSI also meet FSP eligibility standards, and there is no need for two separate application processes. A few states have FNS waivers allowing automated FSP eligibility for SSI **recipients**; the procedure should be available to all states. APHSA urged such legislation during consideration of the 2002 farm bill.

### **Tools, Resources, and Contacts**

APHSA Contacts:

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Policy and Government Affairs,  
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Major sources of FSP information and data include the following Websites:

- APHSA policy positions - <http://www.aphsa.org/policy/foodstamps.asp>
- USDA-FNS - <http://www.fns.usda.gov/fsp/>
- Food Research and Action Center - <http://www.frac.org>
- Center on Budget and Policy Priorities - <http://www.cbpp.org/>



## Medicaid

### Program Description

The Medicaid program was established in 1965 as a limited program of state-administered, federally-assisted medical assistance to low-income women and children. Today, it is the largest single publicly funded health insurance program in country, serving more than 44 million children and families, seniors, and individuals with disabilities. Current estimates are that total expenditures for the program -- state and federal -- will exceed \$270 billion in the current federal fiscal year (FY03).

Eligibility for Medicaid coverage is means-tested, i.e., the applicant's income must be below a certain ceiling. For children and pregnant women, Federal law requires that the minimum income ceiling be 133 percent of the federal poverty level (FPL) for pregnant women and children under six; for children ages 6 through 18, the minimum is 100 percent of the FPL. States must also, with certain exceptions, cover seniors and persons with disabilities who are receiving cash assistance under the federal Supplemental Security Income program, children in foster care or placed in subsidized adoption, and those who would have been eligible for cash assistance under the old AFDC program as it was configured in July 1996. For other population groups, the income standards are established by the states.

In general, all covered individuals must fall into certain categories -- children, the parent(s) or caregivers who live with them, persons age 65 or over, or persons with permanent disabilities. States can, however, apply to the federal Department of Health and Human Services for a waiver to cover other population groups, such as single males at risk of becoming permanently disabled. A number of states have received waivers to cover such "expansion" populations.

Federal law also mandates all state Medicaid programs offer a certain package of "core" benefits, including inpatient hospital care, outpatient hospital, physician, lab and x-ray, nursing facility care, home health, health screening and treatment for children (the EPSDT component) and family planning. A broad range of optional services may also be covered for which states will receive federal matching funds for their cost; the most significant of these options is prescription drugs. Since 1981 states have also been able to apply for a federal waiver to offer home and community-based services to seniors and persons with disabilities in lieu of placement in a nursing home. Every state now has at least one of those waivers.

The Medicaid programs are funded jointly by the state and federal governments. In some states counties share in a portion of the state's cost. The federal matching percentage (FFP) varies from state to state and from year to year, according to the state's per capita income compared to the national figure. Nationally, the state share hovers around 43 percent.

States employ a variety of service delivery systems in their programs, including fully capitated risk-based managed care plans, partial or shared-risk capitation arrangements,

primary care case management (PCCM) systems in which every beneficiary has a primary provider who coordinates all other care, and straight fee for service. States can also buy beneficiaries into an employer-based plan if it is cost effective.

### **Program Goals**

To support the quality of life of Medicaid beneficiaries whose income and resources are insufficient to meet the cost of the appropriate, high quality, cost effective health care and related services they need.

### **Populations Served**

The Medicaid programs serve two major population groups:

- Families and children. This includes pregnant women; children in foster care or placed in subsidized adoption; and children with major medical expenses due a significant disabling condition whose families cannot afford the cost of their care.
- Persons age 65 and over, or adults under 65 who have major disabilities, and whose incomes are insufficient to meet their costs of medical care. This includes persons receiving SSI cash assistance, persons with incomes above that level but below a certain percentage of the FPL (some of these groups do not receive full Medicaid benefits, but only Medicare premium assistance and cost-sharing), and persons who "spend down" to the state's income standard because of their need for nursing home or ICF/MR or community-based care. Many of this population also have Medicare coverage and are referred to as the "dual eligibles."

Some states also have elected to adopt several "niche" eligibility options set forth in the Medicaid statute, such as workers with disabilities, uninsured women with breast or cervical cancer, and individuals ages 18-21 who were in foster care on their 18<sup>th</sup> birthday. In addition, as mentioned above, states have also received federal waivers to cover selected nontraditional populations, such as single adults or seniors in need of prescription drug assistance.

### **Constituencies and Critical Community Partners**

- Medicaid beneficiaries and their families.
- State and county agency colleagues -- eligibility intake centers, mental health programs, public health (especially maternal and child health), child welfare, services to individuals with disabilities, Offices on Aging, public school districts, state and county transportation agencies, and Attorney General's office.
- Health care providers, and their state associations (medical association, hospital association, independent pharmacists, home health agencies, etc.).

### **Major Funding Sources and Supervising Agencies**

- At the federal level, the Center for Medicaid and State Operations in the Department of Health and Human Services.
- At the state level, state Medicaid agencies are located in a variety of state governance structures. About half are in umbrella agencies that also include the TANF operating arm; the rest either are "stand alone" agencies reporting directly to the governor or are part of the department of public health.

### **Areas of Current Interdependence**

State Medicaid agencies collaborate with other state or county agencies in various ways to operate the Medicaid program. These include:

- Eligibility intake/determination, which can be combined with the TANF and/or Food Stamp programs, and can be performed by state staff or under agreement with county staff.
- State licensing boards and facility inspection agencies (sometimes the inspection function also includes local agencies, such as fire departments)
- School districts (for outreach and referral).
- Public health (for educational campaigns, clinical consultations, vital records, immunization registries, etc.).
- Information technology systems (feeder systems to Medicaid eligibility files, combined eligibility intake, provider location demographics, state Websites, etc.).
- State universities (staff training, research and data analysis, specialized clinical expertise).
- Attorney General's office (fraud and abuse investigations and prosecution, defense against lawsuits).

In most of these instances, the Medicaid program shares in the administrative costs of the collaboration provided.

State agencies also pay other state agencies or programs, or county agencies or facilities, for services they provide to Medicaid beneficiaries. These include:

- State or county or city hospitals (including university hospitals), outpatient clinics, and nursing homes
- Public clinics and mental health centers
- Public programs for persons with disabilities
- Adult day centers
- School-based clinics
- Transportation agencies (ambulances, handicapped networks, etc.)
- Public home health agencies
- Mental health, mental retardation, or child welfare agencies for case management services

### **Future Opportunities for Collaboration and Examples of Collaboration**

Potential collaboration efforts, already in place in some states, include:

- Partnering with vocational rehabilitation and other employment services to support Medicaid beneficiaries with disabilities who wish to continue in or enter the world of work.
- More intensive sharing of data, especially with public health, to identify areas of provider shortage, high incidence of certain diseases or conditions, pockets of underserved populations.
- Linking quality improvement and performance measurement initiatives across various programs, identifying common goals, and reducing provider burden -- partners could include state employee benefit agencies, mental health and mental retardation agencies, Title V maternal and child health programs.

## **Tools, Resources and Contacts**

APHSa contacts: Jerry Friedman, Executive Director, 202/682-0100; Elaine Ryan, Deputy Executive Director for Policy and Government Affairs, 202/682-0100, email: [eryan@aphsa.org](mailto:eryan@aphsa.org); Michelle Mickey, Acting Director, Health Policy, 202/682-0100, email: [mmickey@aphsa.org](mailto:mmickey@aphsa.org)

There is a wealth of information and data available about the state Medicaid programs. Some of the most frequently used resources are:

- APHSa's Website ([www.aphsa.org](http://www.aphsa.org)) or its National Association of State Medicaid Directors affiliate Website ([www.nasmd.org](http://www.nasmd.org)). It includes a searchable database of state-by-state eligibility policy for aged and disabled individuals, a membership list of all the Medicaid Technical Advisory Groups, and a special section for its Center for Workers with Disabilities project
- Center for Medicare and Medicaid Website ([www.cms.hhs.gov](http://www.cms.hhs.gov)). A wealth of statistical information and policy issuances is found on this site.
- State's own Websites. They often include state Medicaid data and special reports.
- The KaiserNetwork.org, for broad coverage of health policy issues nationally and Webcasts of conferences and meetings of special interest
- Reports of The Kaiser Commission on Medicaid and the Uninsured, available through the Kaiser Family Foundation Website ([www.kff.org](http://www.kff.org))
- The National Health Policy Forum ([www.nhpf.org](http://www.nhpf.org)). Good papers, from a nonpartisan perspective, on a variety of health policy topics
- Center for Health Care Strategies ([www.chcs.org](http://www.chcs.org)). For Medicaid managed care issues
- NY Times and *Health Affairs*

## **State Mental Health Agencies (SMHAs)**

### **Program description**

Collectively, the state mental health agencies (SMHAs) administer the nation's \$23 billion public mental health system that provides critical services and support to more than 6 million people in 50 states, the District of Columbia, and the territories. They provide services that cross a broad continuum of care, ranging from critical inpatient acute care and crisis intervention to community-based case management, treatment and rehabilitation services, peer support, and early intervention.

### **Program Goals**

The principle purpose of SMHAs is to minimize the impact of mental illness and to promote mental health and recovery by providing accessible, comprehensive mental health services for all those in need.

### **Populations Served**

In general, an SMHA's focus is to serve adults and children with the most serious psychiatric disorders. Most are unemployed, poor, and uninsured. They are frequently homeless and are significantly over-represented among the segment of the population in contact with the criminal and juvenile justice systems. Most adults served by SMHAs suffer from mental disorders including schizophrenia, bipolar disorder, major depression, panic disorder, and obsessive-compulsive disorder. The children served are generally those with diagnosable mental health problems that severely disrupt their ability to function socially, academically, and emotionally.

### **Constituencies And Critical Community Partners**

In some states, county governments are partners in the effort to produce effective public mental health services. In addition, private, nonprofit organizations such as community mental health centers are sometimes contracted by SMHAs to provide services. Local chapters of organizations such as the National Mental Health Association (NMHA), the American Psychological Association (APA), the American Psychiatric Association (APA), and the National Association for the Mentally Ill (NAMI) also partner with SMHAs on various efforts.

### **Overview Of Major Funding Sources And Supervising Agencies**

Funding for SMHAs is derived from a variety of sources, including state appropriations and federal funds in the form of block grants, Medicaid, Medicare, and other miscellaneous sources. As with all state government offices, the governor is ultimately the supervisor of each SMHA. In some states, an appointed board of directors guides the development and progress of each SMHA. An SMHA could be located in a state's health or human services department, or it could be an independent state agency. Many SMHAs include the state's offices of substance abuse, trauma/domestic violence, and mental retardation services.

## **Future Opportunities For Collaboration**

As described by the President's New Freedom Commission on Mental Health in its October 2002 *Interim Report to the President*, states are facing enormous challenges in serving the needs of people with mental illness. While the reasons for this are complex and varied, there is little doubt that state mental health systems would be enhanced by better collaboration. The report explains the unintended consequence of de-institutionalization within the mental health system.

Responsibility is scattered across levels of government and across multiple agencies. New programs created to fill gaps in care added to the complexity and fragmentation. The federal government pays for most services for people with a serious mental illness, while responsibility for providing them rests with states and localities. Compounding this problem, most federal resources are in mainstream programs (e.g., Medicaid, Medicare, vocational rehabilitation, housing) that are not tailored to the requirements of good mental health care.

The following issues, excerpted from *State Mental Health Commissions: Recommendations for Change and Future Directions* (Bell & Shern, 2002), help illustrate the interrelated nature of the major challenges facing the public mental health system today, as well as the opportunities for existing and potential collaboration.

- Although millions of Americans rely on public mental health services, thousands of people in need of such services do not have access to them. Children and older Americans are particularly underserved. Without outreach to people with mental health problems where they live, work, gather, or go to school, and absent preventive and early intervention services, problems become progressively worse, with devastating personal and societal consequences.
- Stigma, discrimination, and lack of insurance coverage for mental illnesses continue to inhibit access to care for many Americans.
- A lack of community mental health care has led to widespread, inappropriate use of hospital emergency departments, crisis stabilization units, and institutional and residential care, including jails, prisons, and juvenile justice facilities.
- Our nation's prisons have become, in effect, our largest mental hospitals. In many states, a greater number of individuals with severe mental illnesses are incarcerated than are hospitalized in state psychiatric facilities. Proven community care strategies exist to keep many of these individuals out of correctional settings but aren't widely available.
- Especially for persons with severe mental illnesses, desperately needed support and rehabilitation services (housing, transportation, employment, disability benefits, health care, etc.) are not available. The lack of such support services frequently leads to an exacerbation of symptoms and ultimately higher costs than would have occurred with adequate support services.
- Billions of dollars are spent on public mental health across multiple sectors, but funds are often disproportionately allocated to deep end, intensive services. At the

same time, many critical prevention and early intervention programs are underfunded.

**Positive Example of Collaboration:**

**The Criminal Justice / Mental Health Consensus Project**

This project is an unprecedented, two-year national effort to prepare specific recommendations that local, state, and federal policy makers and criminal justice and mental health professionals can use to improve the criminal justice system's response to people with mental illness. Coordinated by the Council of State Governments, guided by a steering committee of six organizations (including the National Association of State Mental Health Program Directors, which represents SMHAs), and advised by over 100 prominent criminal justice and mental health experts and professionals, the Consensus Project provides concrete, practical approaches that can be tailored to the unique needs of communities. The *Consensus Project Report* is a collection of 47 policy statements created by the group to aid legislators, policy makers, practitioners, and advocates in making a broad systemic impact on the problem. The statements include specific recommendations to implement the policies, along with examples of programs, policies, or elements of state statutes that illustrate one or more jurisdictions' attempts to implement a particular policy statement (Criminal Justice/Mental Health Consensus Project, 2002).

**Tools, Resources and Contacts**

For more information on SMHAs, contact:

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National Association of State Mental Health Program Directors (NASMHPD)  
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Alexandria, VA 22314  
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Or, for more info visit the following sites on the World Wide Web:

[www.nasmhpd.org](http://www.nasmhpd.org)  
[www.nasmhpd.org/ntac](http://www.nasmhpd.org/ntac)  
<http://nri.rdmc.org/>

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<http://www.mhmr.state.tx.us/>

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Criminal Justice/Mental Health Consensus Project. (2002). *The Consensus Project Report*. <http://www.consensusproject.org>

The President's New Freedom Commission on Mental Health. (October 29, 2002). *Interim Report to the President*. Washington, DC: The President's New Freedom Commission on Mental Health.

## Special Education

### Program Description

The Individual with Disabilities Education Act (IDEA) is the federal law that mandates special education supports and services to the nation's infants and toddlers, preschoolers, children and young adults. Originally passed by Congress in 1975 as the Education for All Handicapped Children Act of 1975 (P.L. 94-142), the law has been amended several times, most recently in 1997. Special education services are funded through a combination of federal, state and local funding. There are three large formula grant programs as well as numerous federal-level programs. The cornerstone of the program is **Part B** – grants to states, which assists states in providing a free appropriate public education to school-age children with disabilities. **Part C**, Infants and Toddlers Program, assists in providing early intervention services to infants and toddlers under the age of three. **Section 619** of Part B provides funding for services to children with disabilities ages three to five. **Part D** of the program provides funding for research, personnel preparation and in-service training.

### Program Goals

The goal of IDEA is to provide children with individualized educational services in the least restrictive environment. Some students may be mainstreamed in a regular classroom environment with a minimum of supports, while other students with severe disabilities at the other end of the spectrum may require residential placements. The local education agency is responsible for providing services that are agreed to by a team of individuals, including the student's parents, teachers, support personnel, special education personnel, administrators and other individuals with knowledge of the student. The team develops an Individualized Educational Program, or IEP, for children found eligible for services under either Part B or Section 619 and an Individualized Family Service Plan (IFSP) for infants and toddlers and their families. (Some school districts continue their IFSPs for 3-5 year olds.) These plans determine what services the child will receive. The local education agency (LEA) is responsible for providing the services described in the IEP or IFSP and for paying the full cost of these services. If parents are dissatisfied with the services that their child is receiving, they may elect to ask for a due process hearing conducted by an independent hearing officer to resolve differences that they have with the school. School districts are not required to cover the costs of educating children whose parents unilaterally decide to place them in private schools (without the consent of the IEP team); however, the school district is obligated to provide *some* services to these children, but not necessarily all of the services that the child received in a public school setting or in a private school setting agreed to by the IEP team.

### Description of the Populations Served

Generally, IDEA provides services for children from birth through age 21, unless state law dictates otherwise. (States must provide services to 6-18 year olds). Services are provided through the Part C Program for Infants and Toddlers; the Section 619 program for preschool children ages 3-5 and the Part B program for children and youth. To be served, a child must be evaluated and a determination made that the child has a disability

as defined in 20 U.S.C. Section 1401(c) of the regulations. Covered disabilities include: mental retardation, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments or specific learning disabilities and “who, by reason thereof, needs special education and related services. A child with a disability aged 3 through 9, may, at the discretion of the state and the local educational agency, include a child “experiencing developmental delays, as defined by the state and as measured by appropriate diagnostic instruments and procedures in one or more of the following areas: physical development, cognitive development, communication development, social or emotional development or adaptive development” and who needs special education and related services. Local education agencies operate “Child Find” services that are charged with helping their communities identify children with special needs.

According to the 23<sup>rd</sup> Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act (containing data from the 1999-2000 school year, the most recent report available), 5,683,708 students ages 6 through 21 were served, representing a 2.6 percent increase over the 1998-99 school year. One-half of the students served in this age group have specific learning disabilities. Five percent of all preschoolers, or 588,300 children were served and 205,769 children and their families received early intervention services under Part C. This later figure represents 1.8 percent of the nation’s infants and toddlers.

### **Constituencies and Critical Community Partners**

The key stakeholders in special education include state and local administrators of special education; teachers; local school administrators; support services personnel; parents; parent organizations; disability groups; and others who work with children with disabilities and their families. IDEA also funds parent information centers in every state that provide information to parents on special education and their rights under the law. There are many other federally funded education and employment-related programs that provide services to students with disabilities, including vocational education, vocational rehabilitation, community mental health services, SSI, Medicaid, and the Ticket to Work Project. Other involved entities include teachers unions; the Council of Administrators of Special Education (CASE), which represents local directors of special education; and the National Association of State Directors of Special Education (NASDSE), which represents the state directors of special education.

### **Overview of Major Funding Sources and Supervising Agencies**

A major funding source for the IDEA is the federal government. For FY02, the federal government provided \$7.5 billion for Part B; \$390 million for Section 619 and \$417 million for Part C. The Part D program, which supports national activities, is funded at \$337 million. The federal government pays approximately 17 percent of the cost of the Part B program; the remainder of the funding comes from state and local expenditures. President Bush’s budget for FY03 proposed a \$1 billion increase in funding for Part B and a \$20 million increase for Part C. However, the impasse in Congress over the FY03 budget has left spending levels for all education programs in doubt. When P.L. 94-142

was enacted, Congress pledged to provide 40 percent of the cost of special education; the federal portion has never come close to that amount. It is important to note that, with certain exceptions, federal funds cannot be used to supplant local or state funding for the IDEA and the law also includes a maintenance of effort that prevents states and local government from cutting back on their funding for special education.

At the federal level, oversight of special education is provided by the Office of Special Education Programs (OSEP) at the Department of Education. Each state department of education has a division of special education. These state entities are directed by a state director of special education (the titles differ from state to state) and are usually appointed by the state superintendent. In most cases, they serve at the discretion of that individual. State departments of education are responsible for monitoring local education agencies to ensure that their programs are being properly implemented, for providing in-service training for special education services and for addressing issues that arise in providing services to students with disabilities and their families.

### **Areas of Current Interdependence**

Collaboration of other community entities is desperately needed to address the needs of students with disabilities. The need for services is particularly acute when students are transitioning out of the special education system – either because they have graduated or aged out of the public education system. Many such students will need support from vocational rehabilitation agencies, other employment agencies, community mental health services, Medicaid, social services and other community services if they are to make a successful transition to work or post-secondary education. These entities should be involved with transition planning, which under IDEA is required to begin at age 14. Other community entities need to become involved at all stages of special education, e.g., community health centers that provide services to infants and toddlers and young children with disabilities. Medicaid funds can be used to support costs related to the evaluation of eligible children and the provision of some medical services that children need in order to attend and participate in school. However, the current policy of the Centers for Medicare and Medicaid (CMS) is to be as restrictive as possible in reimbursing school districts for health-related expenditures.

### **Future Opportunities for Collaboration and Examples**

Future opportunities for collaboration include:

- Collaboration with vocational rehabilitation in providing transition services to youth existing the special education system; including services to that will lead to employability for youth;
- Collaboration with community mental health agencies to address the mental health needs of children and youth with severe emotional disturbance;
- Collaboration with development disability agencies to address the needs of students with cognitive impairments;
- Collaboration with the Social Security Administration to engage youth in the Ticket to Work Program (TTW) or to provide Supplemental Security Income (SSI) to individuals who cannot be employed;

- Collaboration with Title I programs, which provides educational services to economically disadvantaged children, to provide an array of educational services to children who are eligible for both Title I and IDEA services;
- Collaboration with vocational education programs to provide career education opportunities to youth with disabilities while they are still in school.

### **Tools, Resources and Contacts**

- To find your state director of special education go to [www.nasdse.org](http://www.nasdse.org)
- For information from the U.S. Department of Education, go to <http://www.ed.gov/offices/OSERS/>
- For links to many organizations that are involved with special education, federal law and regulations, go to <http://www.ideapolicy.org/>.
- For information on state policy and links to state directors of special education, go to the National Association of State Directors of Special Education at <http://www.nasdse.org/>
- The Council for Exceptional Children (CEC) at <http://www.cec.sped.org/>. CEC has a link to the Clearinghouse on Disabilities and Special Education.
- The National Governors Association, <http://www.nga.org/>
- The Council of Chief State School Officers, <http://www.ccsso.org>
- For a list of research organizations, go to: <http://www.ed.gov/EdRes/EdFed/specedrs.html>

Bill East, Executive Director  
 Nancy Reder, Deputy Executive Director  
 National Association of State Directors of Special Education  
 1800 Diagonal Road, Suite 320  
 Alexandria, Virginia 22314  
 Phone: 703-519-3800  
 Fax: 703-519-3808  
 Email: [east@nasdse.org](mailto:east@nasdse.org); [nreder@nasdse.org](mailto:nreder@nasdse.org)  
 Website: [www.nasdse.org](http://www.nasdse.org)

## **State Substance Abuse Agencies (SSAs)**

### **Program Description**

State substance abuse agencies, also known collectively as Single State Authorities (SSAs), administer the nation's public substance abuse system that provides vital services to millions in States and territories across the country.

### **Program Goals**

The purpose of SSAs is to address the problem of addiction by providing comprehensive prevention and treatment services for those in need and collaborating with other agencies and stakeholders on addiction related problems.

### **Populations Served**

Overall, it is estimated that between 13 and 16 million people need substance abuse treatment in any given year. However, it is estimated that approximately 3 million people actually receive treatment each year. As a result, more than 10 million people do not receive the services they need. (1)

With this in mind, SSAs serve a range of populations presenting with a number of conditions requiring clinically appropriate care. In terms of demographic characteristics, clients vary in age, ethnic background, gender, socio-economic background, family status, etc. In addition, SSAs serve many clients with "co-occurring problems," or those having at least one other diagnosable condition other than substance abuse. Some examples include HIV/AIDS, TB, mental illness, etc.

### **Constituencies And Critical Community Partners**

Substance abuse systems are as diverse as the States in which they reside. However, common partners include state legislatures, county governments, mayors, town councils, community anti-drug coalitions, law enforcement officials, schools, faith-based organizations, private or nonprofit provider and consumer organizations, universities, and many others.

### **Overview of Major Funding Sources And Supervising Agencies**

SSAs receive funds from a number sources. At the federal level, for example, SSAs receive a allotment from the Substance Abuse Prevention and Treatment (SAPT) Block Grant managed by the Substance Abuse and Mental Health Services Administration (SAMHSA), which is located in the Department of Health and Human Services (HHS). Other examples of funding sources include state appropriations, county and local funds, Medicaid and other funding streams.

SSAs can be found in a number of agency locations - depending on the state configuration. For example, a few states have established cabinet level agencies. However, the Governors in each state have the ultimate authority over substance abuse agencies.

## **Current Interdependence and Future Opportunities For Collaboration**

At the national level, the National Association of State Alcohol and Drug Abuse Directors (NASADAD), Inc. works with a number of federal agencies, including SAMHSA, the Office of National Drug Control Policy (ONDCP), National Institute of Drug Abuse (NIDA), National Institute of Alcohol Abuse and Alcoholism (NIAAA), Department of Justice (DOJ), Department of Education (ED), Department of Housing and Urban Development (HUD), Center for Medicare and Medicaid Services (CMS) and others.

NASADAD also partners with non-governmental organizations that include National Governors Association (NGA), National Association of State Mental Health Program Directors (NASMHPD), National Association of State and Territorial AIDS Directors (NASTAD), American Public Human Services Association (APHSA), Community Anti-Drug Coalitions of America (CADCA), National Association of County Behavioral Health Directors (NACBHD), and many others.

At the State level, SSAs collaborate with a number of other stakeholders on an ongoing basis, including:

- Mental health agencies
- Juvenile justice agencies
- Drug court systems
- Criminal justice agencies
- Child welfare administrators
- TANF administrators
- HIV/AIDS agencies
- Education agencies
- Employment agencies
- Departments for the Aging
- Homeless departments
- Developmental disability services
- Transportation departments
- Tribal governments

One example of collaboration at the national level relates to the link between child welfare and substance abuse. In particular, the National Center on Substance Abuse and Child Welfare (NCSACW) is a service of the Department of Health and Human Services' (DHHS) Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) and the Administration for Children and Families (ACF), Children's Bureau's Office on Child Abuse and Neglect (OCAN). The Center for Children and Family Futures (CCFF), under contract with DHHS, leads a consortium of national experts in the implementation of the NCSACW. Consortium member organizations include: NASADAD, American Public Human Services Association (APHSA), Child Welfare League of America (CWLA), National Council of Juvenile and Family Court Judges (NCJFCJ) and National Indian Child Welfare Association (NICWA). A key feature of NCSACW's efforts is assistance in developing

the cross-system partnerships and practice changes that are needed to address the issues of substance use disorders among families in the child welfare system.

Another collaborative effort relates to services to those with co-occurring mental health and substance use disorders. In particular, NASADAD teamed with NASMHPD to form a Joint Task Force on Co-Occurring Disorders to provide leadership; promote partnerships; exchange information; and facilitate technical assistance on issues related to persons with co-occurring disorders. The activities of that Joint Task Force were sponsored by SAMHSA's Center for Substance Abuse Treatment (CSAT) and its Center for Mental Health Services (CMHS). Specific publications stemming from this collaboration include:

- National Dialogue on Co-occurring Mental Health and Substance Abuse Disorders (1998),
- Conceptual Framework for Improving Systems of Care for Co-Occurring Mental Health and Substance Abuse Disorders (March 1999),
- Financing and Marketing the New Conceptual Framework for Co-occurring Disorders (April 2000), and its supplement, Successful Programs for Co-Occurring Disorders: NASADAD-NASMHPD Case Study Report (2002).

### **Tools, Resources and Contacts**

For more information on SSAs, contact:

Lewis E. Gallant, Ph.D., Executive Director  
National Association of State Alcohol/Drug Abuse Directors (NASADAD)  
808 17<sup>th</sup> Street, NW, Suite 410  
Washington, D.C. 20006  
Phone: (202) 293-0090  
Fax: (202) 293-1250

Or, for more info visit the following sites on the World Wide Web:  
<http://www.nasadad.org>

For information related to the National Center on Substance Abuse and Child Welfare (NCSACW), please see <http://ncsacw.samhsa.gov>.

### **References for this Summary Report:**

(1) Changing the Conversation: Improving Substance Abuse Treatment: The National Treatment Plan Initiative, (November 2000), Substance Abuse and Mental Health Services Administration (SAMHSA).



## **Temporary Assistance for Needy Families (TANF)**

### **Program Description**

The enactment of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, P.L. 104-193, also known as welfare reform legislation, marked the end of the federal entitlement to cash and child care assistance and ushered in a new era of work and personal and parental responsibility. The law repealed the former Aid to Families with Dependent Children (AFDC) entitlement and replaced it with the Temporary Assistance for Needy Families (TANF) block grant to states to provide time-limited assistance, to employ strict work requirements, and to address a range of family formation goals. Under the law, states were guaranteed a fixed grant amount of funding from the federal government for six years, and in return were required to maintain state spending or face penalties. States were afforded flexibility to design TANF programs that met their individual goals and respected the diversity of each state and its citizenry.

### **Program Goals**

The statute provides that a state may use the TANF grant “in any manner that is reasonably calculated to accomplish the purpose of this part.” The four purposes of the TANF program are:

1. To provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives.
2. To end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage.
3. To prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies.
4. To encourage the formation and maintenance of two-parent families.

### **Populations Served**

TANF funds can be used for both “needy” and “nonneedy” families depending on which goal of the program is being addressed. States may use federal TANF to provide up to five years of assistance to needy families that include a minor child and/or a pregnant woman. There is no limitation on those who can be served with TANF in order to meet goals three and four that address out-of-wedlock pregnancies and family formation. However, there are some populations that are ineligible for assistance. Unwed, teenage mothers under the age of 18 are not eligible unless they attend high school and live in an adult supervised living arrangement. Legal immigrants who entered the country on or after August 22, 1996 are ineligible for TANF for five years after their arrival. Also, persons ever convicted of a drug-related felony are banned for life from TANF, although states can opt out of the ban or limit it.

### **Constituencies and Critical Community Partners**

Since TANF focuses on both cash assistance and a wide array of support services, the key constituencies are diverse and extensive. In addition to the administrators, they include employment-related and employment support partners, as well as those necessary to

make sure TANF recipients and their children are safe. Constituents include the following:

- State, County and Local Public Sector Administrators
- Nonprofit and Faith-based Providers of Family Support Services
- Business Community
- Child Care and After-School Providers
- Community Colleges and Technical Training Schools
- Child Support Enforcement Administrators
- Local Workforce Investment Boards
- Mental Health Providers
- Family Planning Providers
- Local Transportation Authorities

### **Overview of Major Funding Sources and Supervising Agencies**

The block grant is presently funded at \$16.5 billion annually and is categorized as mandatory funding and is therefore, not subject to the yearly appropriations process. Funding for both the high performance and out-of-wedlock bonus and supplemental grants to states are not included in the base funding. To receive federal block grant funds, states are required to maintain funding for qualified program expenditures at a level equivalent to at least 80 percent of the state share of AFDC expenditures in federal FY94—when welfare caseloads were at their highest levels in recent history. If the state meets the work participation rate requirement, the MOE requirement drops to 75 percent.

The TANF block grant is administered federally, through the Office of Family Assistance at the Department of Health and Human Services, Administration for Children and Families (ACF). ACF is supported by ten regional offices across the country that supports both states and U.S. territories. Research on TANF is provided through the ACF Office of Planning, Research, and Evaluation and the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE). In addition, the Office of Civil Rights at HHS guards against unlawful discrimination within the administration of the TANF block grant.

### **Areas of Current Interdependence**

At the federal level, interdependency exists between TANF and a host of other block grants and funding streams; the most notable being with the Child Care and Development Block Grant, the Child Support Enforcement System, the Social Services Block Grant, and Transitional Medicaid.

- Child Care and Development Block Grant (CCDBG)  
The Child Care and Development Block Grant is integral to the success of the TANF program even though there is no federal mandate for states to provide child care assistance. States have used a growing percentage of their TANF block grant to provide child care and are also able, through statute, to transfer up to 30 percent of their TANF funds into the CCDBG.

- Child Support Enforcement  
The child support program is widely considered to be a welfare-related program. In order to be eligible for TANF, families must assign child/spousal support rights to the state. In addition, the fundamental funding source for the administration of the federal program was designed to be the state and federal share of child support collections made on behalf of current and former welfare families. In other words, federal and state governments, through the Aid to Families with Dependent Children (AFDC)/TANF program, would support families, and once child support was collected from the noncustodial parent, federal and state governments would share that collection as repayment for the period the family was on welfare.
- Social Services Block Grant (SSBG)  
Presently, states may transfer up to ten percent of the TANF funds into SSBG. In addition, SSBG has supported families involved in the TANF program. Since TANF legislation was passed in 1996, HHS reports show that SSBG expenditures for housing services have increased 89 percent; substance abuse services have increased approximately 62 percent; and information and referral services, as well as employment support for persons with disabilities or barriers to employment have doubled.
- Transitional Medicaid  
The TANF law requires that states provide 12 months of medical assistance to children and adults who lose TANF eligibility due to increased earnings.

### **Future Opportunities for Collaboration**

As the TANF block grant moves into its next phase and related programs are reauthorized, the need for increased collaboration with other systems such as the Workforce Investment Act, food and nutrition programs, and tax support is recognized.

- Workforce Investment Act (WIA)  
Within the WIA regulations, the TANF agency is specifically suggested as an additional partner in the one-stop system, although there is no federal mandate. According to the Department of Labor, “TANF recipients will have access to more information about employment opportunities and services when the TANF agency participates in the one-stop delivery system. The governor and local board should encourage the TANF agency to become a one-stop partner to improve the quality of services to the Welfare-to-Work (W-t-W) and TANF-eligible populations. In addition, becoming a one-stop partner will ensure that the TANF agency is represented on the Local Board and participates in developing workforce investment strategies that help cash assistance recipients secure lasting employment.” In addition, when adult training and employment funds are limited in a local area, the WIA statute requires that TANF recipients be given priority. Many states have already taken steps to better coordination and integration between systems and house both programs under the same department. Others locate TANF staff in the one-stop centers to provide income eligibility and services and some states finance the one-stops with TANF funds.
- Food and Nutrition

TANF children automatically are eligible for free school meals. In addition, continuing from the former AFDC entitlement, women, infants, and children enrolled in TANF automatically are income-eligible for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). The present TANF law also includes a high performance bonus measure on the amount of low-income working families that receive food stamps in a state. Also, one of the triggers for accessing the TANF contingency fund is based on a ten percent increase in a state's food stamp caseload.

### **Tools, Resources, and Contacts**

- *Temporary Assistance for Needy Families (TANF) Fourth Annual Report to Congress*, May 2002, U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research and Evaluation.
- *Indicators of Welfare Dependence, Annual Report to Congress 2002*, U.S. Department of Health and Human Services.
- *Status Report on Research on the Outcomes of Welfare Reform*. DHHS, Assistant Secretary for Planning and Evaluation <http://aspe.hhs.gov/hsp/welf-ref-outcomes02/index.htm>.

APHSA contacts:

Jerry Friedman, Executive Director

Elaine Ryan, Deputy Executive Director for Policy and Government Affairs  
202-682-0100

email: [eryan@aphsa.org](mailto:eryan@aphsa.org)

APHSA Website: [www.aphsa.org](http://www.aphsa.org)

An extensive list of welfare-related Websites can be accessed via the Welfare Information Network Web page at <http://www.welfareinfo.org/sites.htm>.

## **The Public Vocational Rehabilitation (VR) Program**

### **Program Description**

*The Rehabilitation Act of 1973* (Rehab Act), as amended, authorizes multiple programs that provide comprehensive and complementary services to empower individuals with disabilities to maximize employment, economic self-sufficiency, independence, and inclusion and integration into society. The **Public Vocational Rehabilitation (VR) Program**, authorized under Title I, is one of the most cost effective programs ever created by Congress. Each year, more than 1.2 million Americans with disabilities receive services from VR to assist them in overcoming barriers to employment. Of those served each year, more than 233,000 enter competitive employment.

### **Program Goals**

The purpose of the Public VR Program is to assist states in operating statewide comprehensive, coordinated, effective, efficient, and accountable programs of vocational rehabilitation. During its 83-year history, VR has assisted approximately fourteen million Americans with disabilities to prepare for and engage in gainful employment. The VR program is designed to assist eligible individuals obtain employment. The 1998 amendments to the Act require each state VR program to be an integral part of the statewide workforce investment system created under *The Workforce Investment Act of 1998*.

State VR agencies provide a comprehensive array of services and supports, including:

- Assessment of eligibility and the need for VR services;
- Vocational counseling and guidance;
- Job development and placement services;
- Rehabilitation technology services;
- As appropriate, training and post-secondary education; and
- Other services and supports to facilitate meaningful participation in employment and training services.

All of the programs authorized under the Rehab Act must be carried out in a manner consistent with the principles of respect for individual dignity, personal responsibility, self-determination, and pursuit of meaningful careers. The VR system must ensure that individuals with disabilities and their authorized representatives are full partners in the VR process. Individuals with disabilities must also be involved on a regular basis and in a meaningful manner with respect to policy development and implementation. VR agencies must assist eligible individuals in exercising informed choice throughout the VR process. Services are provided under an Individualized Plan for Employment (IPE). The IPE, which is jointly developed and signed by the VR counselor and the eligible consumer, outlines the services and supports required for that individual to achieve the vocational goal of his or her choice.

The VR counselor is the cornerstone of the VR program. As the key professional in the system, the VR counselor is responsible for interacting with individuals with disabilities who are seeking or receiving VR services. To be qualified to serve the varied and diverse

needs of persons with disabilities, VR counselors must meet a federal professional standard or the highest state standard for the profession, which usually includes completion of a master's degree.

### **Populations Served**

Eligibility for VR Services and Targeted Populations: To receive services, an individual must have a physical or mental impairment that results in a substantial impediment to employment, and the individual must require VR services to prepare for, secure, retain, regain or advance in employment. Any service an individual receives from the VR system must ultimately be connected to an employment outcome. Employment outcomes include entering or retaining full-time or, if appropriate, part-time employment in the integrated labor market. This includes supported employment, self-employment, telecommuting and business ownership, as well as other vocational outcomes the Secretary of Education may determine to be appropriate.

Recipients of Social Security disability benefits (SSDI/SSI) are presumed eligible for VR services; provided they are seeking employment. An individual with a disability, regardless of the significance of the disability, is presumed capable of benefiting from VR services in terms of an employment outcome unless the VR agency can demonstrate by "clear and convincing" that he or she cannot benefit. Prior to making such a determination, VR must explore a person's work potential through a variety of trial work experiences, with appropriate supports.

With limited exceptions, the State Unit designated to implement the VR program (DSU) must determine eligibility within a reasonable period of time, not to exceed 60 days, after the individual submits an application. To the extent possible, existing information is used to make eligibility determinations.

Each DSU is required to monitor its resource utilization on an ongoing basis and project whether or not the fiscal and human resources available to it are sufficient to continue the full range of VR services to consumers with IPEs and to provide the full range of services to individuals who are expected to apply and be determined eligible during the upcoming year. If resources are determined to be inadequate, VR is required to implement an Order of Selection (OOS), i.e., a system of prioritization for service delivery whereby eligible individuals with the most significant disabilities (as defined by the state) are served first. However, VR must also be able to continue its outreach efforts to unserved and underserved populations, to accept and process all referrals and applications, and to provide diagnostic and evaluation services necessary to assess each applicant's eligibility and priority for services. Under an OOS, individuals with less significant disabilities may be placed on a waiting list until such time as sufficient resources are available to serve them.

### **Constituencies and Critical Community Partners**

The Public VR Program has a long history of working in partnership with different constituencies and community partners. With increased emphasis on informed choice throughout the process, VR continues to expand the universe of service providers from which they purchase services and supports. Under the Rehab Act, states are required to

develop a comprehensive state plan that provides assurances of compliance with the statute and governing regulations, and descriptions of certain policies and plans that the state will undertake. The state plan also identifies certain state options such as financial needs test. The plan must ensure the coordination and timely delivery of services.

Assistive technology (AT) is a fundamental tool that individuals with disabilities can use to overcome barriers to employment. Some State VR Agencies report that the number of customers benefiting from the use of AT has doubled in the last 5 years. As qualified VR counselors conduct individualized assessments and as individualized planning occurs, VR works closely with state AT projects, various state agencies (e.g., developmental disabilities and Medicaid), community rehabilitation programs, independent living centers, and other state and local service providers to ensure the meaningful participation of eligible individuals in training and employment services, and to assist eligible individuals in overcoming barriers to employment.

### **Overview of Major Funding Sources and Supervising Agencies**

Title I of the Rehab Act provides formula grants to states for services and supports to assist eligible individuals to engage in gainful employment. Funds are allocated to the states and territories according to a formula based on state population and per capita income. States with lower per capita income receive a relatively higher allotment. States have the option of using part of the VR allotment to create a separate State Agency for the Blind. Currently, twenty-four (24) states have a separate agency for the blind (AR, CT, DE, FL, ID, IA, KY, ME, MA, MI, MN, MO, NE, NJ, NM, NY, NC, OR, SC, SD, TX, VT, VA, WA). States are required to match federal funds at a rate of 78.7 percent federal to 21.3 percent state. The requirement for the state match creates a state/federal partnership that has worked well for over 80 years.

The Rehab Act mandates that the annual federal appropriation for VR grow at a rate at least equal to the change in the Consumer Price Index (CPI) over the previous fiscal year. While this mandate was intended to create a floor for the VR appropriation, Congress appears to view it as a ceiling, appropriating only the mandated CPI increase for the last six years. Unfortunately, when the federal formula is applied to these minimum increases in funding, there are significant variations in the increases to individual state allotments and significant numbers of states receive less than the annual CPI increase. In FY02, 22 states received less than the mandated 3.4 percent CPI increase. Receiving less than the CPI increase has had a cumulative effect on the VR program in many states.

The Rehab Act was incorporated into title IV of *The Workforce Investment Act (WIA)* when it was first passed in 1998. While most programs authorized under WIA are administered by the Department of Labor, VR is administered by the Rehabilitation Services Administration (RSA) under the Office of Special Education and Rehabilitative Services (OSERS) within the Department of Education. RSA is responsible for administration and oversight of VR, for the promulgation of governing regulations and policy interpretations, and for working with other federal agencies to ensure the integrity of the Public VR Program as it works cooperatively with other employment and training programs (Federal/State; Public/Private; Profit/Non-Profit) and other programs designed to meet the unique needs of individuals with disabilities.

### **Areas of Current Interdependence (The Need for Collaboration)**

The services, supports and assistance available through VR to eligible individuals may be provided directly or purchased. State VR agencies work cooperatively and in collaboration with significant numbers of community partners (both public and private) to provide the full-range of services and supports that individuals with disabilities may need to prepare for, enter, retain or advance in employment.

In addition to informal arrangements for cooperation, collaboration and coordination, VR agencies are required to enter into cooperative agreements with certain state agencies and community partners. Under WIA, states are required to develop both statewide and local plans, and to include the VR system in the planning process. As part of this effort, VR is required to enter into memorandum of understanding with local one-stop centers throughout the state. Under the Rehab Act, VR must enter into cooperative agreements with "other" one-stop partners and work toward increasing the capacity of those partners and the one-stop system to better address the needs of individuals with disabilities. Cooperative agreements established at the state level are to be replicated at the local level. The VR state plan includes descriptions of interagency cooperation with, and utilization of the services and facilities of a variety of federal, state, and local agencies and programs. VR is also required to develop working relationships and coordinate their activities with the Statewide Independent Living Council and the independent living centers throughout the state. VR must also enter into a formal cooperative agreement with each recipient of an American Indian VR grant in the state.

The VR state plan must also include plans, policies, and procedures for coordination between VR and education officials responsible for the public education of students with disabilities. The plans must be designed to facilitate the transition of students with disabilities from the receipt of educational services in school (a system of entitlement to services) to the receipt of VR services (an eligibility-based system). With the federal appropriation for special education increasing by more than 150 percent since 1997, state VR agencies, which have seen little more than the mandated CPI increases during recent years, are finding it extremely difficult to meet the employment and training needs of increasing numbers of transitioning students with disabilities.

Under the Rehab Act, VR is the "payer of last resort" for certain services, i.e., services for which similar or comparable services/benefits are available through other public providers or funding sources. Nevertheless, VR is expected to provide the services if another entity refuses to do so in a timely manner, and then seek compensation.

### **Future Opportunities for Collaboration and Examples of Collaboration**

On the national level, the Council of State Administrators of Vocational Rehabilitation (CSAVR) is the membership organization for nearly all of the state VR programs. CSAVR recently expanded its Washington-based staff and got involved in several coalitions, including the Consortium for Citizens with Disabilities (CCD), the National Rehabilitation Coalition (NRC), and the Coalition of State Executive Branch Organization Executive Directors.

As the **Ticket to Work Program** is implemented nationwide over the next two years, many Social Security disability beneficiaries receiving tickets will go to VR for information and assistance. A key feature of the Ticket Program is its outcome payment system. Unlike VR, where these beneficiaries are presumptively eligible for services, private providers approved to function as employment networks (ENs) have the ability to choose who they serve. As a result, a significant percentage of SSDI and SSI beneficiaries, who have the most significant disabilities and more costly service needs, are expected to be referred to VR for services. Since the structure of the Ticket Program does not provide any “upfront” funding to serve beneficiaries, ENs who want to participate in the program will have to absorb considerable costs, pending payment from SSA, after the beneficiaries they serve obtain and maintain employment with salaries high enough to result in the discontinuation of cash benefits. VR and private providers are teaming up in a variety of ways to serve Social Security beneficiaries with tickets. In some states, VR is partnering with other providers to form a coalition which functions as a single EN. In other states, VR will be operating independently and competitively with other ENs.

The General Accounting Office (GAO) recently reported that individuals with disabilities and family members of such individuals represent approximately 44 percent of the remaining TANF population. Many of these individuals have previously unidentified or undisclosed disabilities. Many have multiple and significant barriers to employment. State welfare agencies are increasingly turning to VR for assistance in meeting the needs of these individuals. Many states have established formal arrangements to deal with such shared clientele, while others rely on more informal procedures. As more referrals are made between state welfare agencies and state VR agencies, more formal agreements will probably emerge.

Many states are focusing on implementing the Supreme Court’s *Olmstead decision*, which mandates that individuals with disabilities residing in institutions be moved into community settings whenever possible. As this happens, a number of community agencies will have to work together to meet the needs of these individuals in the community. VR will play a key role in assisting these individuals to enter the workforce.

### **Tools, Resources, and Contacts**

The Public VR Program can be a crucial resource for individuals with disabilities who are planning to enter or re-enter the workforce. VR provides a comprehensive array of services and supports to assist people with disabilities to become gainfully employed and increase their economic self-sufficiency. The success of VR is dependent to a large extent on VR’s ability to build and maintain community partnerships. A recent Longitudinal Study completed by the Research Triangle Institute demonstrated the success of the Public VR Program in securing sustained employment for VR consumers. For additional information on the Public VR Program, please visit the Council of State Administrators of Vocational Rehabilitation’s (CSAVR) Website at: [www.rehabnetwork.org](http://www.rehabnetwork.org). The Website includes a list of all state VR agencies, as well as information on the challenges facing VR and issues of concern to state VR directors. It includes links to many of the websites of the state VR agencies. You can also contact the

following CSAVR staff at 301/654-8414: Carl Suter, Executive Director; Rita Martin, Director of Membership Services; and Sallie Rhodes, Director of External Relations.

## **Workforce Development Programs**

### **Program Description**

In 1998, Congress passed the Workforce Investment Act (**WIA**), the first major reform of the nation's job training system in over 15 years. It was designed to replace the patchwork federal system that developed over the last sixty years with a locally designed and driven system to improve the quality of the workforce, enhance the productivity and competitiveness of the nation and reduce welfare dependency.

The Workforce Investment Act took effect on July 1, 2000. It passed by a wide bipartisan majority in part because it was designed to permit communities and states to build a workforce investment system that respects individual choices, reflects local conditions, and results in increased employment, retention, and earnings of participants, and increases occupational skills attained by participants.

The Workforce Investment Act is up for reauthorization in 2003.

### **Program Goals**

The WIA redesigned the nation's publicly-funded workforce development system to:

- Streamline multiple employment and training programs into an integrated one-stop career center system, simplifying access to services for job seekers and employers.
- Empower individuals to get the services and skills they need to improve their employment opportunities through qualified training programs of their choosing.
- Increase accountability of states, localities and training providers for their performance based on job placement rates, earnings, retention in employment, skill gains, and credentials earned.
- Involve local elected officials and the private sector in business-led boards for the local areas focusing on strategic planning, policy development and local oversight.
- Allow state and local flexibility to implement innovative and comprehensive workforce investment systems to meet the needs of their communities.
- Improve youth programs by creating youth councils that are linked more closely to local labor market needs and the community.

### **Populations Served**

The WIA authorizes core services to be made available to all adults with no eligibility requirements, and intensive and training services, for unemployed individuals who are not able to find jobs through core services alone. The Act also places a larger emphasis on serving the workforce needs of businesses.

Some of the programs administered under WIA are still targeted toward various populations (i.e., dislocated workers, veterans, vocational rehabilitation customers); however, these services should be provided “seamlessly” to customers through the one-stop career center system.

### **Constituencies and Critical Community Partners**

In the new system, the local level remains the focal point for operational and administrative decisions. It is where customers access services and where the design for the new one-stop career center system and the consumer-driven training system is implemented. Local WIBs have important roles in the new system.

The chief local elected officials have a central role in the administration of workforce investment activities. Specifically, the chief local elected official:

- Appoints the members of the local board that establishes workforce investment policies in the local area;
- Develops, in collaboration with the local board, the local workforce investment plan, which specifies the types of services that are provided;
- Serves, or designates an entity to serve, as the grant recipient for job training funds provided under the Act;
- Works with the local board to conduct oversight of the one-stop career center in the local area, designates and certifies one-stop operators, appoints one-stop partners from participating programs and develops and approves the memoranda of understanding under which one-stop career centers are administered; and
- Works with the local board to negotiate with the governor the performance levels that will be applicable to local areas and that could result in incentive funds or sanctions.

Additionally, representatives of chief elected officials are members of the state board that develops the state plan and carries out other statewide activities.

The Act includes numerous features designed to provide states with increased flexibility in designing and implementing workforce investment systems. It also prescribes new roles for governors. For example, the Workforce Investment Act:

- Requires that each state establish a business-led state WIB, consisting of the governor and appointees of the governor representing business, education, labor, local elected officials and others.
- Requires states to develop a comprehensive 5-year strategic state plan for all workforce investment activities, and monitor the operation of the workforce investment system.
- Increases significantly the governor's flexibility to finance activities that are state priorities by allowing the state to reserve fifteen percent from each of the three funding streams to use for an array of workforce investment activities.
- Provides the governor with a significant role in developing performance measures used to evaluate the effectiveness of the workforce investment system in his/her state.

State WIBs also play an important role in the design and implementation of state systems. For example, the Board assists the governor in developing a 5-year strategic plan, continuously improving the system, designating local workforce investment areas, developing state performance measures, and developing funding formulas.

### **Major Funding Sources and Supervising Agencies**

The major public funding sources for the employment and training services provided under WIA are federal general revenue funds that are appropriated to the U.S. Department of Labor. The funds are allocated by formula to states and further distributed by formula to local workforce investment areas. In most cases, the state grantee is the state workforce agency, sometimes also referred to as the state Labor Department or state Employment Security Agency.

In addition to funding for employment and training programs, states also receive funding to administer the unemployment insurance and employment services programs. These funds are derived from the Federal Unemployment Tax, and are also appropriated by Congress. State workforce agencies are responsible for the delivery of these services that are also provided through the one-stop career center system (although in many states, UI benefits are provided via telephone claim centers or over the Internet).

### **Areas of Current Interdependence (The Need for Collaboration)**

The partners required by WIA to be part of the one-stop career centers are:

- Adult, Dislocated Worker, and Youth Activities
- Employment Service
- Adult Education
- Post-secondary Vocational Education
- Vocational Rehabilitation
- Welfare-to-Work
- Title V of the Older Americans Act
- Trade Adjustment Assistance
- NAFTA Transitional Adjustment Assistance
- Veterans Employment and Training Programs
- Community Services Block Grant
- Employment and training activities carried out by the U.S. Department of Housing and Urban Development
- Unemployment Insurance

Each one-stop career center partner is required to serve on the local board and to enter into a Memorandum of Understanding (MOU) with the local board describing what services are to be provided at the one-stop career center, how the costs of the services and the operating costs of the system will be funded, methods of referral of individuals between the one-stop operator and the one-stop partners, the duration of the MOU, and the procedures for amending the MOU. In some states and local areas, the partners work well together and a truly seamless and integrated system is in place. In other locations, the partnership may exist on paper, but true integration is still a “work in progress.”

### **Future Opportunities for Collaboration and Examples of Collaboration**

As indicated above, there are many partners/programs that are required to participate in the WIA/one-stop career center system. In addition, some states have integrated the service delivery of their welfare programs with their workforce programs so that they are provided in the same location. In other states, rather than “re-inventing” a job placement

service at their own agency, the state or local welfare/human service agency will contract with the state workforce agency or local one-stop career center for the provision of job search/placement services for welfare clients. Depending on the contract, welfare clients are directed to the one-stop career center to receive these services or one-stop staff are out-stationed at the local welfare/human service office to provide these services.

Some states have created partnerships with the economic development agency with the goal of keeping and attracting new businesses and creating jobs for its citizens. Local education institutions (such as community colleges) frequently collaborate with state and local workforce and economic development officials to provide/offer courses in various fields that are identified by local employers and/or industry-wide associations to update the skills of the local workforce.

### **Tools, Resources, and Contacts**

All state workforce agencies are members of the National Association of State Workforce Agencies (NASWA). This organization, based in Washington, DC, provides opportunities for its members to network with each other and come together on areas of common interest. In addition, NASWA serves as a liaison for the state workforce agencies with the U.S. Department of Labor. NASWA staff work closely with staff from the National Governors Association and other intergovernmental organizations on workforce issues. NASWA's Website, the Workforce ATM ([www.WorkforceATM.org](http://www.WorkforceATM.org)), includes links to the Websites for all State Workforce Agencies as well as current legislative and programmatic information related to the publicly funded workforce development system.

For more information on NASWA, call or e-mail Kate Cashen, NASWA's Executive Director, at 202-434-8020 or [kcashen@naswa.org](mailto:kcashen@naswa.org).

## **Workforce Investment Boards**

### **Program Description**

Each state and local area has a workforce investment board (WIB), appointed by the local elected official, to assist in the development of the state plan and set policy for the local area. Each state and local board must develop and submit to the governor or local-elected official a comprehensive five-year local plan.

As part of the goal of Workforce Investment Act (WIA), in addition to replacing the Job Training Partnership Act (JTPA), it mandates the use of one-stop operating systems. The Act is designed to streamline services, eliminate duplication of services, and empower individuals to obtain the services and the skills they want and need. More flexibility for the Local Workforce Development Boards to operate programs, along with more accountability for their programs, is an essential part of the Act.

Workforce boards are business-led and will consist of the governor and his appointees at the state level, and the local-elected official appoints the board at the local level. Private employers must comprise a majority of each workforce board and the chair must be elected from the private sector membership, with the local elected official as the nominating agent. Workforce boards should be representative of the employer mix in the community, in terms of both size and type of industry. Employers bring to the table practical knowledge of the skills required by workers to satisfy the needs of area businesses. Working in conjunction with business members on the board are representatives of local government, education agencies, organized labor, economic development and community-based organizations, and social service agencies.

Approximately 10,000 business volunteers serve on the nation's local workforce boards, with the average local board consisting of between 25 and 50 members.

### **Program Goals**

The goals of the WIA are to improve the quality of the workforce, enhance the productivity and competitiveness of the nation and to reduce welfare dependency. WIBs are in charge of setting policy for their state and local areas.

To create local plans, WIBs must identify the workforce investment needs of business, job seekers and workers in the area; current and projected employment opportunities in the local area; and the job skills necessary to obtain such employment opportunities. WIBs are also charged with creating a description of the one-stop delivery system in the local area, including ensuring continuous improvement of eligible providers of services through the system and seeing that these providers meet the employment needs of local employers and participants.

In addition, local workforce investment boards, in agreement with the chief local elected officials, must develop and enter into a memorandum of understanding describing services to be provided through the one-stop delivery system, how the costs of services

and operations will be funded, and methods for referring individuals between one-stop operator and partners.

### **Populations Served**

Workforce boards do not directly provide services. Instead, workforce boards lead their state and local areas in directing workforce development policy and define their objectives.

### **Constituencies and Critical Community Partners**

In this system that remains focused on the local level, businesses are the principal “constituency” of the workforce boards. They are mandated to have at least half of the boards to be representatives from the private sector. Additionally, boards are required to have a representative from each of the 18 federally mandated partners and several optional partners as part of the workforce investment system. In this way, WIBs can become a public-private partnership that will help guide the workforce development system. These partners include:

- Adult, Dislocated Worker, and Youth Activities
- Employment Service
- Adult Education
- Post-secondary Vocational Education
- Vocational Rehabilitation
- Welfare-to-Work
- Title V of the Older Americans Act
- Trade Adjustment Assistance
- Veterans Employment and Training Programs
- Community Services Block Grant
- Employment and training activities carried out by the U.S. Department of Housing and Urban Development
- Unemployment Insurance
- Migrant and Seasonal Farmworkers Employment and Training programs
- Native American Employment and Training programs

Other optional partners include:

- Temporary Assistance for Needy Families (TANF)
- Community- and Faith-Based Organizations

These groups must all work in conjunction to agree to and enter into a Memorandum of Understanding (MOU) describing the services that will be provided at the local one-stop career center, how the costs of the services and the operating costs of the system will be funded, methods of referral of between the one-stop operator and the partners, the duration of the MOU, and procedures for amending the MOU.

## **Overview of Major Funding Sources and Supervising Agencies**

The U.S. Department of Labor is the major funder of the workforce investment system and workforce boards. These funds are allocated to states by formula and redistributed by states to local areas.

Additional contributors to the system include the U.S. Departments of Education, Health and Human Services, Housing and Urban Development, and Veterans' Affairs. These agencies will house job training and education services in the one-stop, partially paying for rent, a receptionist and other costs related to bringing these partners together to better serve all individuals. As contributing partners to the system, they sit on the state and local workforce boards, helping direct policy and funding.

## **Areas of Current Interdependence (The Need for Collaboration)**

There is a strong need for all federally mandated partners to collaborate on the WIBs. By participating in the one-stop workforce delivery system, these partnerships ensure that participants will be able to serve more people with fewer costs.

More importantly is the need for local employers to participate and steer activities of WIBs. Their participation allows the workforce development system fill gaps in the private sector, while performing a social service to individuals seeking jobs.

## **Future Opportunities for Collaboration and Examples of Collaboration**

Due to the current nature of the workforce investment system, opportunities for collaboration are diverse. Through integration of new partners, like Chambers of Commerce, TANF or community and faith-based organizations, the workforce development system can leverage new funding streams, be better equipped to meet the needs of customers, and eliminate some duplication of service.

## **Tools, Resources and Contacts**

Eighty-five percent of the nation's WIBs are members of the National Association of Workforce Boards (NAWB). NAWB provides opportunities for members to become informed on national issues, as well as learn about how to solve problems on a local scale. Providing members an opportunity to network with other members, NAWB also serves as a liaison for state and local WIBs with the U.S. Department of Labor. NAWB's Website, [www.nawb.org](http://www.nawb.org), provides contact information for all the WIBs around the country, as well as current legislative and programmatic information that will help workforce boards succeed.