



Minnesota Department of **Human Services** \_\_\_\_\_

## **Minnesota Family Investment Program Child-only Cases, Caregivers, and Children**

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## Executive Summary

The Minnesota Family Investment Program (MFIP) is Minnesota's cash assistance program for poor families. A MFIP child-only case is a case where the caregivers are not personally eligible, but care for eligible children. Child-only cases went from 19 percent of 41,534 total MFIP cases in December 1999 to 32 percent of 32,855 total MFIP cases in December 2008, an absolute increase of more than 2,700 cases. The purpose of this report is to improve understanding of the needs of caregivers and children in MFIP child-only cases. This report seeks to answer two broad questions:

- Who are the caregivers and children in Minnesota's MFIP child-only caseload?
- Does the well-being of adults and children in child-only cases differ from that of other groups on MFIP?

This report will examine child and caregiver characteristics by the three most common reasons for a child-only case in Minnesota: relative care, Supplemental Security Income (SSI) eligible parent, and undocumented immigrant caregivers who have eligible, US citizen children with data for families active on MFIP in December 2005.

Families receiving child-only MFIP tend to be long-term welfare recipients with an average of 58 months of MFIP receipt, low rates of employment, and many disability and health-related challenges. While relative caregivers in child-only cases have higher incomes, are more likely to have a high school diploma, and are more likely to be married than SSI-eligible parents, undocumented immigrant parents, or MFIP-eligible caregivers, both the children and caregivers in relative care child-only cases tend to have serious health concerns. Children in relative care families have higher rates of social, emotional, and behavioral disabilities and higher rates of serious diagnoses such as asthma, Attention Deficit Hyperactivity Disorder, and childhood chemical dependency than other children receiving MFIP and are less likely to have preventive health care visits.

SSI-eligible parent households have the longest welfare histories, averaging 74 months, and had very little income beyond SSI and MFIP. They were most likely to have access to medical care as evidenced by high rates of both Medical Assistance (MA) eligibility and use of preventive care by both children and caregivers. In addition to the disabled caregiver, children in SSI-eligible households have high rates of disability and diagnoses of serious health conditions. About one-quarter of SSI-eligible caregivers are legal non-citizens that may lose their SSI eligibility if they do not achieve U.S. citizenship within seven years of becoming SSI-eligible, potentially leaving their families with little to no income. Currently SSI income is excluded from the MFIP grant calculation.

Families in which the caregiver was an undocumented immigrant tended to look like families with MFIP-eligible caregivers in terms of length of time receiving MFIP, marital status, age of the caregivers, and age of the children. These families were the least likely to have access to health care and had the least amount of income from paid work or other programs such as Food Support. They were also the least likely to receive Special Education services, to have a documented disability, or to have received Child Protection services.

On nearly every measure of family and child well-being, families receiving MFIP child-only assistance fared poorly compared to MFIP-eligible adult cases and all Minnesotans. In the absence of funding for targeted services for these families, they should be made aware of existing services related to disabilities, family support groups and parenting education, and, in the case of relative care, the possibility of receiving Title IV financial assistance available if they became formal foster care parents of the children in their care.

## Introduction

A MFIP child-only case is a case where the caregivers are not personally eligible, but care for eligible children. Under Minnesota's MFIP policies, a case may be child-only if a parent (including natural parents, step-parents, and adoptive parents) is eligible for Supplemental Security Income (SSI); has committed welfare fraud or is a convicted felon fleeing prosecution, custody, or confinement; is an immigrant who lacks documentation of his or her legal status; or has reached the 60-month lifetime limit of MFIP receipt and has a second caregiver in the household that meets one of the above conditions. A child-only case may also be a case where the caregiver is a relative or other guardian who decides not to participate on the case. An eligible relative caregiver would be required to participate in work activities and would be subject to the time limit whereas a caregiver not receiving a cash grant would not. Since the 2005 passage of the Deficit Reduction Act (DRA), caregivers that are ineligible due to fraud or felony have been required to participate in work activities. The caregivers not being subject to work requirements or time limits are defining policy characteristics that differentiate child-only from eligible adult MFIP cases.

This report seeks to answer two broad questions:

- Who are the caregivers and children in Minnesota's MFIP child-only caseload?
- Does the well-being of adults and children in child-only cases differ from that of other groups on MFIP?

It will examine child and caregiver characteristics in relative care, SSI-eligible parent, and undocumented immigrant cases which are the three most common reasons for a child-only case in Minnesota. The purpose of this report is to improve understanding of the needs of caregivers and children in MFIP child-only cases. Policymakers are concerned that the children in these cases may be particularly vulnerable, but are being underserved in part due to their MFIP child-only case status.

Using information from national literature and administrative data from the Minnesota Department of Human Services (DHS), the Minnesota Department of Employment and Economic Development (DEED), the DHS Child Safety and Permanency Division (CSPD) and, through a partnership with the University of Minnesota School of Social Work, the Minnesota Department of Education (MDE), this report looks at child-only caseload trends nationally and in Minnesota; the demographic, economic, and health characteristics of child-only caregivers; and the demographic, health, and education outcomes of children in these cases. Using national literature, it will identify service needs of caregivers and children in child-only cases.

The MFIP cases included in this study were all cases active in December 2005. December 2005 was chosen so that sufficient time could pass to be able to look at future outcomes and to allow for matching to University of Minnesota School of Social Work files.<sup>1</sup>

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<sup>1</sup> For case-level information about MFIP child-only cases, see the MFIP and DWP Caseload and Participant Characteristics Report series available at the DHS website ([www.dhs.state.mn.us](http://www.dhs.state.mn.us)) under Economic Supports (top menu), then MFIP/Reports (left menu).

## Child-only Caseload

### National Child-only Caseloads

DHS knows very little about the caregivers and children in these cases as compared to its knowledge of eligible-adult cases. This is largely because the focus of MFIP has been on getting caregivers into employment. Work participation requirements exclude most ineligible caregivers from participating in employment services.<sup>2</sup> Interest in this group is growing, both in Minnesota and nationwide, as child-only cases have increased in both absolute numbers and as a proportion of the total caseload. Nationally, although absolute number of child-only and eligible-adult TANF cases decreased since 1992, the eligible-adult caseload decreased more rapidly than the child-only resulting in the a growing proportion of child-only cases. Child-only cases increased from 15 percent of the Aid to Families with Dependent Children (AFDC) caseload in 1992<sup>3</sup> to 37 percent of the Temporary Aid to Needy Families (TANF) caseload in 2002. (Anthony, Vu, and Austin, 2007)

The increase in child-only cases has been driven by four factors. First, changes in SSI policy and TANF policies related to SSI increased the number of SSI-eligible people and the incentives for outreach efforts to potentially eligible people. SSI eligibility was opened to people with mental impairments with the 1984 Disability Reform Act and was expanded further during the 1990s. The legislation that created TANF, the Personal Responsibility and Work Reconciliation Act of 1996 (PROWRA), changed states' incentives to move clients from welfare to SSI. According to Wamhoff and Wiseman (2006), "states retained less than half of any savings achieved through such transfers under AFDC, but they retain all of the savings under TANF." (p. 21) When a participant is moved from TANF to SSI, the state can use all of the TANF money saved for other purposes allowed under the TANF block grant regulations.

Second, U.S. Census data show an increase in non-parental caregiving. Farrell, Fishman, Laud, and Allen (2000) explain that the 8.4 percent growth in children living with adults other than their parents between 1983 and 1993 coincided with growing awareness that AFDC or TANF assistance for relative caregivers was available. Anthony, et. al. (2008) report a 30 percent increase in children living with their grandparents between 1990 and 2000. Furthermore, passage of the Adoption and Safe Families Act of 1997 (ASFA) placed greater emphasis on kinship care while requiring that families receiving Title IV-E reimbursements for fostering relative children meet the same licensing and approval standards as non-relative foster care. (Anderson, 2006) Kinship caregivers may not want to formalize their guardianship of their relative children or may not be able to meet the foster care standards and, therefore, be ineligible for Title IV-E funding and be more likely to apply for TANF. (Anderson, 2006; Gordon, McKinley, Satterfield, and Curtis, 2003; Murphy, Hunter, and Johnson, 2008; Nielson, 2004)

Third, U.S. Census data show an increase in undocumented immigration at the same time as changes to assistance policy disqualified many immigrant parents, whether in the United

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<sup>2</sup> The Deficit Reduction Act (DRA) of 2005 changed work participation rules and now require MFIP caregivers ineligible due to fraud and felony to participate in work activities.

<sup>3</sup> TANF began enrolling participants between 1996 and 1997, depending upon the state. Cases prior to that were Aid to Families with Dependent Children (AFDC) cases.



States with or without documents. PRWORA made newly arriving legal immigrants ineligible for TANF during their first five years in the United States, although states were allowed to fund these cases with state dollars. (Gibbs, Kasten, Bir, Hoover, and Duncan, 2004) Minnesota provides state funding for legal immigrant MFIP cases. Gibbs, et. al. (2004) also state that through the 1990s illegal immigrants increased by about 200,000 to 300,000 each year and that “the citizen children of these ineligible immigrants may also be eligible for child-only TANF benefits.” (p. 2-9)

The final factor does not affect Minnesota. Changes to TANF grant sanction policies increased the number of ineligible caregivers in other states. A sanction is a financial penalty for not complying with the program’s requirements. For example, a caregiver may be sanctioned for not attending financial orientation classes or providing information necessary to collect child support. Minnesota’s sanction policy has never allowed for MFIP cases with sanctioned caregivers to become child-only cases. Nationally, however, states approach sanction policy in many different ways. The most common form of partial sanction results in a child-only case by removing the non-compliant adult from the case until he or she is in compliance. (Pavetti, Derr, and Hesketh, 2003)

### **Composition of the National Child-only Caseload**

Nationally, the largest group of child-only cases has historically been SSI-eligible parents. Anthony, et. al. (2007) report that:

“While parents receiving SSI benefits represent the largest exclusion group at the national level, the proportion of SSI benefit, citizenship, and other reasons for parent exclusion varies considerably by state. For example, Alaska, Arizona, California, and Texas have a much higher percentage of citizenship cases when compared to all other states. While some states’ differences are the results of both demographic variation and state policy, others are largely policy driven.” (p. 4)

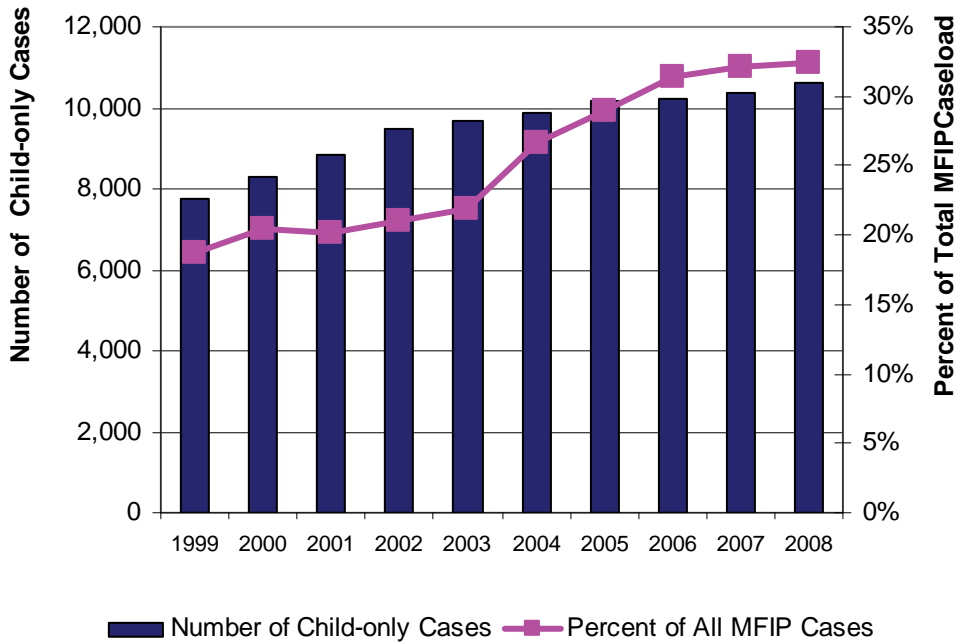
Sanction policies, time limit policies, and treatment of eligibility for legal immigrants vary by state and can greatly influence the composition of a state’s child-only caseload. For example, in California, which has one-fourth of the nation’s child-only caseload, caregivers that reach the 60-month time limit and sanctioned caregivers are removed from the grant and the children become child-only under that state’s Safety Net program. By contrast, in a study of child-only cases in New Jersey (Wood & Strong, 2002), 63 percent were relative caregiver cases, 25 percent were SSI-eligible parents, 10 percent were immigrant parents, and only 2 percent were in the Other category. New Jersey does not fund legal immigrant cases with state funds.

### **Minnesota’s Child-only Caseload**

Figure 1 shows how the growth in the national child-only caseload has also occurred in Minnesota. Child-only cases went from 7,777 (19 percent of 41,534 cases) in December 1999 to 10,533 (32 percent of 32,855 cases) in December 2008, an absolute increase of 2,756 cases. In Minnesota, relative caregiver and SSI-eligible parent cases have been the two largest child-only groups. In December 2005, 4,511 child-only cases were SSI-eligible, 4,145

were relative care, 1,283 had caregivers who were undocumented immigrants with eligible US citizen children, and 226 were child-only for other reasons. Figure 2 shows the percentage of each group within the child-only caseload for each December since 1999.

**Figure 1. Number of Child-only MFIP Cases with Percent of Total MFIP Caseload, December 1999 to December 2008**

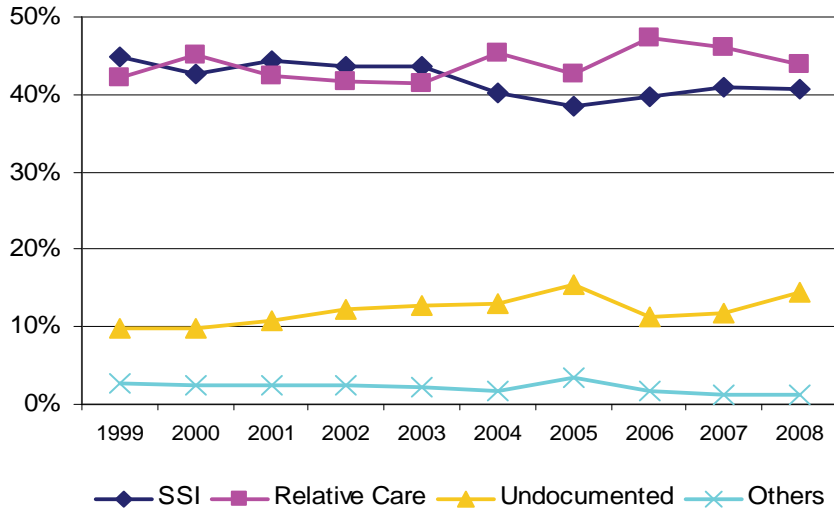


As stated in the introduction, one of the two defining characteristics of child-only cases is that they are not subject to the 60-month time limit. In Minnesota, months counted toward the time limit are attached to the eligible caregiver and with no eligible caregivers, child-only cases can remain active so long as there are eligible children in the household. Given this policy, it is not surprising that child-only cases are active on MFIP for much longer than eligible-adult households. Looking at total months where the case was eligible (“benefit months”), as opposed to months counted toward the time limit (“counted months”), December 2005 eligible-adult cases averaged 38 benefit months and child-only cases averaged 58 benefit months on MFIP since January 1996.<sup>4 5</sup> Child-only cases with SSI-eligible caregivers averaged the most MFIP benefit months; those households received an average of 74 benefit months or just more than 6 years. Undocumented cases averaged the fewest months – undocumented cases averaged 33 benefit months or just more than two and half years. Figure 3 shows the number of months child-only and eligible adult cases received MFIP from January 1997 to December 2005.

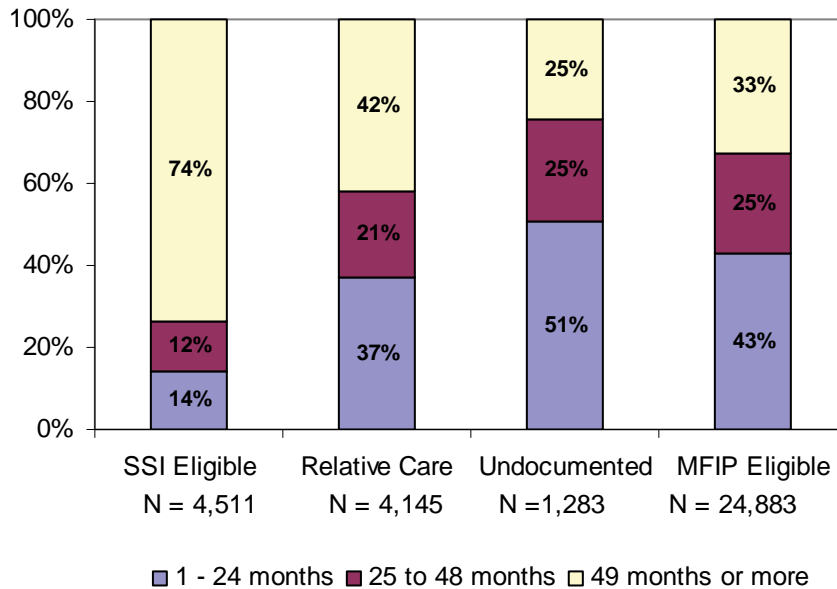
<sup>4</sup> There are a few reasons why an eligible-adult case would have months not counted toward the time limit. Caregivers that are under age 20 and in high school, that are age 60 or older, and that have special medical criteria are exempt from the time limit. Months in which a case does not receive a cash grant are not counted (food-only). Cases can also be extended beyond the time limit for documented hardships or if the caregivers are working a certain number of hours but have income low enough to remain MFIP-eligible.

<sup>5</sup> Minnesota started funding family assistance with TANF in July 1997. Cases receiving assistance before that time were either receiving Aid the Families with Dependent Children or Family General Assistance.

**Figure 2. Composition of MFIP Child-only Caseload by Type of Caregiver, December 1999 to December 2008**



**Figure 3. Months of Family Cash Assistance Use: Child-only and Eligible-adult Cases, January 1997 to December 2005**



### Caregivers in Child-only Cases

MFIP services are largely focused on the employment requirements of eligible caregivers and, therefore, the potential needs of caregivers in child-only cases have not received much attention. Up until now only case-level data on the child-only group as a whole have been reported by DHS. Literature shows three different groups of caregivers with different types of needs: relative caregivers, SSI-eligible caregivers, and undocumented immigrant caregivers. This section will look at the demographics, health, and income of each of these groups in turn.

## **Relative Caregivers**

WorkFirst New Jersey's study of relative caregivers (Wood & Strong, 2002) showed that relative caregivers tend to be better off economically relative to TANF-eligible caregivers and are more likely to be married. Other studies have shown that they also tend to have more health problems, lack health insurance for themselves, and face challenges associated with unexpectedly becoming caregivers at a time in their lives when they thought that they were finished raising children. Anthony, et. al. (2007) report that relative caregivers had unmet needs for respite care, child care, and parenting support. Caregivers in a South Carolina study (Edelhoch, Liu, and Martin, 2002) reported that they would like to participate in a support group for relative caregivers, parenting or child development classes, financial assistance for school expenses, and home visiting services.

While caregivers stated that they intend to raise the children to adulthood and had mostly positive feelings about that decision, bringing children into their home posed many challenges. (Gordon, et. al. 2003; Murphy, et. al. 2008, Wood, et. al. 2002) They reported social isolation from their childless peers, loss of freedom and flexibility, stress on their marriage, strains in the relationship with the birth parents (often their own adult children), financial stress including spending their retirement savings on the children, and the difficulties of role changes from an aunt or grandparent to the role of a parent that must impose discipline.

In most states there is greater financial assistance for families with formal foster care arrangements than for TANF child-only families. There are also often more services available for both caregivers and children if the caregivers become foster parents rather than the informal relationships found on many TANF child-only families. Caregivers were usually aware of these benefits, but had many reasons for not pursuing that status. Some were nervous about becoming involved with child welfare agencies that they viewed negatively. They cited the fear that children would be taken away from them, that they could not meet the licensing requirements to be foster parents, poor treatment by child welfare workers, and confusion with legal terms and agency jargon. Caregivers were also concerned about the effects formalizing the relationship would have on their families. Often the children were grandchildren and caregivers did not like to think of their own children as failures or unable to recover from the situation that prevented them from parenting. Extended families were sometimes in disagreement about the situation and caregivers did not want to further disrupt relationships with their children or siblings. (Murphy, et. al. 2008; Wood, et. al. 2002)

## **SSI-eligible Parents**

There have been very few studies of SSI-eligible caregivers in TANF child-only cases. The WorkFirst New Jersey study (Wood & Strong, 2002) found that these families have very long welfare histories and were often eligible on a TANF case before becoming eligible for SSI. They also found that these caregivers often have difficulty shopping and cooking related to their disability which leads to the use of expensive prepared foods. A study in California (Anthony, et. al. 2007) also reports long term use of cash assistance as well as difficulties associated with disability and age. SSI-eligible parents tend to be older than non-SSI-eligible

parents, which is not surprising as it takes time to apply for and become eligible for SSI. Anthony's study also found that very few SSI-eligible parents had a work history.

### **Undocumented Immigrants**

There are also very few studies of undocumented caregivers receiving TANF. One study in California (Lieberman, Lindler, and O'Brien-Strain, 2002) surveyed immigrant parents in two counties and found that these families not only face the challenges of other families receiving TANF child-only assistance such as disability, chronic illness, and lack of access to services, they also have larger barriers to self-support due to being undocumented immigrants. Although most families had at least one working adult, the wages were often below minimum wage and these families were in very deep poverty. Caregivers had very little education, many were illiterate, and more than half did not speak English. They were not eligible for other services such as the federal Supplemental Nutrition Assistance Program<sup>6</sup> (SNAP), child care assistance, transportation assistance, job training, or case management due to their immigration status. Demographically they resembled TANF-eligible adults except that they were more likely to be married and have larger families. Ineligible non-citizens tended to have unmet mental and physical health needs related to trauma in their home country, substandard and dangerous housing, and chronic health conditions such as asthma.

### **Minnesota's Child-only Caregivers**

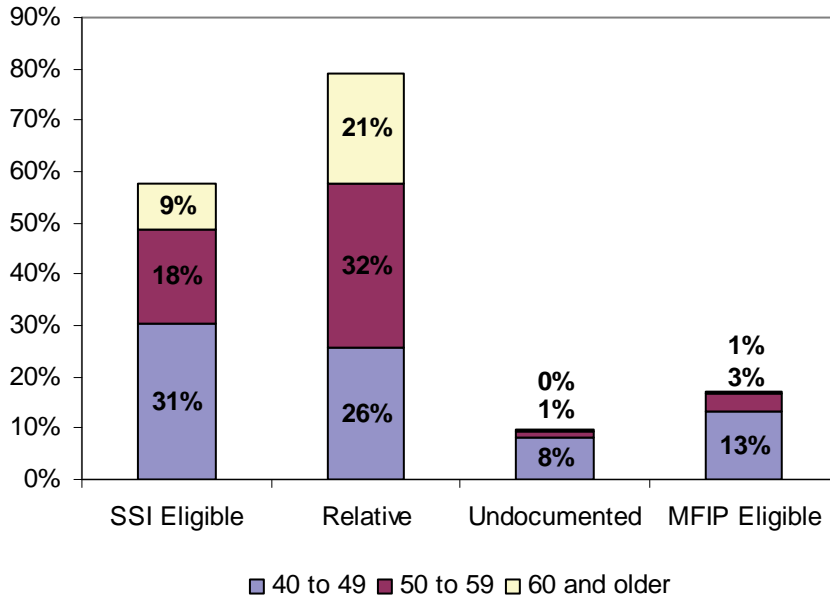
Administrative data<sup>7</sup> show that Minnesota's child-only caregivers share many of the same characteristics as their national peers. SSI-eligible and relative caregivers tend to be older than other caregivers on child-only cases and MFIP-eligible caregivers. The average age of SSI-eligible caregivers was 42 years and the average age of relative caregivers was 50 years compared to 30 years for both undocumented child-only caregivers and MFIP-eligible caregivers. Figure 4 shows the percentage of each group that was age 40 or older. Eighty percent of relative caregivers were 40 or older compared to 58 percent of SSI-eligible caregivers, 17 percent of MFIP-eligible caregivers, and 10 percent of undocumented caregivers.

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<sup>6</sup> SNAP is the new name for Food Stamps.

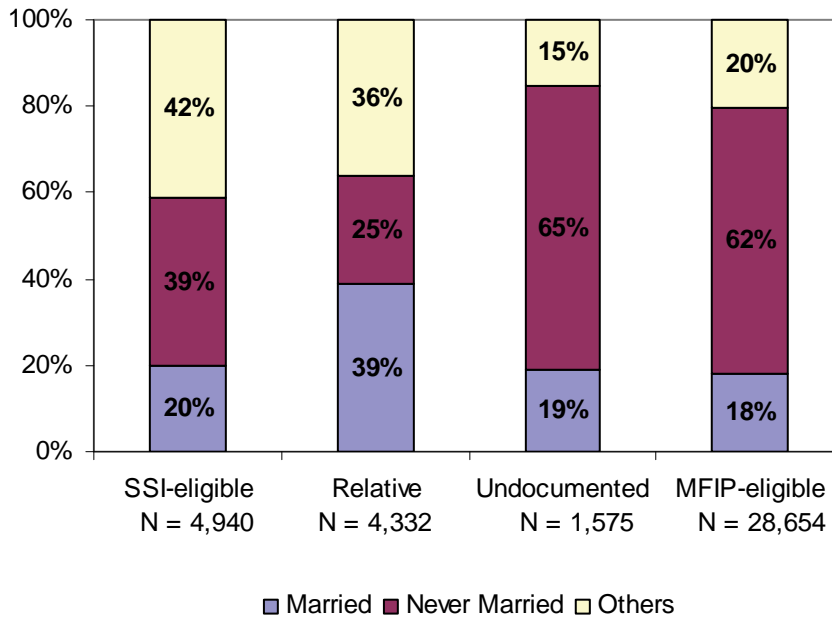
<sup>7</sup> Demographic data that do not impact program eligibility may not be updated regularly, particularly for ineligible caregivers. High school graduation, marital status, and U.S. citizenship especially may be underreported.

**Figure 4. Percentage of MFIP Child-only and Eligible Caregivers Age 40 and Older, December 2005**



Relative caregivers were twice as likely as others to be married and living with their spouse. Figure 5 shows the percentage of caregivers that were married and living with their spouse, caregivers that had never married, and those with other marital statuses, including divorced, widowed, and married but living apart. Nearly two-thirds of MFIP-eligible and undocumented child-only caregivers had never married.

**Figure 5. Marital Status of MFIP Child-only and Eligible Caregivers, December 2005**



The education level of caregivers varied greatly by caregiver type and is consistent with data from other states. Undocumented caregivers were least likely to have reported a high school diploma, including General Educational Development (GED) diploma, or higher levels of education and relative caregivers were mostly likely (Figure 6).

**Figure 6. Percentage of MFIP Child-only and Eligible Caregivers with at Least a High School Diploma, December 2005**

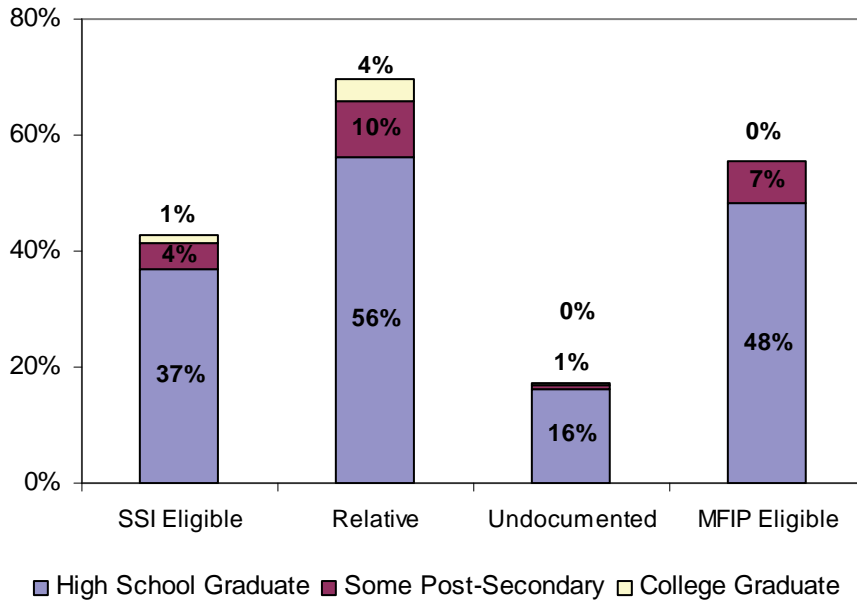


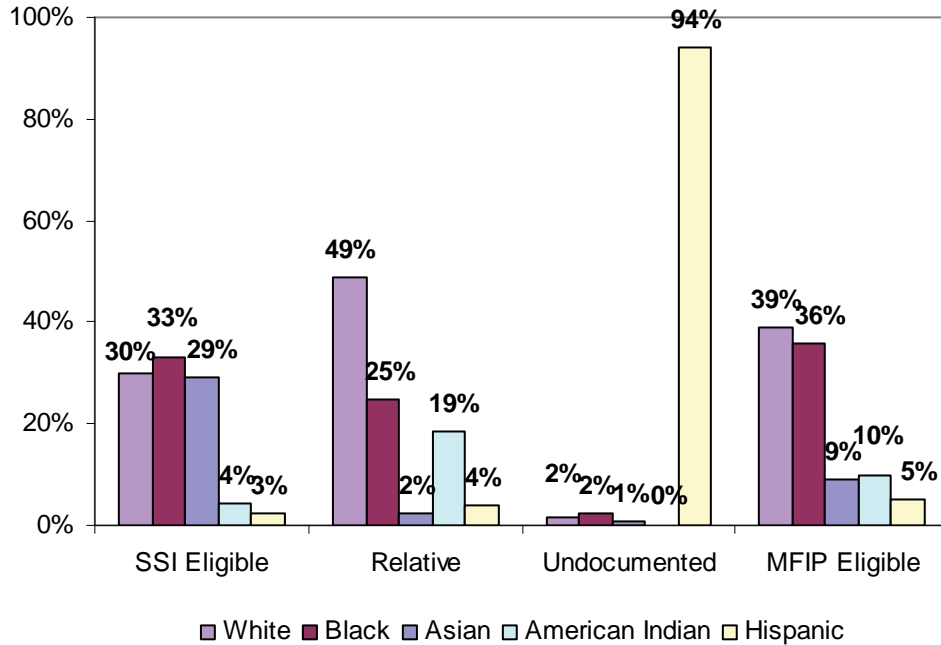
Figure 7 shows the race/ethnicity of caregivers. Compared to the MFIP-eligible caregivers, whites and American Indians were overrepresented in relative caregiver cases. Whites made up 39 percent of MFIP-eligible caregivers and 49 percent of relative caregivers. American Indians made up 10 percent of MFIP-eligible caregivers and 19 percent of relative caregivers. Undocumented caregivers were nearly all Hispanic (94 percent). Asian caregivers made up 29 percent of SSI-eligible caregivers compared to 9 percent of MFIP-eligible caregivers. Sixty-one percent of Asian caregivers (in any child-only case type) were Hmong and 77 percent of black caregivers were African American rather than an African immigrant.

Eighty-four percent of MFIP-eligible caregivers were U.S. citizens compared to 91 percent of relative caregivers and 78 percent of SSI-eligible caregivers.<sup>8</sup> Citizenship data that are unrelated to program eligibility may not be promptly updated in the state’s administrative database so some legal non-citizens may have achieved citizenship since applying for MFIP. Twenty-two percent of SSI-eligible caregivers were not citizens. A legal non-citizen may receive up to 7 years of SSI before becoming ineligible. A new immigrant must be in the United States for 5 years before applying for citizenship and the process is time-consuming and costly. Due to a long wait for citizenship application and processing, time permitted on SSI for non-citizens was temporarily extended to 9 years. If these caregivers are not able to

<sup>8</sup> As a rule, undocumented caregivers are not U.S. citizens.

become citizens before they lose SSI eligibility, their families would lose a significant source of income and there may not be other cash assistance available.

**Figure 7. Race/Ethnicity of MFIP Child-only and Eligible Caregivers, December 2005**



Only one of the studies reviewed discussed the relationship of the children to the caregiver. In their survey of TANF relative care child-only cases in South Carolina, Edelhoach, et. al. (2008) found that 76 percent of caregivers were grandparents, 19 percent were an aunt or uncle, and the remaining were other relatives or friends. Minnesota’s data show that 68 percent of relative caregivers were grandparents and 32 percent were other relatives. Relative caregivers often had their own biological, adopted, or step children in the household in addition to relative children. Nearly all caregivers in the other child-only case types were caring for only their own biological, adopted, or step-children, but 5 percent of SSI-eligible caregivers were also caring for related children in addition to their own.

### Health

Poor health and illnesses related to aging are cited as challenges that affect the ability of child-only caregivers to care for their children and to maintain employment. (Wood & Strong, 2002; Anthony, et. al. 2007; Gibbs, et. al., 2004; Farrell, et. al., 2000; Lieberman, et. al., 2002; Edelhoach, et. al., 2002; Gordon, et. al., 2003; Murphy, et. al., 2008) This section will look at three measures of health and health care access that may impact a caregiver’s ability to maintain employment or care for his or her family:

- How many caregivers were eligible for Medical Assistance<sup>9</sup> (MA) for at least one year?

<sup>9</sup> MA is Minnesota’s Medicaid program.



- How many caregivers had at least one preventive examination at some point between January 2003 and December 2005 (as a measure of health care access)?
- How many caregivers had ever been diagnosed with a condition that may pose a barrier to daily living or the ability to retain employment?

**Figure 8. Months of Medical Assistance Eligibility for MFIP Child-only Caregivers, January 2003 to December 2005**

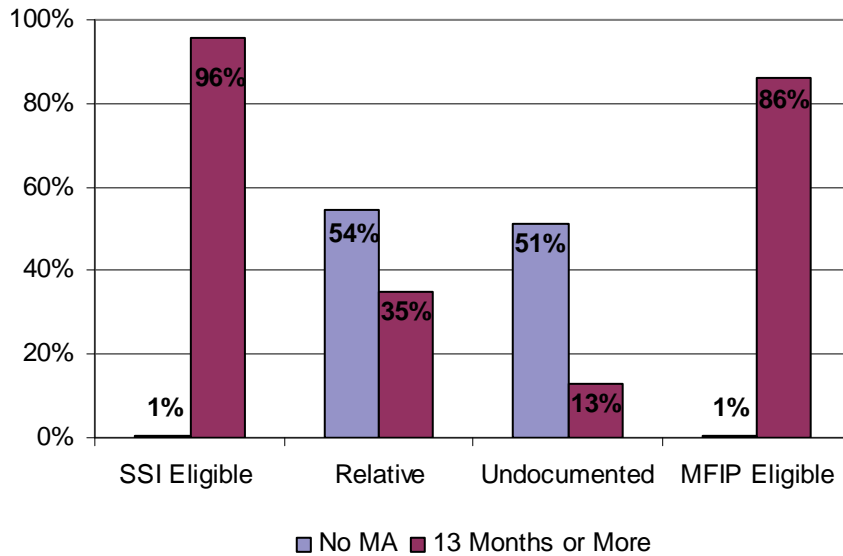


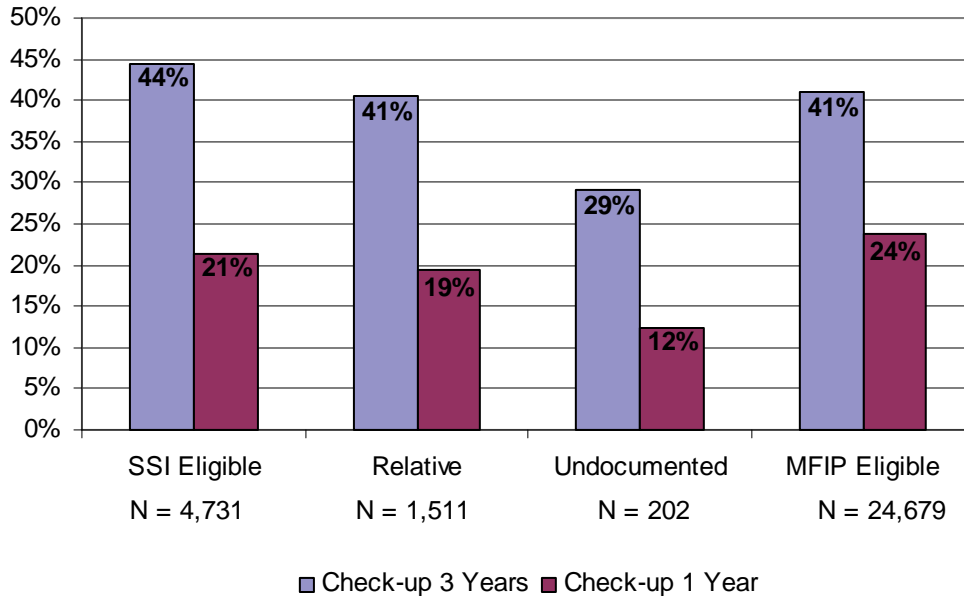
Figure 8 shows the percentage of caregivers who received MA for 13 or more months and the percentage of caregivers that did not receive MA in the three years up to December 2005. Seventy-one percent of child-only caregivers received MA at some point between January 1, 2003, and December 31, 2005, which is the three years prior to MFIP case activity in December 2005. Undocumented caregivers were the least likely to have been eligible for MA with fewer than half eligible at some point during the three years. Nearly all SSI-eligible and MFIP-eligible caregivers received MA for some part of the period studied. Nearly 80 percent of SSI-eligible caregivers had received public health insurance for the entire period.

Data about the health of child-only caregivers is limited to those that received publicly paid health care. Due to this limitation, health data reported in this section only includes caregivers that received 13 or more months of MA. As shown in Figure 8, this includes nearly all SSI-eligible caregivers, 35 percent of relative caregivers, 13 percent of undocumented caregivers, and 86 percent of MFIP-eligible caregivers.

As shown in Figure 9, about forty percent of caregivers in SSI-eligible, relative care, and MFIP-eligible cases had at least one preventive examination in the three-year period studied in which they were MA-eligible for at least one year. Less than one-third of undocumented caregivers had a routine examination during the period, despite being MA-eligible. Twenty-one percent of American adults have a physical each year. (Mehrotra, Ateev; Zaslavsky, Alan M.; and Ayanian, John Z., 2007) SSI-eligible caregivers, relative caregivers, and MFIP-

eligible caregivers have similar rates as all American adults, but undocumented caregivers have a much lower rate.

**Figure 9. Caregivers Eligible for MA for More than 1 Year: Percent with a Preventive Exam During 2003 to 2005 or During 2005**



To measure health conditions that may pose barriers to daily living tasks and employment retention, caregiver history of eleven diagnoses that may make them eligible for SSI are reported. Diagnoses for a severe mental health condition, chemical dependency, the Human Immunodeficiency Virus (HIV), nine cancers, quadriplegia, emphysema, morbid obesity, asthma, mental retardation, and paralysis were counted if the caregiver had the diagnosis more than once at any time known to administrative records through December 2005.<sup>10</sup>

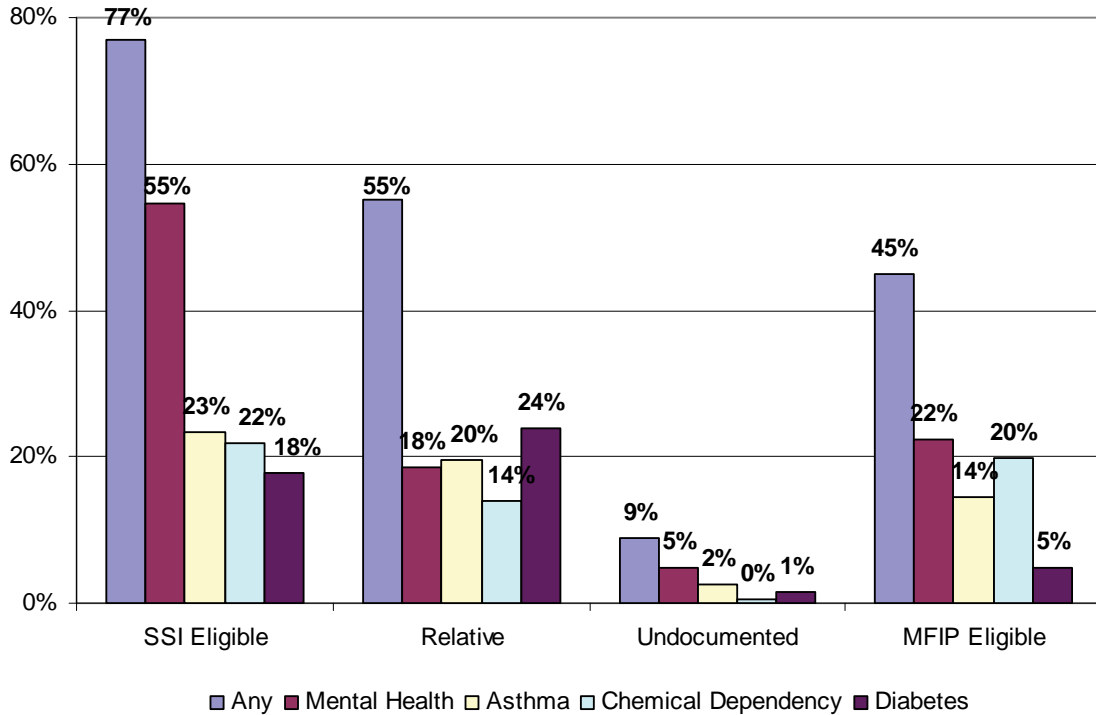
Figure 10 shows the percentage of caregivers that had any of these diagnoses and the percentage that each had one of the most frequent diagnoses: severe mental health condition, asthma, chemical dependency, and diabetes. As expected, SSI-eligible caregivers had the highest rate of diagnosis for at least one of these conditions as well as the highest rates for three of the four most frequent. More than three-quarters of SSI-eligible caregivers had at least one of these serious conditions diagnosed compared to 55 percent of relative caregivers and 45 percent of MFIP-eligible caregivers.

Rates of serious mental health disorders, chemical dependency, asthma, and diabetes were higher than those found in the general U.S. population. According to the Substance Abuse and Mental Health Administration, 11 percent have had at least one serious mental health episode in the year prior to being surveyed and 11 percent of the adult U.S. population is

<sup>10</sup> Severe mental health includes schizophrenic disorders, manic disorders, major depressive episode, bipolar disorder, and paranoid states. Chemical dependency excludes tobacco dependency.

chemically dependent. More than half of SSI-eligible caregivers, 18 percent of relative caregivers, and 22 percent of MFIP-eligible caregivers had a diagnoses for a severe mental health disorder. About 20 percent of both SSI-eligible and MFIP-eligible caregivers had a chemical dependency diagnosis.

**Figure 10. Caregivers Eligible for MA for More than 1 Year: Percent with a Serious Diagnosis through December 2005**



According to the Centers for Disease Control (CDC), 6 percent of adults have diabetes and 11 percent of adults have asthma. At least four times as many relative caregivers and 3 times as many SSI-eligible caregivers have diabetes than the general population. Twice as many SSI-eligible caregivers and nearly twice as many relative caregivers have asthma than in the general population. Rates of these conditions among MFIP-eligible caregivers are similar to the total U.S. adult population. The low incidence among undocumented caregivers may not reflect actual rates of illness. It may be due to less time living in Minnesota, less time eligible for MA, or lower rates of use of health care in general.

### Household Income

An accurate picture of total household income for all child-only cases is impossible using only administrative data available to DHS. The most accurate data available are those that determine program eligibility and grant size as those are the primary purposes for data collection. Most child-only caregivers' income is not considered and, therefore, is not reported unless the caregiver is eligible for another cash or food program that requires income reporting. This section reports income data collected through the Department of Employment and Economic Development's (DEED) Unemployment Insurance (UI) Wage

Detail<sup>11</sup> database, child support disbursements made through DHS' Child Support Enforcement Division (CSED), and Food Support payments (not including the MFIP Food Portion). Table 1 shows average income amounts reported by case type and the percent of cases with different income types. The average income amounts only include cases with that type of income reported.

**Table 1. Average UI Wages, Child Support, and Food Support Payments, December 2005**

	UI Wages		Child Support		Food Support		Total Child-only Cases
	Average	Percent of Cases	Average	Percent of Cases	Average	Percent of Cases	
SSI Eligible	\$1,620	24.4%	\$234	15.0%	\$107	90.1%	4,523
Relative	\$7,896	64.2%	\$231	17.6%	\$140	18.5%	4,142
Undocumented	\$3,299	11.7%	\$244	5.2%	\$104	3.8%	1,277
All Child-only	\$5,840	39.6%	\$236	14.9%	\$112	48.3%	10,165
MFIP Eligible	\$2,234	52.2%	\$256	14.0%	\$103	11.5%	24,883

Relative care cases had the highest average quarterly wages reported to DEED's UI system and were the mostly likely to report this kind of income. The average quarterly earnings in the fourth quarter 2005 for relative care cases was \$7,896 compared to \$3,299 for undocumented households and \$1,620 for SSI-eligible households. Sixty-two percent of relative care cases had UI earnings compared to 24 percent of SSI-eligible and 12 percent of undocumented cases. Just more than half of MFIP eligible-adult cases had UI wages reported for the fourth quarter of 2005, but the average amount of income (\$2,234) was less than all other groups except for SSI-eligible caregivers.

Very few cases received child support payments. Relative caregivers were most likely (18 percent of relative care cases), also 15 percent of SSI-eligible caregivers, 5 percent of undocumented caregivers, and 14 percent of eligible-adult cases. The average monthly amount for all cases with a payment was in the mid-\$200s.

Household members that were ineligible for MFIP may be eligible for Food Support.<sup>12</sup> Ninety percent of SSI-eligible cases also received a Food Support grant in addition to the MFIP cash grant and food portion (which is funded by Food Support). The average grant amount was \$107. Nineteen percent of relative care cases received a Food Support grant with an average grant amount of \$140. Relative caregivers may not have applied for Food Support for themselves or may have income or assets that make them ineligible for Food Support. Only 4 percent of undocumented cases have additional Food Support, which is not surprising as the citizenship status that prevents MFIP eligibility would also prevent Food Support eligibility.

<sup>11</sup> Employers covered by the UI system, which excludes federal government, religious, seasonal, temporary workers, and others, must report wages to the state. Neither income earned outside of Minnesota nor cash income is included. This is quarterly income and could have been earned at any point during the quarter and, therefore, cannot be divided by three to determine monthly income.

<sup>12</sup> Food Support is Minnesota's name for the federal Supplemental Nutrition Assistance Program (SNAP), formerly known as Food Stamps.

## **Children in Child-only Cases**

Very little research has been done about children in child-only cases. Most of the studies cited in this article looked at either TANF child-only caseload issues or the needs of the caregivers. The few studies that discussed the children found that not only did they face challenges related to poverty, they also had challenges based upon the circumstances that resulted in a child-only TANF case. Anthony, et. al. (2008) found that children with SSI-eligible caregivers tended to be older with older caregivers and had lived in poverty for most or all of their lives. Anthony reports that children of SSI-eligible caregivers are more likely to be on TANF as adults than other children that receive TANF. Children in undocumented immigrant cases were found to have higher rates of injury, infection, and respiratory health problems than other children.

The most research has been done on children in relative care cases. Nielson (2004) found that these children were less likely to receive needed services and they experienced long waits for services when compared to children in licensed family foster care. These families were less likely to have any ongoing case management or supervision despite reported difficulties between the caregiver and other family members, including the biological parent. Wood and Strong (2002) report more school and behavior problems which are confirmed by Anthony et. al. (2008) who report that 26 percent of youth ages 12 to 17 in relative care cases had been suspended or expelled compared to 13 percent of TANF-eligible youth living with their parents.

Children's health problems and disabilities can pose particular challenges for caregivers. Disability and chronic health problems are associated with "higher numbers of out-of-home placements, longer stays in foster care, decreased likelihood of return to parental care, and higher foster care costs." (Rosenberg and Robinson, 2004) Edelhoch, et. al. (2002) found that often both the caregiver, most frequently a grandparent, and children had health problems that posed a financial burden and affected the quality of care the grandparents felt they could provide. Caregivers in their study reported that they needed more financial assistance to pay for medical costs and respite care. Anthony, et. al. (2008) found that children that were living with their parents in TANF households were healthier and had fewer mental and behavioral health programs than children living with relative caregivers. However, children of undocumented caregivers were the least likely to have access to health care and suffered more often from chronic respiratory problems and frequent injury.

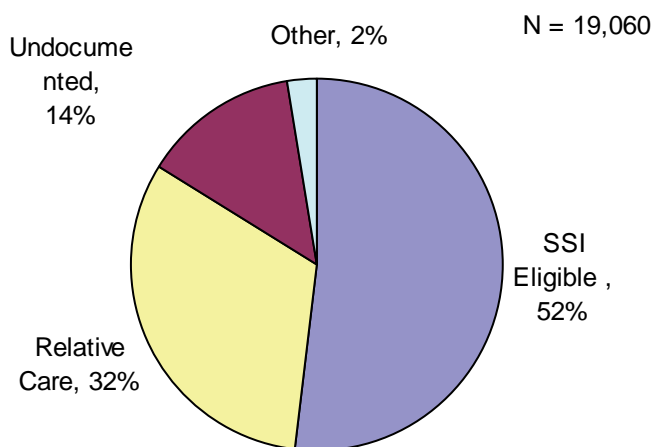
## **Children in Minnesota's Child-only MFIP Cases**

This section will look at some basic demographics, followed by data on health, education, and child protection involvement by child-only case type. In December 2005, 19,060 children lived in households receiving child-only MFIP. Ninety-four percent of these children were personally eligible for MFIP; 4 percent were eligible for SSI and, therefore, not eligible for MFIP, and 2 percent were ineligible for other reasons. As Figure 11 shows, just more than half of children were in SSI-eligible households,<sup>13</sup> one-third resided in relative care households, and 14 percent lived in undocumented households.

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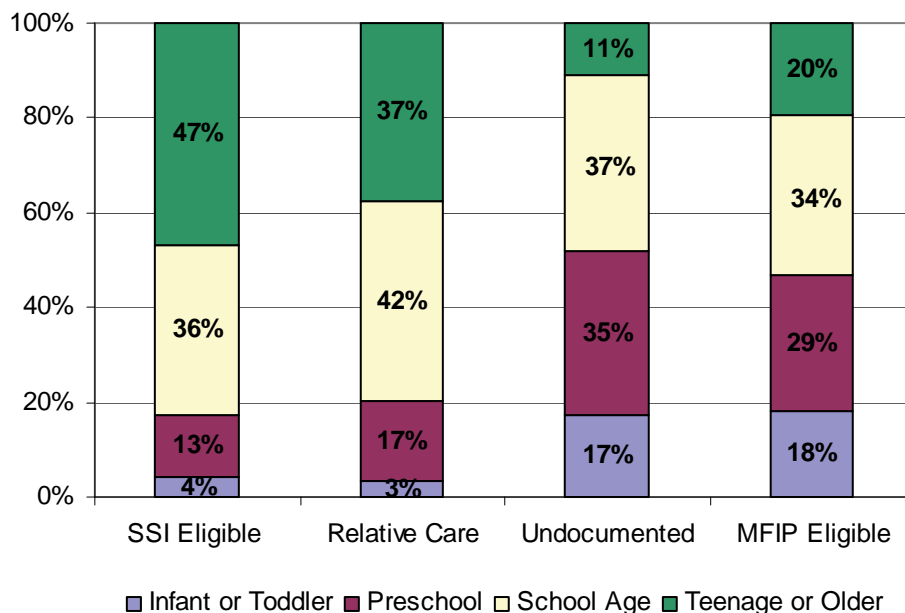
<sup>13</sup> To clarify, children may be personally eligible for SSI with or without residing in a SSI-eligible household. Households refer to the reason why the case is child-only, which is due to the caregiver's status.

**Figure 11. Case Type of Children in MFIP Child-only Cases, December 2005**



As reported by Anthony (2008), children with SSI-eligible caregivers tended to be older than other children; the average age of Minnesotan children with SSI-eligible caregivers was 11. Children living with relative caregivers also tended to be older with an average age of 10 years. The average age of children with MFIP-eligible caregivers was 7 years and with undocumented caregivers was 6 years. As seen in Figure 12, about 80 percent of children with SSI-eligible caregivers and relative caregivers were school aged or older compared to about half of children with MFIP-eligible or undocumented caregivers.

**Figure 12. Age of Children in MFIP Child-only and Eligible Caregivers, December 2005**



The race/ethnicity of children in MFIP child-only cases varied greatly by household type and as compared to cases with MFIP-eligible caregivers. Table 2 shows the race/ethnicity of children by household type. As with their caregivers, when compared to children in MFIP-eligible cases, Asian children are overrepresented in SSI-eligible cases and white and American Indian children are overrepresented in relative care cases. Undocumented cases are nearly all Hispanic children. Children of unknown race/ethnicity are included in the totals, but not in the racial/ethnic categories.

**Table 2. Race/Ethnicity of Children in MFIP Child-only and Eligible Adult Cases, December 2005**

MFIP Case Type		Asian	Black	Hispanic	American Indian	White	Multiple	Total
Child-only	SSI Eligible	36%	33%	3%	4%	21%	2%	9,922
	Relative	3%	29%	6%	23%	35%	4%	6,060
	Undocumented	1%	2%	94%	0%	1%	1%	2,615
<b>All Child-only</b>		20%	28%	17%	10%	23%	3%	19,060
<b>MFIP Eligible</b>		11%	40%	7%	9%	27%	5%	46,424
<b>Total</b>		8,828	23,991	6,419	5,838	16,692	2,858	65,484

## Health

As in the caregiver health section, three measures of health are reported. First, to measure access to health care and whether children see a doctor for regular care, Medical Assistance (MA) eligibility from December 2005 to November 2006 was found. Second, for those children that were MA-eligible for all 12 months, the percentage that had at least one well-child exam or routine medical exam during that 12-month period is reported.<sup>14</sup>

Finally, as a measure of chronic health problems, ten diagnoses were chosen that would require substantial caregiver involvement on a long-term basis. A diagnosis at any point while a child was covered by publicly paid health insurance in Minnesota of childhood psychosis, Attention Deficit Hyperactivity Disorder (ADHD), mental retardation, cystic fibrosis, nine cancers, Downs Syndrome, epilepsy, quadriplegia, asthma, or childhood chemical dependency was tallied as a serious diagnosis.

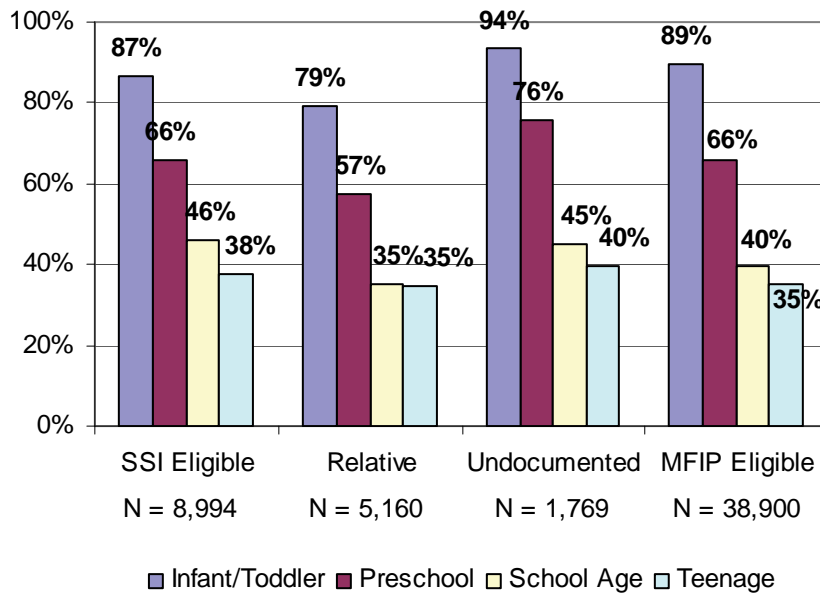
Nearly all children in child-only cases were eligible for MA for at least one month between December 2005 and November 2006 – including more than 99 percent of children in all case types except children in undocumented cases -- and 85 percent were eligible for MA for the entire year. Children in undocumented households were least likely to receive MA with 13 percent ineligible for the entire year. Most of these ineligible children were undocumented

<sup>14</sup> There are three guidelines for well-child check-ups. The American Academy of Pediatrics recommends visits at 1 month, 2 months, 4 months, 6 months, 9 months, 1 year, 15 months, 18 months, yearly between ages 2 and 6, age 8, and yearly between ages 10 and 21 years. The Minnesota Child and Teen Checkups guidelines recommends visits at 1 month, 2 months, 4 months, 6 months, 9 months, 1 year, 15 months, 18 months, yearly between ages 2 and 6, and even ages between years 8 and 20. The Institute for Clinical Systems Improvement (ICSI) recommends visits at 2, 4, 6, 9, 12, and 15 months and 2, 4, 6, 7, 9, and 12 years, and 2 visits between ages 13 and 18.

siblings of eligible citizens (families where some children were not born in the U.S. and other siblings were born in the U.S.).

There were 15,923 children that were eligible for MA for the entire year. Overall, 67 percent were seen for a well-child check-up or routine exam between December 2005 and November 2006 although this rate varies by case type and by the child’s age. Infants and toddlers less than two years old were most likely to have had a check-up and teenagers were the least likely; 89 percent of MA-eligible infants and toddlers had a check-up compared to 58 percent of these teenagers. Figure 13 shows the percentage of children with twelve months of MA-eligibility that received a well-child check-up or routine exam during the year by age and child-only case type.

**Figure 13. Children Both Eligible for MA and Having a Well-child or Routine Exam between December 2005 and November 2006**



As seen in Figure 13, children of all ages in relative care cases were the least likely to have had an exam while children in undocumented cases were most likely. According to the Minnesota Department of Health (MDH), between 72 and 83 percent of Minnesotan children met well-child frequency guidelines in 2002, depending on the guideline. More than 97 percent of children younger than 2 years had at least one well-child check-up, but only 50 to 70 percent of those children met the frequency guidelines. The MDH study found that children were less likely to have well-child visits if they did not have a regular doctor, had parents without medical insurance coverage, lived in Greater Minnesota, or had a parent age 25 years or younger. Insured children under age 2 in MFIP child-only cases were less likely to have at least one well-child visit than children in the MDH study (between 81 and 94 percent in child-only cases compared to 97 percent statewide).

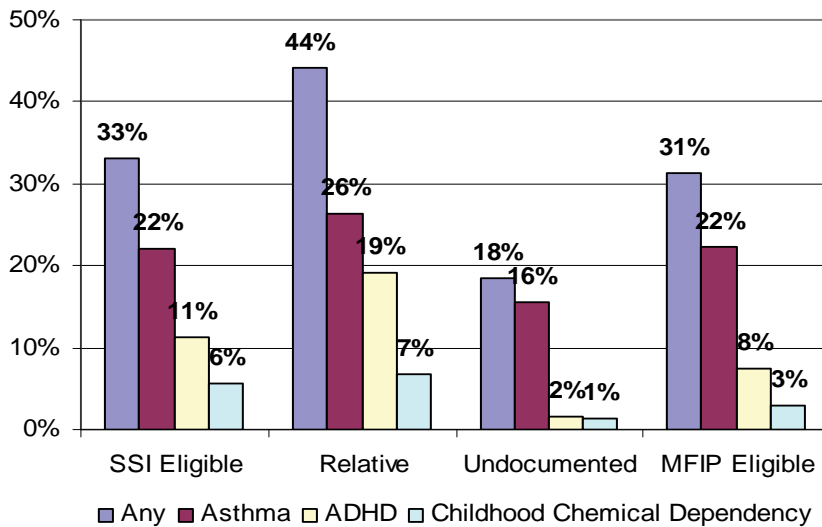
Children in relative care cases were more likely to have at least one of the serious diagnoses and were more likely to have a diagnosis for asthma, ADHD, or childhood chemical dependency than children in the other types of child-only cases (Figure 14). This is



consistent with research showing that children with health problems are more likely to live with caregivers other than their parents. (Rosenberg, et. al., 2004) Forty-four percent of children in relative care cases had at least one serious diagnosis as did one-third of children in SSI-eligible and MFIP-eligible cases.

According to the CDC, 9 percent of U.S. children have asthma and between 3 and 7 percent have ADHD. Children in relative care cases had rates of asthma that were nearly three times higher than all U.S. children and rates of ADHD that are about 2.5 times higher than the upper estimate of U.S. children with ADHD. Children in SSI-eligible and MFIP-eligible cases were more than twice as likely as all American children to have asthma.

**Figure 14. Children Eligible for MA for 12 Months: Percent with a Serious Diagnosis at Any Time through December 2005**



### Education

Through a partnership with the University Of Minnesota School Of Social Work, DHS was able to obtain certain summary education data for children in households receiving MFIP. University researchers were able to match 83 percent of the MFIP children ages 5 and older to their MDE records for the 2005-2006 school year. This resulted in records for 14,383 children in child-only cases and 22,448 children in eligible-adult cases. Data available through this partnership include special education disability status, special education enrollment status, and student inter-district mobility, but not academic or disciplinary data.

Children in MFIP cases, with or without eligible caregivers, were more likely to be receiving Special Education services than all Minnesotan children. During the 2005 - 2006 school year, 13 percent of all Minnesotan children received Special Education. Children in MFIP-eligible and relative care cases were more than twice as likely as all children to be receiving Special Education (35 percent and 28 percent, respectively). Twenty-four percent of children in SSI-eligible cases and 14 percent of children with undocumented caregivers were receiving Special Education.

Twenty-four percent of children in MFIP child-only cases had a disability according to their school record compared to 22 percent of children in MFIP cases with eligible adults and 12 percent of all Minnesotan students. Table 3 shows the percentage of children by category with different types of disabilities. Children receiving MFIP were twice as likely as all Minnesotan children to have a learning disability or a social, emotional, or behavioral disability. Children in relative care cases were three times as likely to have a social, emotional, or behavioral disability as all Minnesotan children.

**Table 3. Special Education Disability Status and More than One Inter-district Move for MFIP child-only, MFIP eligible-adult, and All Minnesotan Children**

	SSI Eligible	Relative	Undocumented	MFIP Eligible	All Children
<b>Disability Type</b>					
<b>Non-disabled</b>	76%	72%	86%	78%	88%
<b>Physical and Cognitive</b>	7%	7%	5%	6%	4%
<b>Learning Disability</b>	9%	8%	7%	7%	4%
<b>Social, Emotional, Behavioral</b>	6%	9%	1%	6%	3%
<b>Other and Multiple</b>	2%	4%	*	2%	2%
<b>More than 1 Inter-district move</b>	6%	6%	8%	9%	12%†
<b>Total Students</b>	8,429	4,322	1,131	22,448	916,541

\* U of M data privacy rules do not allow reporting certain small cell sizes and, therefore, these data have been removed.

† These data are for the 2006-2007 school year.

The final measure of education is inter-district mobility, which are children with more than one move from one school district to another during the school year. Families may move to improve their circumstances, for example by leaving substandard housing or to be closer to employment, but frequent moves can also show instability. This measure does not include moves within a district so it undercounts actual relocations, particularly for children in large urban districts.

According to the MDE, 12 percent of all children experienced more than one inter-district move for the 2006-2007 school year. Children in MFIP-eligible households moved less frequently than all Minnesotan children. Figure 15 shows the percentage of each household type that had more than one inter-district move during the 2005-2006 school year. Households receiving MFIP are more likely to live in urban areas; 56 percent lived in either Ramsey or Hennepin Counties, so these low numbers could be hiding multiple moves within a district. On the other hand, living on a fixed income with a disability may eliminate many of the reasons why a family would relocate.

### Child Protection

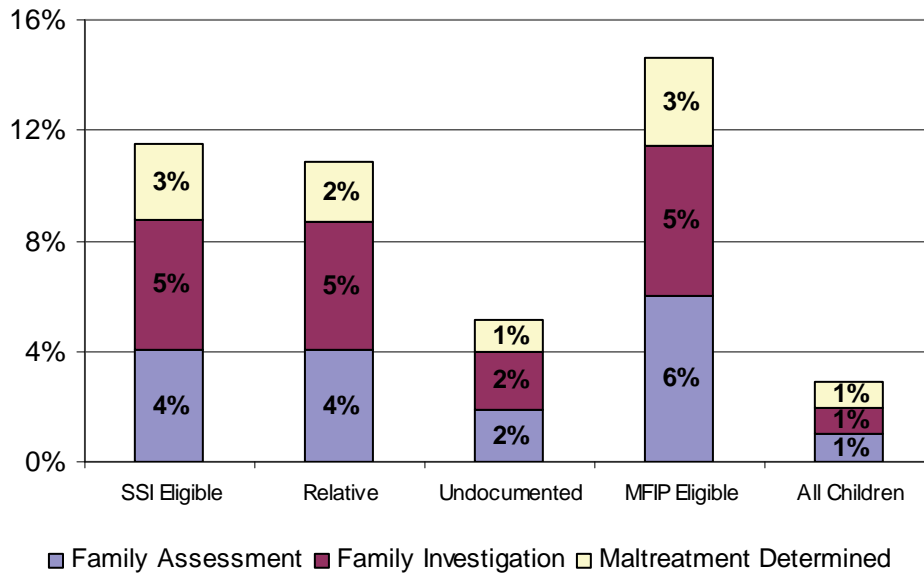
Children in MFIP child-only and eligible-adult cases were matched to records for December 2005 to December 2006 in DHS' Social Service Information System (SSIS) to see if the child had an open Family Assessment or Family Investigation (previously called Traditional Investigation) that may or may not have resulted in a maltreatment determination and whether the child was in an out-of-home placement during that time. Family Assessment (FA) is an alternative to traditional child protection investigation and services for families where the child is not in imminent danger and allegations do not include egregious harm,

sexual abuse, or maltreatment/abuse in a day care or foster home. In a FA no determination of maltreatment is made. County workers meet with the family to assess and discuss child safety concerns and provide services to help the family meet the child's safety needs. In a Family Investigation (FI) county workers interview persons involved with the report and investigate the allegation. If there is a preponderance of evidence that a child has been a victim of maltreatment and the harm was caused by an act, or failure to act, by a person responsible for the child's care, the county or tribal child protection worker makes a determination that maltreatment has occurred and a determination of whether Child Protection services are needed.

As shown in Figure 15, children in MFIP child-only cases were less likely to have a FA or FI than children in MFIP-eligible adult cases, but children in MFIP cases of any type were more likely to have a FA or FI than all Minnesotan children. About 3 percent of all Minnesotan children either had a FA, a FI that did not result in a maltreatment determination, or a FI that did result in a maltreatment determination between December 2005 and December 2006. This compares with nearly 15 percent of children in MFIP-eligible adult cases, 12 percent of SSI-eligible caregiver cases, and 11 percent of relative caregiver cases.

One and one-tenth percent of all Minnesotan children were in some sort of out-of-home placement between December 2005 and December 2006. This includes child welfare/protection placements, corrections, and medical or chemical dependency placements. Out-of-home placement was more likely for children in SSI-eligible (3.9 percent) and relative care cases (2.9 percent) than for those with undocumented caregivers (0.2 percent) or in MFIP-eligible adult cases (0.6 percent). For those MFIP-eligible children (in both eligible-adult and child-only cases), 86 percent of the placements were for child welfare/protection, 10 percent for corrections, and the remaining 4 percent for mental health, developmental disabilities, chemical dependency, or because the child was medically fragile.

**Figure 15. Percent of Children in MFIP Child-only and Eligible-adult Cases that Had an Open Family Assessment or Family Investigation between December 2005 and December 2006**



Presumably, because they were not living with their parent, children in relative caregiver cases had reason to be removed from a parent’s care at some point. The national literature describe how many of these arrangements are informal agreements between family members and are not the result of a formal child protection report or maltreatment determination. (Edelhoch, et. al., 2002; Gibbs, et. al., 2004; Murphy, et. al., 2008) That is likely the situation in Minnesota as well. To be a MFIP relative caregiver, the caregiver must either be the legal guardian or related to the child by blood or marriage, but are not required to have a formal foster care arrangement. In addition, these data look at December 2005 to December 2006 and the event that resulted in the children being in a relative’s care likely predated this time period. MFIP relative care cases in this report are not court-ordered placements supervised by the county child welfare agency. These informal arrangements may be noted in the state’s administrative database for Child Welfare, but, for the three percent of children in MFIP relative care cases with out-of-home placements between December 2005 and December 2006, these are most likely in addition to their current informal arrangements with a relative. These data support the idea that many of the relative care situations are informal arrangements and are not receiving services available to families formally involved with county child welfare.

## Conclusion

On nearly every measure of family, caregiver, or child well-being included in this report, families receiving MFIP child-only assistance fared worse than both families with eligible caregivers participating in MFIP and all Minnesotan children. Being on MFIP is an indication that these families have challenges that have prevented them from self-support.

In the current budget climate there are few funds for additional services for these families. There are, however, existing services that these families may be eligible for. It is unknown how many of these families are already using community-based services such as caregiver support groups, disability or health services, or food shelves and other in-kind assistance programs. Relative caregivers should be made aware or reminded of the potential benefits and disadvantages of becoming licensed foster care providers for the children in their care. Greater financial assistance and case management services are available to foster care parents although, as research in other states shows, they may have very important and valid reasons for foregoing the assistance. Caregivers should be made aware of services for disabled children and caregivers including respite care, personal care attendants, and other support services as well as voluntary vocational-rehabilitation programs, such as the Social Security Administration's Ticket to Work, which could provide avenues for greater income through work. More work needs to be done to help non-citizens on SSI, many of whom are refugees, to achieve citizenship before they lose eligibility for SSI.

Administrative data only provide limited information, even across DHS division and state agencies. Future research that goes beyond administrative data to surveys, interviews, or focus groups is necessary to provide greater context for information presented in this report, understand the needs of families receiving MFIP child-only assistance, and develop more effective policies.

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