Community-Based Organizations:

Paving the Way to Children's Health Insurance Coverage

March 1999

covering kids

A National Health Access Initiative for Low-Income Uninsured Children

start healthy stay healthy

A project of the CENTER ON BUDGET AND POLICY PRIORITIES

Prepared by

Donna Cohen Ross
Center on Budget and Policy Priorities
820 First, NE, Suite 510
Washington, DC 20002

Introduction

Providing health insurance for children from low-income working families has emerged as a top priority for the nation. Through the new federal child health block grant (known as the Children's Health Insurance Program or CHIP), states are expanding Medicaid coverage to more children or they are creating or expanding separate state child health insurance programs. In addition to allocating billions in government funding for children's health insurance, greater attention is being paid to removing the road blocks that stand between families with eligible children and the health care coverage their children badly need. Such obstacles include: a lack of information about available programs, confusion about eligibility, lengthy or complicated application procedures, inaccessible enrollment sites, and the reluctance on the part of many families to participate in government programs. Unprecedented efforts are underway to address these issues. Large-scale media campaigns are being launched, and states are taking steps to simplify and streamline application procedures.

While fundamental policy and procedural changes are needed to lay the essential groundwork for increasing enrollment in children's health coverage programs, that goal must be achieved one child at a time, application by application. No matter how easy the application system, many children will miss the opportunity to obtain health coverage if their families do not get easy-to-understand information about available programs and direct help with the enrollment process. Community-based organizations that interact regularly with families, and have earned reputations for fairness and trust, are best-suited to providing these essential services.

This issue brief is for community-based organizations that are planning child health insurance outreach and enrollment assistance activities. It covers some basic principles and approaches to consider as a local outreach campaign moves forward. More than 30 individuals with experience conducting outreach in community settings were consulted in the preparation of this paper. They include child health advocates, outreach workers, representatives of state and local government agencies and others, from California, Connecticut, Georgia, Massachusetts, Mississippi, Missouri, Montana, Nebraska, New York, Ohio, Oklahoma, Virginia, Wisconsin and Washington. Their insights and ideas form the basis of this document.

What's Ahead?

Community organizations have a significant role to play in helping low-income families obtain health care coverage for their children. In the effort to increase enrollment in children's health insurance programs, the main tasks are to disseminate information about available health coverage, to create convenient opportunities for families to apply, and to provide application and enrollment assistance tailored to families' needs. The key to accomplishing these objectives is to involve a broad array of outreach partners and to build on their existing relationships with families.

Organizations may find these basic "rules of the road" helpful as they embark on a children's health insurance outreach campaign:

I. Travel With Others

A vibrant, community-based outreach campaign requires a mix of knowledge, skills, talents, and resources, including:

- basic understanding of children's health insurance programs;
- technical expertise, such as how to complete applications;
- staff and time to devote to outreach and enrollment activities;
- financial and in-kind resources;
- connections to families with eligible children;
- experience working with diverse populations;
- communication skills; and
- working relationships with program administrators.

Since no single organization is likely to bring all these elements to the table, it makes sense for a lead group to convene other interested parties that have a commitment to improving children's health. Working together, members of a community-based outreach coalition can assemble the tools necessary to implement successful outreach activities. Community organizations that could potentially have an interest in becoming involved in a children's health insurance outreach campaign may include: community health clinics, child care centers, community action agencies, tenants associations, after-school centers, and programs that offer recreation, adult education, literacy classes, job training, food and shelter assistance, family counseling or other services.

Forming partnerships among community-based organizations creates opportunities to interact with a wider network of families in settings that families find familiar and comfortable. When community organizations also link up with established institutions that have a longstanding interest in children's health, they can expand outreach efforts even further. Hospitals and schools can provide formal methods for reaching families. Seeking the participation of less-traditional partners, such as the faith community and employers, can open new doors for outreach as well.

In communities with pressing basic needs, local organizations are often constrained by tight budgets, and staff members are likely to have a "full plate" of job responsibilities. It is important for each potential partner organization to view the goals of the outreach work as consistent with its own mission and to understand how proposed activities fit in with its established routines. Organizations will usually be willing to incorporate new tasks if those activities are perceived to be a logical extension of current work. If suggested new activities appear to place extra burdens on staff or funding, organizations may not be open to undertaking these activities without additional resources. But, if expectations of outreach partners are realistic, they are likely to be willing to participate.

The concerns of potential outreach partners need to be addressed before they can be expected to contribute their time and resources to the goals of the outreach coalition. To obtain the "buy-in" of new partners:

- **Start with a broad appeal**. The support of an association, authoritative body or umbrella group will give you clout. For example, a letter from the president of the Merchants Association endorsing your project may help you persuade local store owners to display posters promoting your toll-free number.

- **Identify a champion**. A popular teacher who has seen how a lack of medical attention can affect school performance could become a health insurance outreach "ambassador" within the school district.

- **Find a "hook"**. An existing child health initiative can provide a context for outreach activities. Illustrate how your proposed activity can advance the established agenda. For example, many child care programs across the country are working with nurses associations to train teams of health consultants. The nurse-consultants will advise child care providers on child health issues. A community outreach campaign could offer to enrich the effort by providing information for the nurse-consultants on children's health insurance programs and how to enroll. Adding this aspect to the

training will help achieve the goal of improving the health of children in child care settings.

- **Design activities so they dovetail with the organization's routine**. For example, if you want to provide information about children's health insurance to the parents of children involved in Boys and Girls Club activities, arrange for your mailing to coordinate with a notice to families about the Club's upcoming summer camp registration. Since children will need a check-up to attend summer camp, it will be helpful for families to learn about health coverage at the same time.

- **Offer resources to help support extra work**. If your project creates more work for staff in another organization, the idea is more likely to be accepted if you can provide additional resources. These could be financial resources, additional staff or volunteers, training or materials. In one school district, Americorps members conduct children's health insurance outreach activities and also provide tutoring and other enrichment for students.

Outreach coalitions across the country have applied these principles in their efforts to involve all kinds of organizations and institutions in outreach activities. The experiences and lessons learned by those who have successfully engaged the participation of three important outreach partners — schools, the faith community, and businesses[1] — are described below.

Schools

Why are schools important outreach partners?

- **Schools are where the kids are !** Conducting child health insurance outreach at school is a common-sense, high-impact strategy. A March 1998 report by the U.S. General Accounting Office found that 69 percent of uninsured, Medicaid-eligible children were either in school or had school-age siblings.[2]

- **School staff see the problems first-hand.** School administrators and teachers understand the link between a child's health and school performance. Children who do not get the health care they need suffer academically.

- **Schools may already provide health services.** Schools may provide some health services, either through a school-based clinic or a visiting or in-school nurse or counselor. These activities may

[1] Early childhood programs, health care providers and others also can be important outreach partners. For more information about working with these partners, see Donna Cohen Ross and Wendy Jacobson, *Free and Low-Cost Health Insurance: Children You Know are Missing Out* (Washington DC: Center on Budget and Policy Priorities, December 1998).

[2] U.S. General Accounting Office, *Medicaid: Demographics of Nonenrolled Children Suggest State Outreach Efforts*, (Washington, DC: Government Printing Office, March 1998).

provide opportunities to inform families about health insurance. If the school is already certified to receive Medicaid reimbursements, helping students enroll in Medicaid is in the school's financial interest.

- **Schools are trusted institutions.** Parents tend to trust schools and the information they provide. Hearing about Medicaid or other children's health insurance programs from their child's school may diminish the stigma that is often associated with receiving public benefits.

How can you involve schools in outreach activities?

- **Get your foot in the schoolhouse door.** This depends largely on knowing how schools in your community work. There is no simple formula. In some communities, a first connection needs to be made at the school district level with superintendents; in others, schools may be more autonomous and principals can be approached directly. Other key players might include an assistant principal, a teacher who supervises or advises a student organization, a team coach, a school nurse, a guidance counselor or a parent group leader.

- **Capitalize on the "ebb and flow" of the school year.** Schools often set their schedules way in advance for things like mass mailings to families or family visits to schools. Coordinate your outreach efforts so they fit with the school calendar. For example, if you want to insert a notice about children's health insurance with school lunch applications that are mailed to families in September, you may need to have your notice prepared and approved before the end of the previous school year. Be aware that some schools now operate year-round, with students on staggered cycles. Mailings may be scheduled for certain points in each cycle. If you want to provide application assistance at school, find out when families are most likely to be at school for another purpose, such as registration, report card pick-up or parent/teacher conferences.

- **Involve existing school staff, but don't overwhelm them.** If your outreach activities will involve school nurses, foodservice staff or classroom aides, try to minimize the extra work they will be asked to do. Provide training so staff knows what is being asked of them, and be sure your request does not cause conflict with their existing duties. For example, some schools issue a school lunch application on which parents

Families Find Support for Getting Children Insured in Seattle Schools

Seattle schools are the focal point for Kids Health 2001, an all-out effort to get children enrolled in Medicaid — and a contingent of grassroots "family support workers" and school nurses are making it happen! The family support workers are available in 65 elementary schools to help families obtain a range of benefits and services. Along with school nurses, they now have been trained by the Washington Health Foundation's Child Health Access Program (CHAP) to assist families with applications for Medicaid. To ensure adequate support for the outreach effort, the Washington Health Foundation also has provided the funding to increase the work hours for four family support workers and four school nurses who now can devote their full time to providing application assistance.

A series of school-based promotional activities have focused attention on the help parents can get from the family support workers. First, a letter from the school superintendent on the importance of health insurance for children was mailed to 36,000 families in nine different languages. The letter encouraged families to call their school's family support worker or school nurse — or the CHAP telephone line — for application assistance. The letter generated a huge response. Each school now displays posters which emphasize that ongoing help in applying for children's health insurance is available from the family support worker or school nurse. In addition, City Year Youth Corps workers are helping with outreach and application assistance at special events. Soon they will have pagers so they will be able to receive messages and get back to families within 24 hours.

The next step is to make application assistance a systematic part of the school routine. At kindergarten registration and school sports registration families will be able to apply for health insurance for their children. Seattle schools have already been experimenting with linking Medicaid application assistance to the School Lunch Program. By checking a box on the school lunch application, families can now give permission for their name and address to be shared with the Medicaid agency so that a Medicaid application can be mailed to them. Next year the school district is planning to pilot a new idea that takes the school lunch connection a step further. The school lunch application will be printed on a self-duplicating NCR form. By checking the box on the form, families will give permission for a copy of the form, which includes family income information, to be mailed to the Medicaid agency for the purpose of determining income eligibility for coverage. The Medicaid agency will contact families to get any additional information they may need — such as the child's immigration status — to make a full eligibility determination.

For more information, contact Elizabeth Garcia-Bunuel, Washington Hospital Association, Seattle, WA, (206) 281-7211.

can check a box to give permission for the School Lunch Program to share information from their application with Medicaid. School foodservice staff need training to identify and properly forward applications that have been checked. The procedures for forwarding applications need to be feasible in the context of the school employees' regular duties. Be aware that school foodservice workers have been trained to protect families' confidentiality. They need to be clear that the check-box authorizes them to change their traditional procedure.

- **Enable the school to make outreach someone's full-time job, if possible.** Some outreach campaigns have been able to provide resources to hire new staff or increase the work hours of existing school employees. Others have found ways to assign Americorps members or other volunteers to schools for the purpose of conducting outreach. In some cases, health centers or other providers have "loaned" staff to schools for the purpose of providing on-site application assistance.

The Faith Community

Why is the faith community an important outreach partner?

- **Families trust the clergy.** Many people turn first to a member of the clergy when they are in trouble. This may be true especially for families that are not linked to social service systems.

- **Many religious organizations are paying special attention to health issues.** Through health ministries or parish nurse programs, congregations are getting actively involved in tending to the health concerns of members and the larger community.

- **Congregants "wear other hats" in their daily lives.** A congregant who is a school principal, a business owner, a nurse or a social worker, may be able to act on what he or she learns at church about children's health insurance.

- **Church activities or enterprises offer an opportunity to conduct outreach.** Churches may run child care programs, food assistance sites, thrift stores, summer camps or other programs in which child health insurance outreach and enrollment assistance activities can be incorporated. Many congregations enlist their members to participate in community service projects. They are always looking for worthwhile activities for their volunteers.
-

How can you involve the faith community in outreach activities?

- **Approach clergy associations, ministerial alliances and other organizations**. Influential leaders from such organizations can put your issue on the "radar screens" of local ministers. Suggest ways involvement in outreach activities can be a catalyst for strengthening interfaith collaboration.

- **Provide clergy with the tools they need to help families in their own congregations.** Members of the clergy may not know how to help families that come to them with concerns about paying for their children's health care. Provide them with information about the availability of children's health insurance and how to apply.

Congregations Put Principles Into Action in Mississippi

A pastoral letter on the plight of children, co-signed by the Catholic, Methodist, and Episcopal bishops, was the impetus for an ongoing child health insurance outreach effort in Mississippi. After the letter was issued, human services professionals were asked to create an action guide to help congregations address the issues raised by the bishops. "The challenge is to make the solutions tangible for people," said Sister Donna Gunn, a leading force in the Children's Health Matters project, sponsored by Catholic Charities and a coalition of Catholic health care provider systems. "We try to connect the social teaching of the church — that everyone has a right to health care — with concrete ways people can become involved."

The first step was to conduct a statewide forum to educate a wide range of religious and community organizations on the difficulties Mississippi families face in obtaining health insurance for their children. In addition to catalyzing advocacy efforts aimed at expanding coverage and simplifying application procedures, plans for assisting families in enrolling their children soon were underway. As a result, the group has entered into a partnership with the Mississippi Primary Care Association which has a staffperson traveling throughout the state to train small groups on how to assist families in completing applications for Medicaid. Members of several congregations have become involved and have committed themselves to helping families through the entire enrollment process, including completing the forms, gathering the appropriate documents, getting approved for coverage, and finally, obtaining health care services for their children.

According to Sister Donna, congregants involved in the project are making this "journey" with families who also may be members of the church. Or families seeking help may be unaffiliated with the congregation, but may view the church as a place they can get help in a caring, non-judgmental atmosphere.

For more information, contact Sister Donna Gunn, Catholic Charities, Jackson, MS, (601) 355-8634.

- **Recognize that the level of involvement — what "feels right" — will vary among congregations.** Some churches draw worshipers from a specific geographic region; others draw members from all over who want to attend that particular church. This may affect the ties people will have to the immediate community and can give you clues to whether suggestions for certain activities are likely to resonate with congregants. For example,

will the church's own members benefit if the church offers application assistance on site? Will congregants be more inclined to volunteer if the project that affects the larger community? Some congregations have provided financial support for outreach activities conducted by other groups.

Businesses

Why are businesses important outreach partners?

- **Businesses have *customers* who may have children eligible for health insurance.** Businesses operating in low-income neighborhoods may readily understand that many of their customers could benefit from receiving information about health insurance for their children. Businesses that cater to families — children's clothing stores, toy stores, family-oriented restaurants and others — may be willing to alert customers to the availability of children's health insurance.

- **Businesses have *employees* who may have children eligible for health insurance.** It may be less obvious to business owners that children of their employees also may qualify for coverage. In fact, most uninsured children from families with income below 200 percent of the poverty line — 85.4 percent — are in families with earnings.[3] A March 1998 report by the U.S. General Accounting Office found that uninsured children who were eligible for Medicaid were most likely to have parents who were self-employed or employed in small businesses.[4]

- **Businesses can contribute resources to a community outreach effort.** Businesses may be willing to help underwrite campaign costs, or they may be willing to provide other kinds of help, such as access to the airwaves or advertising space.

How do you involve businesses in your campaign?

- **Let business talk to business**. Make contact with the local Chamber of Commerce, Private Industry Council or neighborhood Merchants Association. Enlisting a business organization as an intermediary can give your organization credibility with employers. In addition, working with business associations will provide links to many more small businesses than could be reached individually. Working with business associations can make it easier to focus on particular industries that may employ low-wage workers, such as the hospitality or retail food industries.

---

[3] Center on Budget and Policy Priorities calculation based on March 1997 Current Population Survey data from the U.S. Census Bureau.

[4] U.S. General Accounting Office, *Medicaid: Demographics of Nonenrolled Children Suggest State Outreach Efforts*, (Washington, DC: Government Printing Office, March 1998).

- "**Size up**" **the employer in terms of his or her comfort level with promoting children's health insurance programs**. Some business owners may feel uncomfortable if it appears they are being targeted for outreach because children of their employees are uninsured. They may prefer to view participating in the outreach campaign as a way to "do their part" in a community-wide activity. Others may want to offer enrollment assistance as a service to their own workers, but will not feel comfortable engaging in a large-scale effort to increase participation in a public program.

- **Convince small business owners they have a stake in helping employees obtain coverage for their children.** When workers' children are healthy, businesses will have fewer employee absences and less staff turnover. Employees will be more productive. One small business owner put it simply: "Stress stability in the workforce — everyone understands this."

- **Sell them on outreach.** Although business owners may realize how important children's health insurance is to families, the cost of dependent coverage is more than many small employers can handle. Business owners have been willing to allow outreach workers on site to talk to employees when they realize it gives them the opportunity to offer a benefit they could not afford to provide on their own.

Doing Business With WIC Has Added Benefits in New York

A unique connection to a network of small businesses is presenting child health insurance outreach opportunities in New York. Medical and Health Research Association (MHRA) of New York City, Inc. is one of four contractors that manages nearly 1,000 of the city's WIC vendors — supermarkets, corner grocery stores, and pharmacies that sell approved foods and infant formulas to families in the Supplemental Nutrition Program for Women, Infants and Children (WIC). These vendors, mostly small businesses that employ low-wage workers, rarely offer health insurance for employees or their dependents. Every 18 months, store owners or managers attend MHRA training on issues related to their participation in WIC. With funding from The Commonwealth Fund, MHRA interviewed vendors at the training sessions to identify ways MHRA could assist them and their employees in enrolling their children in Medicaid or Child Health Plus, New York's CHIP-funded separate program.

Findings from these interviews guided a pilot project that is now underway. WIC vendors in areas of Brooklyn will receive a letter informing them that MHRA application assistors will be coming to their stores to help them and their employees, as well as family and friends, to sign up their children for health insurance. They will be able to complete applications at the store or they can choose to apply at a local MHRA of NYC neighborhood WIC Program center. In either case, an application assistor will screen for eligibility, help them complete a short application, gather necessary documents and send the form to the appropriate place for processing. Families that complete this process will not need a face-to-face interview at the Medicaid office. To accommodate the work schedules of WIC vendor employees, the local WIC sites will have extended hours. MHRA anticipates that many will make the trip to the WIC site, where they are likely to feel more comfortable away from the watchful eye of their employers and less worried about the possible implications of their immigration status.

While the goal of the MHRA strategy is to reach employees, a "ripple effect" could benefit customers as well. If the enrollment assistance effort makes a positive impression on store owners, they may pass on the word about children's health insurance to customers. Customers can get help applying at the WIC sites. If found eligible, they also can get help enrolling in WIC!

For more information, contact Inez Sieben, MHRA of New York City, Inc., New York, NY, (212) 285-0220.

- **Suggest ways that outreach activities and application assistance for employees can be accomplished without interfering with business operations.** Business owners have been amenable to putting notices about the availability of children's health insurance in employee's paychecks or posting information in break rooms. They may be willing to set aside time for employees to get help with child health insurance applications during breaks or on a staggered schedule.

- **Illustrate how outreach activities and on-site application assistance can help boost the bottom line.** The owner of a Food Max grocery store outside Macon, Georgia gave permission for state enrollment workers to provide on-site assistance in applying for Medicaid and Peachcare for Kids, the state's new separate child health insurance program. The store manager agreed to distribute flyers to let customers know about the opportunity to apply for children's health insurance at the store. As word spread throughout the community and families flocked to the store, business improved. Families that came for enrollment assistance also picked up a quart of milk or a loaf of bread. Part-time employees — who are not eligible for the company's health insurance plan — took advantage as well. Enrollment workers have returned to Food Max several times.

II. Come Up to Speed on the Application Process

Conducting a community outreach campaign without understanding the application process is like setting out for a new destination without a road map — you may know where you want to end up, but you don't know how to get there, how long the journey will take, or where there are twists and turns in the road. The best way to learn about child health insurance application procedures is to approach it from two directions: from the perspective of how the system is supposed to work and from the viewpoint of a family going through the process. Understanding the application process is essential even if you do not plan to provide families direct assistance in completing application forms.

Learning about the Application Process

To learn about the "official process", visit staff of agencies that determine eligibility for children's health insurance programs, such as the local Department of Social Services office[5], Medicaid outstation sites, and public or private entities that determine eligibility for CHIP-funded separate state programs. Get to know eligibility supervisors, caseworkers or other key staff. Introduce your organization and let them know you plan to begin providing families information on how to apply for children's health insurance. Ask about how the process works from beginning to end. (See Table A on p. 36 for a list of important questions to raise.) Find out whether any of the application procedures are likely to vary from application site to application site. For example, county DSS offices sometimes have discretion regarding documentation requirements, such as how many pay stubs are required to verify income. If more than one DSS office is likely to serve families with which you work, get clear on how procedures at those offices may differ. Ask whether a liaison can be assigned to your project so there will be a specific contact person to refer questions or problems.

To gain an understanding of how families experience the enrollment process, accompany several families through the system to get firsthand knowledge of how the process works and how difficult cases or problems are handled. A local community group that routinely refers families to the DSS office may be able to introduce you to families that would be willing to have you come along. Also go along with families to a hospital or community clinic outstation site. If your state allows applications to be mailed-in or filed over the telephone, work through those systems with families, as well. Assess each experience in terms of how comfortable families feel with staff, whether their questions are answered appropriately and how long the process takes to complete. Understand whether, from the family's perspective, the real-life process measures up to the way the system is supposed to work.

Learning about the application process will help your staff prepare families for what they are likely to encounter when they apply for health care coverage for their children. For example, families will need to know what documents they should bring

[5] The public agencies that administer Medicaid or other children's health insurance programs are different from state to state. The agency may be called the Department of Social Services, Department of Human Services, Department of Family Assistance or another name. For consistency, in this paper the public agencies that determine eligibility will be referred to as the Department of Social Services or DSS.

with them and how much time the process will take. Having a firm grasp of the way the application process works helps build credibility with families and sets the stage for follow-up. For example, if experience indicates that the family will not receive any communication from the agency for at least two weeks, you can assure an anxious parent that not having heard anything within a few days is no cause for panic. In addition, families can be given a "heads up" about next steps in the process. For example, if applicants usually receive a notice in the mail requesting additional information, you can tell families to expect the notice and encourage them to call you if they need help interpreting it.

Providing Application Assistance

Many community outreach campaigns are now taking their efforts to help families further than ever before. Rather than simply referring families to application sites, such as welfare offices or health center outstations, they are providing families with direct assistance completing the application and assembling documentation. Offering application assistance at community sites increases the opportunities for families to apply for children's health insurance coverage at locations other than a government office and during evening hours or on weekends.

A growing number of states are simplifying their application forms and are instituting mail-in systems. These changes have made it more feasible for staff of community organizations to become "application assistors". As of November 1998, 39 states and the District of Columbia had eliminated the assets test used to determine a child's eligibility for Medicaid, making the application process simpler. Forty states and the District of Columbia were using a Medicaid application that is four pages or shorter, or were using a short, joint application for Medicaid and the state's separate child health insurance program. Thirty-four states and the District of Columbia had established mail-in application procedures that do not require a face-to-face interview.[6] (Table B on p. 38 presents states' use of these approaches to simplify their Medicaid application process for children.) Several states also are moving toward reducing and simplifying verification requirements.

Organizations that provide application assistance agree that adequate training on how to complete applications is essential. The training should include extensive practice completing applications for common — and not-so-common — family situations. Staff of the state or local DSS office or an experienced community organization usually can provide the training. It also is a good idea for application assistors to pair up with outstation staff at hospitals and community health centers to "learn the ropes." Some application assistors have found it helpful to "shadow" staff from programs like WIC. These staff have experience helping families complete applications for public benefits and can be good models for appropriate interviewing techniques. For example, seasoned interviewers suggest beginning the interview by asking less-invasive questions first. Application assistors should ask only for the information necessary for the application, but they must be attentive and willing to listen to families' concerns about needs other than health insurance. Application assistors agree that *nothing is more important than establishing a trusting relationship with families*. This requires establishing credibility, showing respect for families, and appreciating the confidential nature of the information being shared.

---

[6] Center on Budget and Policy Priorities telephone survey, November 1998.

Tips for Application Assistors

Generally, the job of the application assistor entails explaining children's health insurance programs to families, answering any questions they may have, and helping them complete application forms. In some cases, application assistors also help families determine which forms they need to file, as well as help them understand how to choose a health plan. In some states, application assistors may receive payment from the state, county or another entity for performing this service. Application assistors *do not* make final decisions regarding a child's eligibility for coverage.

Assisting families with child health insurance applications requires attention to detail and a commitment to follow-up — but in most cases it does not require becoming an eligibility expert.

Application assistors need training, practical experience with families and a person they can call to get help with situations that are out of the ordinary. Especially in the beginning, assistors will benefit from close supervision by a more experienced person or by getting frequent feedback from a DSS liaison.

Application assistors from around the country shared the following tips for making the job go smoothly:

- Get training from DSS staff so that applications you complete are done correctly and can be processed readily. Ask for a liaison from the DSS office so that you have a personal contact to call if problems arise.

- Never discourage a family from filling out an application, even if it seems that the child does not appear to be eligible. Special circumstances may sometimes help a child qualify for coverage.

- Find out what items on the application are most likely to cause problems for families, such as a particular document that is notoriously difficult to obtain. It helps to be on the lookout for "trouble spots."

- Go the extra mile to help families gather the documents needed to verify the information on the application. When you help with photocopying, don't forget to copy both sides of a two-sided document. In states that require proof of residency, a postmarked letter from your organization to the family at home may suffice. If a family needs a letter from an employer to verify income, offer to draft the letter so that the employer need only supply his or her signature.

- Be a devil about the details! Make sure you have all the signatures you need. If a question requires a "yes" or "no" answer, make sure the appropriate box is checked. In an automated system, a notation in the margin on a form will not be read by the computer.

- Make every effort to get completed applications submitted to the DSS office in a timely manner. The date a Medicaid application is received by the DSS office is "protected" — if the child is found eligible, he or she will be covered from the date the application was received.

- Learn the inner workings of the system so you can maneuver to best advantage. For example, in one state, families are told that eligibility decisions can be made in 10 days. However, according to experienced application assistors, incoming forms are batched and processing begins on the 15th of the month. So, applications submitted by the 14th can be processed by the 25th. Forms received after the 15th may not be processed until the 25th of the following month.

- If the family would like your help keeping track of the application, follow the appropriate procedure. Information about the status of the application is confidential and cannot be shared with a third party without the family's permission. The family can usually designate you as an "authorized representative", so that you can be contacted if more information is needed or if there is a problem with the application.

- Maintain your professionalism at all times. If you take your role as an application assistor seriously, others are likely to be more cooperative.

III. Remember, It's a Two-Way Street

Establishing a good working relationship with staff of the local DSS office is key to helping families navigate the system. However, sometimes community-based groups involved in outreach encounter considerable resistance from DSS staff, who may view outreach activities as "above and beyond" what is expected or desirable.

Many local DSS offices have recently undergone significant change as a result of implementing new welfare programs. Workers may have new job responsibilities or they may still be grappling with new rules and procedures. Getting involved in health insurance outreach activities may seem to be an added burden. They may be worried that outreach efforts will increase already heavy workloads, or that their work will get harder, since community groups will not understand all the nuances of program rules and procedures and will not be able to give families proper guidance. They may be worried about the implications of private groups getting involved in the application process and what that could mean for accountability and job security.

While such concerns need to be anticipated and addressed if they arise, community-based organizations should not assume that local DSS staff will always try to distance themselves from outreach activities. To the contrary, DSS staff can become important allies and full partners in a community outreach campaign. Many of the local DSS staff interviewed for this paper viewed themselves as "team-players" who share the goal of improving children's health, rather than as "gatekeepers" who must guard access to enrollment. They understand that when families have health insurance for their children, they are better able to retain their jobs — and this helps DSS meet its own goals. Many DSS workers realize that some families inherently distrust government agencies or are unable to come to DSS offices due to work hours or a lack of transportation. They recognize that staff of community-based groups can be capable helpers and that everyone benefits when application assistors are trained to complete applications properly. One eligibility supervisor said that application assistors in her area routinely "produce a superior product." Another said that DSS workers should not feel threatened by community organizations that assist families with Medicaid applications, since they are simply assisting with the "initial processing" of applications and the responsibility for eligibility determination still rests with the DSS office. He added that having well-trained community groups involved in the process relieves a great deal of the burden on over-stressed eligibility workers.

County Workers Are On the Job to Get Health Care for Children in Northern Virginia

According to Cheryl Jones, CMSIP Coordinator at Fairfax County (Virginia) Department of Family Services (DFS), "When a family contacts us, it's because they want health insurance for their children. We do what we can to find it for them, one way or another." In addition to processing the state's joint application for Medicaid and the Children's Medical Security Insurance Plan (CMSIP), the state's new CHIP-funded child health insurance program, a team of DFS workers will try to link low-income children who do not qualify for coverage with primary care services that are available in the county through a public/private partnership.

Even before CMSIP officially began, Fairfax County DFS began doing outreach. They started by sending out a "Back to School" flyer announcing that the new health insurance program was slated for implementation. As a result, some 2,400 families called for applications and more than 400 were completed when the program went into effect. In addition, all families receiving subsidized child care were mailed the health insurance application, along with a postage-paid return envelope. Completed applications can be submitted by mail and a face-to-face interview at DFS is not required. DFS workers are now helping families complete the health insurance application at the same time they apply for child care assistance.

The DFS office also is training staff of community-based organizations to help families fill out the children's health insurance application. Recently, 250 Head Start teachers were trained, as well as representatives of county services boards and early intervention programs. "I tell trainees to focus on the health needs of the child and not worry so much about the details of whether the family meets the eligibility requirements," explained Jones. "If they just help complete the application, we'll figure out the rest. Above all, I urge them never to turn anyone away. There's always a chance we can find a health care program for a child, even if he or she doesn't seem to be eligible at first." With so many community groups involved in the application process, and with families completing applications on their own, the DFS office also set up a phone line dedicated to answering questions about the joint application and about health insurance opportunities for children.

For more information, contact Cheryl Jones, Fairfax County Department of Family Services, Fairfax, VA, (703) 324-7500.

Building trust with local DSS staff is important, just as it is with families. Those interviewed said they appreciate groups that approach them in a non-adversarial and collaborative manner, and those that try to understand the constraints on local office staff. It is good practice to involve local DSS staff in planning community outreach activities. When staff are fully apprised of activities that are going on, there is less risk that they will be inundated with applications for which they are not prepared. Some DSS offices have their own staff assigned to conduct outreach and they may be open to

coordinating efforts with community groups. For example, a local DSS worker may be able to make a presentation about health insurance at a Head Start parent meeting, but community outreach workers will be better-suited to meet with Head Start families during home visits to help them fill out applications.

DSS staff that have worked well with community groups say that this experience has helped them in a number of ways. For example:

- Having well-trained staff of community-based groups assisting families with applications helps get the work done more efficiently.

- A good working relationship with community groups helps dispel the negative perception families have of DSS staff. When families see that individuals they trust are working cooperatively with DSS staff, it overcomes their fear that "nobody at DSS cares."

- One county DSS director said that although his goal is to actively seek out and enroll eligible uninsured children in Medicaid, the public is probably "not ready" to have the DSS office advertise the availability of public benefits. Public service announcements or billboards sponsored by a private, nonprofit group are more palatable.

- Another DSS supervisor said becoming involved in outreach coalitions helped her think strategically about other helpful connections her agency could be making. She now tries to initiate new relationships with community groups affiliated with underserved populations. For example, she has begun working with organizations that run pre-release programs for youth in detention so that their Medicaid applications can be processed quickly once they are back in the community.

- In one state, community-based outreach workers and DSS staff meet regularly for case reviews. In this forum, specific problems with enrollment procedures that keep cropping up are discussed; recommended solutions often lead to policy or procedural changes that make the process easier for families, application assistors and DSS eligibility workers.

Walking a Fine Line

One theme emerged repeatedly in conversations with community outreach workers and DSS staff, alike. That theme was the need for balance. Several of those interviewed talked about "walking a fine line" so that they provide the most effective help to families without overstepping boundaries. Here is a sample of what they said:

★ **On empowering families :** *There's a line you walk between what families can do for themselves and what you should offer to do for them during the application process. You want to be sure you give them the ability to pursue the process on their own if they are comfortable doing that, and you also want to offer adequate help without invading their privacy.* ***— A Community Outreach Worker***

★ **On training staff of community groups:** *We need staff of community organizations to help families with applications — they have the links to families and families trust them. So, thorough training is absolutely essential. But, we walk a fine line between delivering too much information or not enough. I've seen the training get so complicated that you can see the outreach workers literally deflate — the wind gets knocked out of them. Outreach workers take their jobs seriously and they don't want to feel they might let a family down or steer them in the wrong direction. The best training is simple, but gives the information necessary to get the majority of families through the process. The training should leave outreach workers with a resource they can turn to if they get a difficult case.* ***— A Child Health Advocate***

★ **On maintaining confidentiality:** *The community groups are always ready to do more to help families. They wanted to be able to contact families who didn't respond to our notice asking for more information. We recognize that individual follow-up with families is critical, but what they were asking to do would cross the line since we are bound to protect clients' privacy. Now, the application assistors encourage families to designate them as "authorized representatives". If the assistor's name appears on the application as the authorized representative it means that the family has given permission for us to share information about its case with that person.* ***— A DSS Eligibility Supervisor***

★ **On understanding the dynamics of the system:** *Outside groups walk a fine line when they get involved in helping families through the application process. While they need to advocate for those families, they also need to have a sense of the big picture — the environment in which the system operates — so they know the right channels for addressing problems. If they find a part of the procedure too complicated or unreasonable, they need to understand that the eligibility worker doesn't set the policy. It's not going to be helpful to focus the problem on the worker.* ***— A Representative for a Public Employees Union.***

IV. Broaden Outreach Channels by Reaching Out to Diverse Communities

Community-based outreach campaigns need to make special efforts to reach culturally-diverse communities with information and assistance in obtaining children's health insurance. For some groups the usual barriers to enrollment may be greatly magnified or they may face barriers that are unique to them. Two points are especially important as outreach campaigns move forward:

- Cultural diversity itself should not be viewed as a barrier to enrollment. Rather, cultural values or relationships among members of a particular group can lend strength to outreach efforts. For example, the respect paid to elders in some communities can help shape activities in which grandparents and other older community members take a lead role in helping families obtain health insurance for their children.

- Community-based outreach efforts need to be just that — community-based. Outreach coalitions need to include organizations that represent the communities they are trying to reach. These participants will be able to make the wisest judgments about campaign messages and outreach strategies. The broader the representation on your coalition, the fewer assumptions you are likely to make about what strategies will work best with a particular group.

This section shares the insights of community outreach workers with experience in immigrant communities and with tribal families.

Working in Immigrant Communities

While establishing trust with families is fundamental for any community organization engaged in children's health insurance outreach activities, it is a greater challenge for those working in communities with large numbers of immigrants. Complicated enrollment systems are even more difficult to navigate when informational brochures and applications are not printed in languages other than English or when interpreters are not available. Yet, working effectively in immigrant communities depends on a lot more than simply having flyers translated into other languages. Fears about revealing personal information or interacting with government agencies may be heightened because of concerns about immigration status or family security.

There is no one "immigrant community". While individuals may share some common concerns by virtue of being immigrants, the issues facing immigrant families vary widely and are influenced by many factors, including their experiences in their country of origin, the length of time they have been in the U.S., their immigration status, socioeconomic characteristics, cultural values, and beliefs about where illness comes from and how to treat it. Before undertaking child health insurance outreach efforts in immigrant communities, it is important to understand the eligibility rules for immigrant children. In addition, it is important to understand why the immigration status of other family members may affect a family's decision to enroll the child. Finally, it is important to understand how the application process may deter immigrant families from enrolling their children in children's health insurance programs.

- **New laws have changed eligibility**. The new federal welfare law made some low-income legal immigrants ineligible for some federal benefits. There are a number of points related to immigrants' continued eligibility for Medicaid and state-funded medical assistance that are important to know:

  1. With the exception of Wyoming, all states have decided to provide Medicaid to qualified immigrants who were in the U.S. before the welfare law was passed (August 22, 1996).

  2. Many immigrants who entered the U.S. after August 22, 1996 are barred from participating in Medicaid and CHIP-funded separate state programs for the first five years.

  3. All immigrants — regardless of their immigration status or when they entered the country — remain eligible for all emergency Medicaid services, immunizations, and the testing and treatment of symptoms of communicable diseases.

  4. In August, 1997, Supplemental Security Income (SSI) and SSI-related Medicaid were restored for most legal immigrants who were in the U.S. before August 22, 1996.

  5. States can use state funds to provide health care coverage or medical services for immigrants who are not eligible for Medicaid. States can also pay for health services for immigrant children using federal CHIP funds available for administration, outreach or other child health initiatives. (The amount spent for all these purposes is limited to no more than 10 percent of the amount the state spends on providing health insurance coverage.)

- **Many immigrants may be reluctant to enroll their children in Medicaid or other children's health insurance programs because they have concerns about how receiving benefits will affect their immigration status**. Many children with immigrant family members are likely to have been born in the U.S. and would therefore qualify for Medicaid or CHIP-funded separate state programs, as long as they meet other eligibility

criteria. Yet, families may be concerned about how a child's participation in a public benefit program could possibly affect other family members in the future. Some immigrants fear that getting public benefits will classify them as a "public charge" — meaning they are likely to be unable to support themselves without government help. They fear that this will be used against them in immigration proceedings, such as when they attempt to adjust their immigration status, when they try to re-enter the U.S. after a time away or when they attempt to sponsor other family members who wish to come to this country.

People may have misperceptions about the level of risk relating to public charge. For example, no one who is eligible for Medicaid can be deported for obtaining or using Medicaid benefits. No one who has received Medicaid legitimately can be asked to repay the government the value of those benefits. In addition, use of Medicaid alone cannot prevent an immigrant from becoming a citizen. *Nonetheless, it remains unclear whether some immigrants could face public charge difficulties if they use Medicaid.*[7] Families also may have fears about potential reporting of undocumented family members to the INS if their status is discovered during the application process. Outreach workers should be sensitive to the legitimate fears families may have and should not push families into taking steps they do not feel comfortable taking.

- **Some aspects of the application process may deter families from enrolling their children**. Be aware that in some states applications for children's health insurance contain questions related to the citizenship or immigration status of non-applicant parents (or other household members). They also may request Social Security numbers (SSN) for non-applicants. Recent guidance from the federal Health Care Financing Agency to state health officials clarified that information about the citizenship of individuals not applying for coverage is not relevant to children's eligibility and states may not require parents to disclose this information.[8]

  The guidance also clarified that states are prohibited from requiring an SSN from another family member as a condition of a child's eligibility for Medicaid, and that a child cannot be denied Medicaid because a family member, including a parent, does not have or is unwilling to provide an SSN. Furthermore, federal law does not permit programs financed with federal CHIP funds to condition children's eligibility on the provision of the child's or another family member's SSN. (An SSN is not required for obtaining emergency Medicaid services, which is available to all

---

[7] At the time this paper went to press a clarification of the federal policy regarding public charge was expected soon. For additional information about public charge, contact the National Immigration Law Center at (213) 938-6452.

[8] Letter from Sally K. Richardson, Director, Center for Medicaid and State Operations, HCFA, September 10, 1998. To obtain a copy of the letter, visit the HCFA website at www.hcfa.gov.

immigrants.) Many states are revising the wording of their applications to reflect this new guidance, but others have not done so.

Even after an application for children's health insurance is submitted, families are likely to need additional help with the process. Outreach workers say it is common for families to receive notices from the local DSS office requesting additional information. They may put aside letters they cannot read and, as a result, their children's application may be denied. Outreach workers have shown family members who cannot read English well how to recognize the return address of the local DSS office and have encouraged families to call them immediately for help in interpreting notices they receive.

Community organizations with experience working in immigrant communities also stress the importance of understanding the factors that may influence how an individual perceives the offer to help enroll the child in a health insurance program. For example:

- A family's understanding of the concept of health insurance may depend on the health care system in their country of origin. Was health insurance available in their country of origin? Was health care available through free clinics? Was a patient expected to repay the cost of care?

- The relationship people had with the government in their country of origin may influence how they view enrolling in a government health program. Some people are used to having had such benefits and expect them. Others, who may have feared the government in their country of origin, may be particularly cautious or suspicious.

- The immigration status of most people in the community will also be a factor. The experience of undocumented persons will be different than that of refugees or legal residents. Families may have special concerns if the immigration status of family members varies.

- Immigrant families' sense of how they are viewed also will be a factor in their willingness to enroll their children. One outreach worker explained that in "today's climate" the system makes people feel as though they are being watched; if they make a mistake it will be considered fraud and they will be punished. Confusing rules and application procedures heighten such fears.

- Sometimes unscrupulous salespersons or con-artists prey on new immigrants, especially those who do not speak English. If people have been the victims of scams or have heard about them, they may be leery of signing their names to anything.

Outreach workers with experience in immigrant communities offer the following suggestions:

- Before starting out, enlist the partnership of community groups and institutions such as churches, settlement houses or other community centers that already have contacts and credibility with families. If these groups have the resources to conduct outreach and enrollment activities, but need to learn the technical aspects of children's health insurance programs, offer to provide the appropriate training. In many communities, lay health workers are already conducting outreach to families to help them understand how to obtain health services. Training these trusted community members to incorporate application assistance into their current work will help enrich their outreach efforts.

  If the community groups lack the time or resources to conduct outreach activities themselves, they may be happy to host outreach workers from your organization. Spend time with the host group getting to know community members, and letting them get to know you, before trying to interest families in signing up their children for health insurance. Be mindful of acceptable communication styles. Seek the host group's advice about the best way to convey respect for families.

- Ask for help creating materials that will "speak to" the group you are trying to reach. In addition to preparing materials in the language of the community, make sure the message is tailored appropriately. For example, it may be especially important for flyers to emphasize that families do not have to go to a government office to apply for health insurance for their children. This may help mitigate concerns about their children's participation in a public benefit program.

- Get a feel for how members of the community communicate with each other. Often word-of-mouth and networks of friends and families can be the most powerful channels. Informal "institutions", such as ethnic grocery stores or restaurants, barber shops or nail salons, may be important places to share information. Utilize the ethnic media, including newspapers and radio stations upon which members of the community rely.

Working with Tribal Families

American Indians and Alaska Natives are among the most pervasively uninsured groups of people in the country. Although tribal families are likely to have children eligible for Medicaid or CHIP-funded separate programs, they may face especially difficult barriers to enrollment. It is important for outreach workers to understand these special factors and make adjustments in outreach plans to account for unique situations, including:

- **Multiple federal health programs for tribal members can lead to confusion.** Many tribal families get health services in clinics operated by the Indian Health Service (IHS) and IHS-funded tribal and urban Indian health programs, and there is often confusion as to whether they can apply for Medicaid or not. In fact, children who are tribal members may be eligible for Medicaid or CHIP-funded child health insurance programs

on the same basis as other children in the state in which they reside, regardless of whether they may be eligible for or receive IHS-funded care.

Tribal members can apply for Medicaid or CHIP-funded child health insurance programs and doing so can be advantageous to them and to their communities for two reasons: First, these programs provide access to a broader range of health services than those generally available through IHS programs. Second, the Indian Health Care Improvement Act grants IHS and IHS-funded programs the authority to bill Medicaid and CHIP-funded insurance programs for services IHS and IHS-funded programs provide directly to Indian persons. Recouping costs for Medicaid or CHIP-funded services can help expand local IHS services and keep clinics viable. In fiscal year 1997, IHS and tribally operated facilities were projected to receive $184.3 million in Medicaid reimbursements compared with the $1.806 billion appropriated for IHS and tribally-provided health services that year.[9]

- **Relationships between tribes and states vary.** The complexities of these relationships sometimes make collaboration difficult. For example, tribes have a direct government-to-government relationship with the federal government. Sometimes state agencies erroneously believe that tribes get all their own federal allocations and should not receive any services from states. However, tribes do not run their own Medicaid programs, nor do they receive their own CHIP funds. They must rely on their state to provide adequate outreach to tribal communities.

  The federal law establishing the new child health insurance program *requires* that each state describe in its CHIP state plan the procedures to ensure the provision of child health assistance to targeted low-income American Indian and Alaska Native children in the state. In addition, the Health Care Financing Agency (HCFA) has issued guidance to states regarding consultation with tribes and organizations concerned with tribal health issues on the development and implementation of the CHIP state plan. *(To obtain this guidance, see letter to State Officials from Sally K. Richardson, Director, Center for Medicaid and State Operations, February 24, 1998, www.hcfa.gov\init\ch022498.htm)*

- **The new welfare law may create additional complications.** Under the new welfare law, tribes have the option to administer their own cash assistance programs through the Temporary Assistance to Needy Families (TANF) block grant. As of March 1, 1999 a total of 19 tribal plans (representing 62 Indian tribes and Alaska Native villages) had been approved by the U.S. Department of Health and Human Services, and several more were pending approval. However, tribes *cannot* run their

---

[9] Andy Schneider and JoAnn Martinez, *Native Americans and Medicaid: Coverage and Financing Issues* (Washington, DC: Center on Budget and Policy Priorities for the Kaiser Commission on the Future of Medicaid, December 1997).

own Medicaid programs, and families in tribes that administer TANF programs may have to apply separately for cash assistance and Medicaid. Tribal TANF workers will need to make special efforts to help children get enrolled in Medicaid, to avoid the danger that they may miss out.

- **Complex family finances can be a barrier to enrollment.** Tribal members may have erratic income from seasonal employment, assets from casino dividends, or other tribal financial holdings. These financial situations can complicate eligibility determination. Families in states that count assets in addition to income in determining eligibility will face further difficulties. Six of the 20 states with the highest tribal populations — Colorado, Montana, North Dakota, Oregon, Texas, and Utah — still count assets in determining Medicaid eligibility for children.

Outreach coalitions need the full participation of tribal organizations to provide leadership and insight into the best ways of ensuring that community-level outreach activities meet the needs of tribal families. Some ideas for conducting outreach activities in tribal communities follow:

- **Reach out through tribal programs that work directly with children and families.** Tribal hospitals, health clinics, Head Start programs, WIC offices, and Indian Child Welfare offices are all potential sites to display posters and provide flyers on health insurance. Staff of these programs may be best able to identify children likely to be eligible for free or low-cost health insurance**.** They can be instrumental in providing accurate information to families and dispelling misinformation about children's eligibility.

- **Conduct health insurance outreach at special events.** Many tribes hold annual health fairs and most tribes have an annual pow-wow. Both are excellent opportunities to provide information on children's health insurance programs. Head Start recruitment day, kindergarten registration, community festivals, sign-ups for extra-curricular activities and summer camp, or story hour at the library also offer opportunities to talk to families about health insurance for their children.

- **Disseminate child health insurance information with the assistance of tribal elders.** Tribal elders are an important resource in tribal communities. On smaller reservations elders frequently know the economic situation of individual families. Having lived through many

Community Outreach Helps Tribal Families Get In on Montana CHIP

When Montana rolled out Phase I of its new children's health insurance program, children of the Confederated Salish-Kootenai Tribes were prepared. Since the program would only be open initially to about 1,000 children from throughout the state, applicants who submitted forms by a specific date would be chosen by lottery. A strong effort was made to ensure that tribal children had a shot at participating:

- ★ The Salish-Kootenai Housing Authority included a notice about the children's health insurance program with all rent bills.
- ★ Head Start and the Parent Infant Stimulation Program conducted a week-long series of open houses in which health teams composed of nurses, community health workers, and fitness center staff were on site to help families with applications.
- ★ Families gathered at a community-wide "Chili Feed" to which they could bring their applications and verification documents and were offered help in completing the forms.

In addition to providing application assistance, the tribe also agreed to pay the $15 application fee that had to be attached with the form. According to Anna Whiting Sorrell, Program Analyst for the tribes, families needed this incentive and as the program expands more will need to be done to help families understand the new system. "Tribal families now get their health care for free," she said. "Suddenly they are being asked to pay, but they may see no reason to do this. Their experience will have to prove to them that the program and the process is worth it." She added that the health care providers available to families will make all the difference. If families will be able to maintain the relationships they have built with providers who are sensitive to their needs and concerns, the program is more likely to succeed.

As one of the entities now running its own TANF program, the Confederated Salish-Kootenai Tribes also is taking steps to ensure that families with children eligible for Medicaid have easy access to that program. A tribal Department of Human Resource Development has been created that oversees the programs providing families assistance with cash, housing, child care and employment. The tribes recently negotiated with the state to co-locate Medicaid at the Department, as well. Now, when a family's eligibility for a TANF cash grant is determined, eligibility for food stamps and Medicaid can be determined, as well.

For more information, contact Anna Whiting Sorell, Confederated Salish-Kootenai Tribes, Pablo, Montana, (406) 675-2700.

social changes, and possibly having been past recipients of social programs, they are often well-suited to helping younger families overcome barriers to receiving services. Network with programs for elders, such as the Tribal Elderly Nutrition Program, to distribute information on child health insurance.

Many tribal elders may be employed by the Green Thumb program. Green Thumb operates the Community Service Employment Program, which provides training and employment opportunities to low-income elders. Tribal participants provide community service by working in such places as IHS clinics, tribal libraries, tribal Head Start programs and other important settings for conducting health insurance outreach.

- **Work with the state or local Medicaid agency to become a Medicaid outstation.** Arrange to have a Medicaid worker on-site at the tribal health clinic, Indian Child Welfare office or the tribal TANF office on a regular schedule. Tribal staff can be trained as application assistors to help families complete the application and gather the documents they need to submit along with it so that eligibility can be determined.

- **Encourage tribal businesses to inform their employees and customers that children in working families may be eligible for free or low-cost health insurance.** In many areas, tribes are the largest employers. They may have employees and customers whose children are eligible for health care coverage under Medicaid or other child health insurance programs. Other businesses in the community also may have employees and customers with children who are eligible.

- **Use the media to inform the public about the availability of health insurance for children.** Tribal newspapers and tribal radio stations can be encouraged to publish articles and run public service announcements. Remember that promotional pieces should always connect families to a place they can go to apply for coverage or to a number they can call to get assistance in applying.

32

V. Track the Progress

Keeping track of outcomes is critical to the success of a community outreach campaign. Tracking can help determine which outreach methods are leading to applications being filed and approved. It also can help pinpoint aspects of the application process that are causing confusion or deterring families from getting their children enrolled. Lessons learned can help provide insight regarding how the campaign's approach to families can be modified, how resources can be better targeted, how messages can be tailored and how training can be enhanced to better prepare application assistors. The results of tracking efforts can generate recommendations to reform policies or procedures related to simplifying enrollment or increasing enrollment sites in the community.

Community outreach campaigns can use various methods to track their efforts, such as:

- **Talk to families.** Ask individuals who call a toll-free number or seek assistance from an application assistor where they heard about the availability of children's health insurance. Keep a record of the types of questions families most frequently ask.

- **Code forms or other materials.** One outreach project displays posters in schools that inform families about children's health insurance and how to apply. Attached to the posters are pads with tear-off sheets containing a number to call for application assistance. The sheets are coded so the assistor can tell where the family obtained the tear-off sheet and the project can tell which schools are getting the most "traffic".

  Some local DSS offices are allowing community outreach campaigns to code applications so they can tell where families have obtained application forms.

- **Survey applicants.** If your community organization is disseminating applications or is helping families apply for coverage, let families know you will be contacting them to follow-up. Several weeks later, the family can be mailed a postage-paid return card containing key survey questions. Families can be asked if an application was filed, if additional help was needed to complete the forms, where they got help and whether the child's eligibility was approved or denied. Families do not have to put

their names on the return cards, but if they can be encouraged to do so, it will give you another opportunity for follow-up.

- **Get feedback on applications that have been filed.** Getting information about child health insurance applications after they have been filed with the DSS office can be difficult, since information from these applications is confidential. However, families can give permission for the DSS office to share information from the application under certain circumstances. For example, a family can designate the application assistor — or another person — as its "authorized representative", which means the application assistor can communicate directly with DSS on behalf of the family. This enables the application assistor to make sure the application is being processed smoothly and that any additional information requested from the family is supplied. Application assistors can document how long applications take to process, which questions on the application may be causing confusion, and whether children are found eligible or ineligible for coverage.

  Some outreach campaigns ask application assistors to sign their names on the application. Outreach campaigns can then work with DSS officials to tell whether families that receive assistance have a better chance of getting the application approved than families who complete the application on their own. They also can tell, based on recurring mistakes on applications, where the wording of questions may need clarification or where assistor training needs to be improved.

Table A:

Learning About the Child Health Insurance Application Process

Community organizations need to know the details about how the child health insurance application process works so they can be a source of accurate information for families. This information can be provided by the local DSS office and other public or private entities that determine eligibility. Keep in mind that families seeking cash assistance in addition to Medicaid may need to use different application forms and procedures than families seeking only health coverage for their children. Be sure to clarify how the process works for families in each of these situations. Answers to the following questions will provide much of the essential information:

- Where can families obtain an application? Where can they go to file an application? (Ask for a list of all public agency offices, as well as outstations and other application sites, including hours of operation.)
- Can applications be submitted by mail?
- Can community organizations maintain a supply of applications to share with families? How can a supply of applications be obtained? Can forms be photocopied?
- Are applications available in languages other than English? How can those forms be obtained?
- What information on the application must be verified?
- What documents are accepted to verify that information?
- If a face-to-face interview is required, does the family need to make an appointment in advance?
  - How long does a family usually need to wait for an appointment?
  - How long does the interview usually take?
- Are interpreters available to assist families that do not speak English? Do families need to request interpreter services in advance?
- If families can mail in their forms, how will they be notified if additional information is needed?
- Can applications be completed over the telephone? If so, what are the hours of service? Are bilingual operators available?
- How long does it usually take for the family to receive an eligibility determination?
- If the family has questions about the status of the application, is there a number to call for information? Under what circumstances can this

information be shared directly with outreach workers who may be helping families with their applications?

- How are families notified of the eligibility determination?
- What is the procedure for appealing a denial, if the applicant believes a mistake has been made?

— — — — — — — — — —

- Can families that wish to apply for cash assistance in addition to Medicaid fill out a single application form?
- If a family's application for cash assistance is delayed or denied, what procedures are in place to ensure their application for Medicaid is processed in a timely manner?
- If a family loses cash assistance — either because of employment or because of welfare rules, such as time limits, or another reason — what procedures are in place to assure that family members maintain Medicaid coverage for as long as they remain eligible?

For more information, see Cindy Mann, *The Ins and Outs of Delinking: Promoting Medicaid Enrollment of Children Who Are Moving In and Out of the TANF System*, (Washington, D.C. / Columbia, SC: Center on Budget and Policy Priorities and Covering Kids, March 1999).

— — — — — — — — — —

- If the state has a separate CHIP-funded child health insurance program, can a single form be used to apply for either Medicaid or the separate child health insurance program?
  - If so, are all completed forms sent to one place for an eligibility determination, or must the family make a decision about where to send the application?
  - If the application forms for Medicaid and the separate CHIP-funded program are different, what happens if eligibility is denied in the program for which the family applied? Is the application automatically transferred to the other program? If not, what happens?

Table B:

Approaches to Simplifying the Medicaid Application for Children: What are States Doing?

The following methods for simplifying the application process are being used by the states listed. Some states are using a combination of approaches.

Mail-In [1]	No Assets Test [2]	Short Application [3]
Alabama	Alabama	Alaska
Alaska	Alaska	Arizona~
California>	Arizona	Arkansas
Colorado~	California	Colorado~
Connecticut	Connecticut	Connecticut
Delaware	Delaware	Delaware
Dist. of Col.	Dist. of Col.	Dist. of Col.
Florida~	Florida	Florida~
Hawaii*	Georgia	Georgia
Illinois*	Hawaii	Hawaii
Louisiana	Illinois	Illinois
Michigan~	Indiana	Indiana
Maine*	Kansas	Iowa
Maryland	Kentucky	Kentucky
Massachusetts	Louisiana	Louisiana
Michigan	Maine	Maine~
Minnesota	Maryland	Maryland
Mississippi	Massachusetts	Massachusetts
Missouri	Michigan	Michigan~
New Jersey~	Minnesota	Mississippi
New Mexico*	Mississippi	Missouri
North Carolina~	Missouri	Nebraska
North Dakota*	Nebraska	Nevada~
Ohio	New Hampshire	New Hampshire
Oklahoma	New Jersey	New Jersey
Oregon	New Mexico	New Mexico
Pennsylvania	New York	New York
Rhode Island	North Carolina	North Carolina~
South Carolina	Ohio	Ohio
South Dakota	Oklahoma	Oklahoma
Utah*	Pennsylvania	Oregon
Vermont	Rhode Island	Rhode Island
Virginia	South Carolina	South Carolina
Washington	South Dakota	South Dakota
West Virginia	Tennessee	Tennessee
Wyoming	Vermont	Texas
	Virginia	Vermont
	Washington	Virginia
	West Virginia	Washington
	Wisconsin	West Virginia
		Wyoming
Total: 36	**Total: 40**	Total: 41

1. AR accepts applications by mail for its Medicaid expansion group (ARKids First) only.
2. AR and UT still count assets in determining Medicaid eligibility for some "poverty level" children.
3. Applications are the same length or shorter than the four-page HCFA Model Medicaid Application. AL, CO and UT use joint applications for Medicaid and separate child health insurance programs of 5, 6 and 6 pages, respectively.
*** After the mail-in application is received, the Medicaid agency will conduct a telephone interview.**
~ Refers to the state's joint application for Medicaid and separate child health insurance program, not the state's separate Medicaid application if the state continues to use one.
> Refers to CA's mail-in packet which includes applications for Medicaid and the separate child health insurance program.

Center on Budget and Policy Priorities— November 1998

Interviews

John Anderson, *Right From the Start Medicaid,* Atlanta, GA

Sandra Baldwin, *Contra Costa County Social Service Department,* Richmond, CA

Bonnie Ballard, *Cherokee County Department of Human Services,* Tahlequah, OK

Shirley Bealor, *Inova Health System,* Falls Church, VA

Judy Brosch, *Arlington County Department of Human Services,* Arlington, VA

Carol Burnett, *Moore Community House,* Biloxi, MS

Elena Chavez, *Consumers Union,* San Francisco, CA

Joanne Clarke, *Massachusetts Department of Health and Human Services, Division of Medical Assistance,* Boston, MA

Michael DiChiara, *AHEC/Community Partners,* Amherst, MA

Jack Frech, *Athens County Department of Human Services,* Athens, OH

Jan Fassbender, *Outagamie County WIC Program,* Appleton, WI

Elizabeth Garcia-Bunuel, *Washington Hospital Association,* Seattle, WA

Rev. Jill Graham, *Ecu-Health Care,* North Adams, MA

Jennifer Grondin, *AFSCME,* Madison, WI

Sister Donna Gunn, *Catholic Charities,* Jackson, MS

Anthony Hicks, *small business owner,* Macon, GA

Gretchen Hogue, *Great Lakes Intertribal Council,* Lac du Flambeau, WI

Cheryl Jones, *Fairfax County Department of Family Services,* Fairfax, VA

Rebecca Lieberman, *Children's Aid Society,* New York, NY

Mei Ju Lui, *Health Care For All,* Boston, MA

Frank Mancuso, *Springfield Massachusetts Enrollment Center, Division of Medical Assistance,* Springfield, MA

Zettawee Mix, *Franklin County Department of Human Services,* Columbus, OH

Lindsay Moore, *Vietnamese Health Center,* St. Louis, MO

Luis Pardo, *Health Care Services Agency,* San Leandro, CA

Barbara Perzigian, *small business owner,* Cupertino, CA

Inez Sieben, *Medical and Health Research Associates, Inc.,* New York, NY

Judy Solomon, *Children's Health Council,* Hartford, CT

Anna Whiting Sorrell, *Confederated Salish-Kootenai Tribes,* Pablo, MT

Sister Mary Lou Stubbs, *Archbishop's Commission on Community Health*, St. Louis, MO

Laurie Sutter, *Comprehensive School Health Project*, Lincoln, NE

Angie Wei, *California Immigrant Welfare Collaborative*, Oakland, CA