# CalWORKs Children with Disabled Parents on SSI

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Raising children is a challenge for virtually all parents. It is made harder when a parent is disabled by poor physical health, mental illness, or learning barriers. In 2008-2009, about 31,000 California parents sufficiently disabled and poor to qualify for Supplemental Security Income (SSI) were raising between them some 55,000 children with assistance from the child-only component of CalWORKs, California's TANF program.

Drawing on data from families in San Francisco, this brief aims to help policy makers assess how adequately the combination of SSI and CalWORKs meets the needs of these particularly vulnerable families. Many of these parents received CalWORKs themselves before their disability was fully recognized and they moved to SSI. Because SSI provides a much larger parent grant than does CalWORKs, and because SSI is not time-limited, it seems that with this shift in aid families should be better off.

Under SSI, however, parents and their children are not automatically linked to social work or other services, even though the parents' limitations are debilitating and the children are likely to be very poor for their entire childhood. The families rarely qualify for auxiliary supports such as transportation, subsidized child care, or behavioral health resources beyond Medi-Cal funded mental health or alcohol and drug services.

Additional non-financial strategies may be available to support healthy child development and adult well-being among SSI-parent families whose children are on CalWORKs. Since counties differ in their welfare funding, in aspects of CalWORKs program design, and in the extent and variety of resources available, the implications and conclusions to be drawn from this brief will differ from county to county.

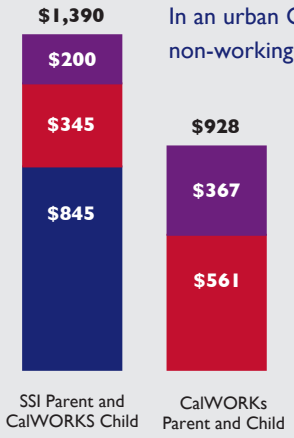
**Study Sample.** Sixty parents, randomly selected from San Francisco's caseload of child-only CalWORKs cases with English-speaking SSI parents, were interviewed between March and June of 2010 by phone or in person (as the respondent preferred). Most respondents (97%) were women, with an average age 40.4 years. The average number of children per household was 1.5. Two-thirds (68%) of respondents were African American, and 27% were white.

**Study Measures.** Health and disability were assessed according to three measures:

## SSI and CalWORKs

SSI is a federal cash assistance program, augmented in many states (including California) with a state supplement (SSP), for low-income people who have a disability, are blind, or are age 65 or older. The minor children of an SSI recipient may receive child-only Temporary Assistance for Needy Families (TANF) aid, known as CalWORKs in California. Although many parents on SSI are on CalWORKs first, some are on SSI before having children. Child-only CalWORKs cases with parents on SSI make up 6% of welfare cases statewide.

## How Much Cash Aid?




In an urban California county, a typical non-working SSI parent with one child receives SSI of $845 and a child-only CalWORKs grant of $345, plus food stamps for the child up to $200, for a total of $1390. This is more than if both parent and child were on CalWORKs, receiving a grant of $561, plus up to $367 in food stamps, for a total of $928.

1. Respondents rated their health and the health of their children on a five-point scale: excellent, very good, good, fair and poor.[1]

2. Respondents were asked if physical health problems, mental health problems or learning disabilities limited their ability to work. Limitations due to mental health problems or learning disability problems were combined for analyses into "mental health limitations."[2]

3. To assess how much help clients needed with everyday activities, the survey included questions about two Activities of Daily Living (ADLs) – bathing and personal care – and ten Instrumental Activities of Daily Living (IADLs): (a) shopping for and (b) carrying groceries, doing (c) housework and (d) laundry, (e) preparing meals, (f) mobility within the home, (g) taking medications correctly, and successfully remembering or handling (h) appointments, (i) instructions and (j) money. All 12 activities are referred to as ADLs in this brief.[3]

**Funded by the Zellerbach Family Foundation and The San Francisco Foundation, with substantial assistance from the San Francisco Human Services Agency.**

**The full study report, *SSI Parents with Children Receiving CalWORKs Cash Assistance in San Francisco: A Population on the Edge*, together with earlier products of the CalWORKs Child-Only Project, is posted at www.cfpic.org.**

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# Parents' Physical and Mental Health

**KEY FINDING**

■ All respondents had serious health problems, and two-thirds (63%) reported both significant mental and physical health problems.

Not surprisingly, half (52%) of respondents rated their own health as only "fair" or "poor" (compared to the 2009 national rate of 9.7% of all U.S. adults in fair or poor health).[4] Virtually all respondents (92%) were limited in at least one ADL, and half were limited in six or more (Table 1). Two in five (43%) needed help with personal care or bathing.

Two-thirds (71%) of respondents listed a mental health diagnosis among the conditions that qualified them for SSI, most often depression (23), post-traumatic stress disorder (PTSD) (13) and bipolar disorder (10). Four in five (82%) reported either a mental health diagnosis for SSI or a work-limiting mental health problem or learning disability.

**KEY FINDING**

■ Almost all respondents (92%) experienced at least one physical or mental health limitation of activities of daily living, and 50% experienced six or more limitations.

Poor physical health and limited mobility combined with serious mental health difficulties for nearly two-thirds (64%) of respondents. More than one-third (37%) needed help with six or more ADLs and also had mental health problems limiting work (Table 2). A further 27% needed help with fewer ADLs but had both physical and mental health problems that limited work. The remaining one-third of respondents reported mental health problems limiting work while needing help with fewer than six ADLs (20%), or reported multiple ADLs but did not report mental health problems (17%).

**TABLE 1. Number of ADLs with which respondents needed help**

| NUMBER OF ADLS | % Respondents | % Cumulative |
|---|---|---|
| 10 – 12 | 18.3 | 18.3 |
| 8 or 9 | 16.7 | 35.0 |
| 6 or 7 | 15.0 | 50.0 |
| 4 or 5 | 18.3 | 68.3 |
| 1 – 3 | 23.3 | 91.7 |
| No help needed with ADLs | 8.3 | 100.0 |
| **AVERAGE NUMBER OF ADLS** | **5.6** | |

**TABLE 2. Distribution of physical and mental health problems within study sample**

| | MENTAL HEALTH | |
|---|---|---|
| **PHYSICAL HEALTH** | **Work Limiting Problems** | |
| **Many Problems** | **Yes** | **No** |
| 6+ ADLs or needs help with bathing and personal care | 22 (37%) | 10 (17%) |
| 1+ physical health problems that limit work | 16 (27%) | |
| **Fewer Problems** | | |
| < 6 ADLs and no work-limiting physical health problems | 12 (20%) | 0 (0%) |

*NOTE:* The 10 respondents with no work-limiting mental health problems had *both* physical health problems limiting work *and* either more than six ADLs or needed help with bathing and personal care.

**Medical Care Utilitization.** These health problems take parents to the hospital or to doctors frequently. Nearly half of the survey respondents (46%) visited a hospital emergency room within the preceding three months, and 8% had spent one or more nights in a hospital.

# Practical and Social Support

**KEY FINDING**

■ While most respondents had enough practical help (86%), fewer had enough emotional support (63%). Almost all of the people who needed a lot of help with everyday activities received it, often from paid IHSS staff (59%).

One-third (33%) of respondents had help from In-Home Supportive Services (IHSS) with tasks such as housecleaning, laundry and personal care, receiving an average of 73 hours of help per month.[5] The overwhelming majority (86%) of respondents said they had either an IHSS worker or someone else they could turn to for practical help, and when asked whether they received all the help they needed, three-quarters (74%) said they did. Emotional support was less available, with 37% of respondents saying they could not think of anyone to whom they could routinely turn for support.

Among those who needed help with six or more ADLs, 59% had assistance from IHSS. When non-IHSS help (friends and family) was included, 89% of them received the needed practical help. People who did not need as much help with physical ADLs but instead had serious mental health needs had slightly less access to practical help and emotional support.

IHSS services were, as intended, targeted to the most physically disabled respondents; only 4% of those needing help with fewer than six ADLs had IHSS. If the four ADLs that are cognitive rather than physical – remembering appointments, managing money, following instructions, and taking medications correctly – are excluded from the count of ADLs, the targeting is even more precise.[6]

# Living Arrangements, Income and Rent

Interviewees were all single parents, and most (62%) lived with their minor children and no other adults.[7] Indeed, two-person families – one parent and one child – comprised 40% of the entire sample. Even among parents with serious physical health problems or multiple limitations, 70% lived alone with their children. The remaining two-fifths (38%) of respondents lived with one or more other adults (rarely a boyfriend or partner, sometimes an adult child or other family member, sometimes a friend or housemate).

**Income, Rent Subsidies, and Food Stamps.** Half (52%) of the parents relied exclusively on public assistance, and half had other sources of income, including earnings (theirs, or others in the household), child support (usually only the $50 routinely passed through to the family under CalWORKs), and payments such as pensions or disability payments received by other family members. Average monthly income from all sources, including food stamps, amounted to $1,615, with SSI providing nearly half ($731), CalWORKs another quarter ($414), and food stamps just over $200 (Figure 1).

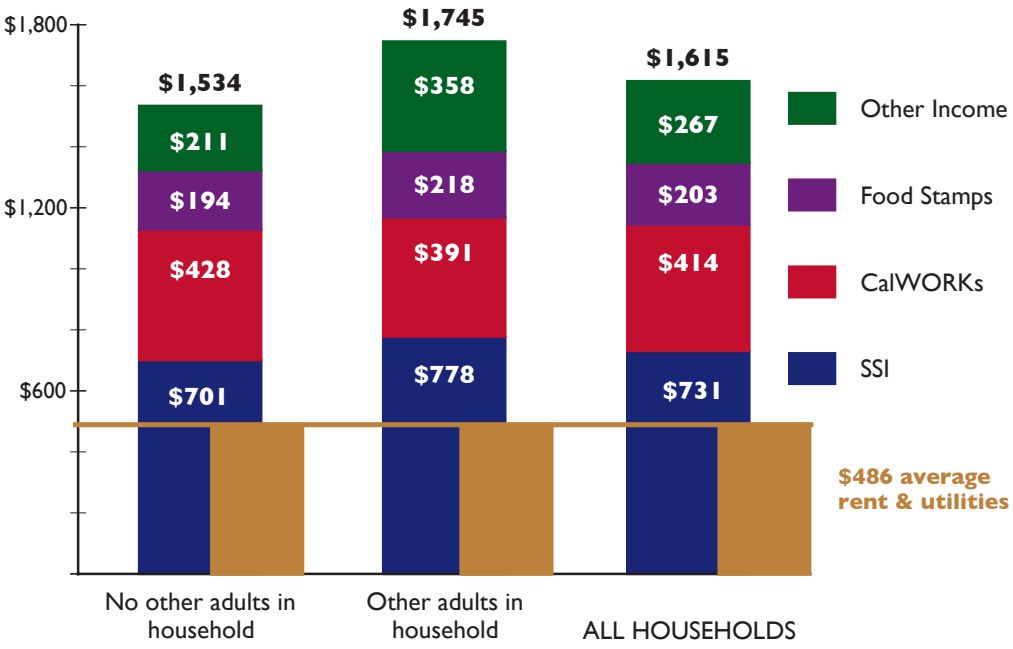
Incomes in multiple-adult households were only slightly higher than in single-adult homes ($1,745 versus $1,534), as most respondents had more income than their adult housemates. Rent and utilities were on average the same in single adult and multiple adult homes ($486 per month). More generally, respondents living with other adults were not assured of practical or emotional support; only 64% of them said they got the help they needed, compared to 80% of respondents who lived alone. The chances that a respondent was hungry in the past year were twice as high if they lived with other adults (35%) as if they lived alone (16%).

## Impact of SSI Food Stamp "Cash Out"

California may decide to end the SSI food stamp "cash out," a policy change that the Legislative Analyst's Office estimates would result in a net increase of $125 million in additional food stamp benefits for SSI recipients in California. However, while most recipients would gain with this policy change, households that receive CalWORKs as well as SSI income – in other words, the families described in this brief – would find themselves with fewer food stamp benefits. Before ending the SSI food stamp cash-out, we urge policy makers to identify ways to protect these families from additional hardships.

**FOR MORE INFORMATION: See the LAO report at http://www.lao.ca.gov/reports/2010/ssrv/ssrv_brief/ssrv_brief_012910.aspx and Karen Cunnyngham (2010), Estimated Effects on the Supplemental Nutrition Assistance Program of Eliminating California's SSI Cash-Out Policy, Final Report, February 12, Washington, DC: Mathematica Policy Research, Inc. at http://www.cfpa.net/mathssi2010.pdf.**

**FIGURE 1. Household incomes and rents in one-adult and multiple-adult homes**




Rental assistance, received by nearly three-quarters (72%) of respondents in the form of Section 8 housing (48%) or subsidized public housing (24%), is a vital resource.[8] The sliding-scale subsidies keep rents at one-third or less of income among most (83%) of the subsidized families. In contrast, three-fifths (59%) of unsubsidized respondents paid more than one-third of their incomes in rent, and for one-third (35%), rent consumed more than half of their income.

Subsidized families paid 27% of their income (including food stamps) in rent and utilities and had $1,181 left for other expenses; unsubsidized families paid much more – 40% of their income – for shelter, with only $970 remaining for everything else.

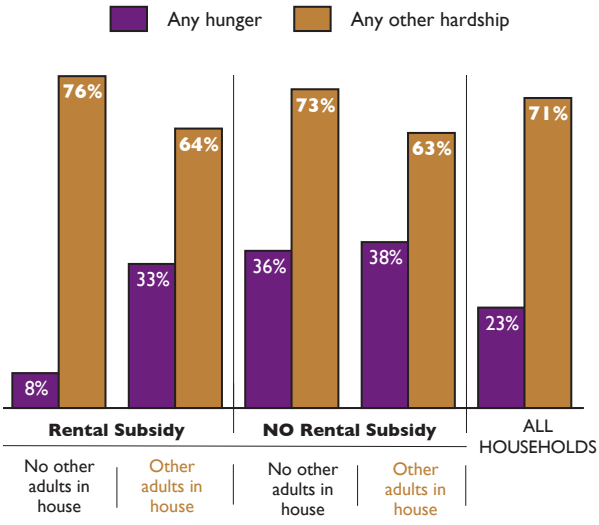
# Hunger and Other Hardships

**KEY FINDING**

■ Material hardships were widespread among respondents: one-quarter had been hungry in the past year, and nearly three-quarters had faced other material hardships. Hunger was concentrated among the most vulnerable respondents, those who had both many limitations on daily activities and disabling mental health problems.

Hunger is quite common in this group. One in four respondents (23%) had gone hungry in the preceding year because they could not afford enough food, and 7% of their children had also gone hungry. Hunger was concentrated among respondents who had many (six or more) limitations in daily activities in combination with disabling mental health problems. Among these particularly vulnerable respondents, more than one-third (36%) reported having gone hungry.

**FIGURE 2. Proportion reporting hunger or other material hardship in past year**




Families who had experienced hunger had rents nearly 40% higher than the average for the entire group, while having a rent subsidy seemed to ward off hunger. Only one in 12 (8%) of subsidized parents living alone with their children reported having gone hungry (Figure 2), a sharp contrast to the one-third of unsubsidized solo households who had gone hungry. One-third of respondents who were living with other adults had also gone hungry, irrespective of rental subsidies.

Hardships other than hunger, such as having been late with rent or utilities or having, by the end of the month, run out of money for necessities, had been experienced by 60% to 75% of respondents. Having a rental subsidy did not seem to protect families from these kinds of problems. The more disabled families, in addition to being most at risk of hunger, were also the most likely to have these other types of problems.

# Children's Physical and Behavioral Health

**KEY FINDING**

■ Half of the most seriously disabled parents reported that they had children who were in poor health or had chronic health problems.

**KEY FINDING**

■ Two-thirds of parents of children over age 5 reported that their school-age children demonstrated behavior problems such as school suspension, fighting, and drug or alcohol use.

A troublingly large percentage of children in these families suffer from physical and mental health problems. National studies have shown that low-income children have worse health than more affluent children, but even when compared to their low-income peers the children in this study suffer from atypically poor health.[9] One in five parents (18%) reported that they had a child in fair or poor health, and an additional 9% had a child with a chronic, activity-limiting health problem. The one-third of parents with both mental health problems and more than six limitations in daily activities most often reported children in poor health. Half of these parents (50%) said their child had a chronic, activity-limiting health problem or was in fair or poor health, compared to only one in six (16%) of less disabled parents.

The causes of the children's ill health cannot be pinned down from this study: we do not know how much was congenital, how much environmental, and how much social psychological, associated, for example, with the parent's disability and poverty. Some of these parents' beliefs about their child's health may have been shaped by their own heightened awareness of health problems and their regular contact with the health care system. Whatever the reasons, these children started their lives inordinately burdened by not only their parents' poor health but also by their own health problems (or the belief that they have health problems) as well.

Behavior problems are exceedingly common among the children in these families. An astonishing two-thirds (64%) of parents of children over age 5 reported a school-age child displaying significant behavior problems such as school suspension, fighting, and drug or alcohol use (behavior problems were not recorded for children under age six). Parents who reported behavior problems in their children were also quite likely to have a child with poor health or a chronic health problem (38%). (In contrast, among parents not reporting behavior problems, 19% had a child in poor health or with chronic health problems.) Parents with below-average incomes or who reported having gone hungry were not more likely than others to describe their children as in poor health or having behavior problems.

# Children's Physical and Behavioral Health (continued)

**KEY FINDING**

■ Behavior problems were 40% less likely to be reported about children whose families had Section 8 certificates – vouchers that provided access to a wider choice of higher-quality housing or housing located in areas with lower poverty concentrations – than they were among youth living in unsubsidized housing or public housing.

When families are grouped by whether they have a Section 8 housing certificate, are in public housing, or live in unsubsidized housing, sharp differences in children's well being emerge (Table 3). Parents reported far fewer behavior problems among children and teens living in Section 8 housing (52%) than among those in unsubsidized or public housing (82% and 89% respectively).

Section 8 subsidies give access to higher-value housing: the 48% of interviewees with these vouchers reported that their units carried monthly market rents of $1,736 on average, although they were paying only $379. In contrast, unsubsidized respondents lived in lower-value units with average market rents of $638 (with respondents' share, on average, of $533).[10] These lower rents presumably implied more dangerous or impoverished neighborhoods. Families in public housing paid little rent ($392, on average) but, typically, got low quality housing in bad neighborhoods.

The three-fold (or greater) gap in the market value of housing between Section 8 clients and the other two groups may be the key to understanding the difference in children's outcomes. The Section 8 units are not larger than public housing or unsubsidized housing (Table 3). However, Section 8 lets families choose their neighborhood, so they can live outside pockets of concentrated poverty and, perhaps, closer to better schools, or near their support networks. Plausibly, differences in the social resources in the neighborhood, the opportunities youth have for getting into trouble, and the peers they meet in the neighborhood and in school make the homes that parents can choose through Section 8 better environments for children than public housing or very low-rent unsubsidized apartments.

Clients with no rental subsidies face greater difficulties overall (Table 3). They have less disposable income than the other groups ($970 compared to $1,182 in subsidized housing), are more likely than the subsidized clients to have experienced hunger (38% compared to 17%), and are very likely to have children with behavior problems (82%).

**KEY FINDING**

■ Subsidized housing helped respondents ward off hunger and hardships. After paying for housing, unsubsidized respondents had only 82 cents for each dollar that respondents with housing subsidies had for food and other purchases each month.

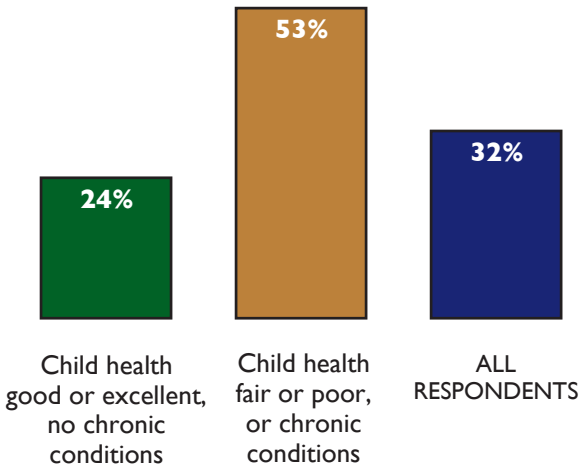
**TABLE 3. Distribution of child health status, hunger, housing characteristics, and disposable income by housing type**

| IMPACT ON FAMILY | SECTION 8 | PUBLIC HOUSING | NO SUBSIDY |
|---|---|---|---|
| **Number of rooms per person** *weighted one child = half an adult* | 1.8 | 2.4 | 1.8 |
| **Actual market rent for housing** | $1,736 | $392 | $638 |
| **Rent paid by respondent** | $379 | $392 | $533 |
| **Disposable income** *net of rent and utilities* | $1,185 | $1,180 | $970 |
| **% with hunger in past year** | 19.2% | 15.4% | 37.5% |
| **% with child behavior problems** | 52.4% | 88.9% | 81.8% |

# Services for Children

**Child Care**. Many parents on CalWORKs receive subsidized child care as an entitlement, but this service is far less available to SSI parents. Among the 19 respondents with a baby or preschooler, one-third (37%) used substantial amounts (more than five hours per week) of child care, averaging 33 hours weekly. Among the two-thirds not using child care or preschool or using very little, half said they had tried, unsuccessfully, to enroll their child, and most of them referenced insufficient subsidies or ineligibility for aid as key barriers.

**FIGURE 3. Prevalence of CPS involvement by children's health status**




**Child Protective Services.** The survey asked respondents whether they or their children had experienced any contact with Child Protective Services (CPS) in the previous five years. Indeed, many had: one-third (32%) reported at least one CPS contact, and of those 20, five had had a child removed and placed in foster care.[11] Rates of CPS contact were similar across levels of child behavior problems, types of parental disability, and living arrangements. Parents who had children suffering from fair/poor health or a chronic health condition, however, were much more likely than average to have experienced a contact with CPS (Figure 3).

In San Francisco, a CPS contact can lead to service referrals and support for families, which is one possible explanation for the strong association between a child's poor health and CPS contact. CPS staff could have connected a family to needed health care, which in turn could have led to new diagnoses of health problems. Equally, neighbors or teachers might have been especially concerned about the well-being of children with chronic health problems and reported the family to CPS. In some respects, the apparent targeting of CPS towards children with health problems (if, indeed, that is what is occurring) seems appropriate. The CPS contact rate in this sample is very high relative to the general population. However, assertive early CPS intervention with resources not otherwise available to CalWORKs or SSI families may minimize the risk of subsequent foster care placement.

# Discussion

## Summary of Findings

It seems from these survey data that SSI is, as intended, serving parents with severe health problems. Most of the respondents were dealing with multiple limitations in everyday activities due to physical health problems, mental health problems, or both. Evidently, the SSI application process is successfully excluding applicants who are not very disabled.

Advocates believe that more CalWORKs clients would be found eligible for SSI if they were helped with the application process. Anecdotally, many ultimately successful SSI applicants require multiple applications or appeals before they qualify. Among the reasons that disabled CalWORKs clients might not apply for or secure SSI include a lack of insight about their limitations and insufficient persistence, management skills, or professional guidance to successfully navigate the process. More specifically, they may not have access to needed medical testing and a "treating physician" (whose reports are by Social Security law given great weight).

Once on SSI, parents have substantially more income than if they were on CalWORKs. Nevertheless, many SSI-parent respondents had experienced hunger and difficulty in making ends meet. It is likely that poor mental and physical health limited these parents' flexibility and resourcefulness. One in four respondents had been hungry and unable to buy needed food in the past year, and a large majority reported other types of material hardships. Living with other adults did not confer benefits, either financial or in terms of support.

Families receiving Section 8 subsidies (who comprise nearly half of the sample) had the greatest disposable income after paying for rent and utilities. The higher quality of their housing or neighborhoods may explain why

their children were far less likely than children in public or unsubsidized housing to have behavior problems.

One-third (30%) of the children were in poor health or had chronic health limitations. Child Protective Services workers had been in contact with more than half of these families, as well as with one-quarter of the families with children in good or excellent health.

Although parents on SSI have substantially more income than families solely reliant on CalWORKs, they are also (by definition) more disabled and unable to earn income to supplement their benefits. The picture painted by this research is of parents facing very considerable challenges with their own health, their children's health, their children's behavior, and their household's material well being.

# Recommendations

## Strategies to Meet Children's Needs and Strengthen Families

- **SSI Advocacy and Family Support.** The increased income that SSI provides and the prospect of continued support beyond time-limited CalWORKs, combined with ongoing Medi-Cal coverage, make a move from CalWORKs to SSI financially advantageous for eligible recipients. The state and the county may also benefit from the transfer. Removing non-working disabled parents from the denominator of the CalWORKs Work Participation Rate (WPR) should help a county meet federal targets for the WPR. Failure to raise this rate sufficiently will trigger fiscal penalties for the state and county.[12]

Given the benefits to individuals, counties, and the state of moving eligible cases from CalWORKs to SSI, agencies should sustain and if possible expand strategies to help eligible parents apply for SSI.

Once parents are on SSI, other services can also help support healthy child development.

- **Subsidized Housing.** Without a subsidy, rent consumes a very large share of most disabled parents' incomes, often leaving them with too little for other necessities. Families with unsubsidized rents report more hunger and other material hardships as well as more behavior problems among their children. Public housing, while costing less and giving families higher disposable incomes, all too often presents a poor environment for children. Some respondents living in unsatisfactory situations with other adults may have felt compelled to double up to reduce housing costs, because they did not receive rental assistance.

In San Francisco neither public housing nor Section 8 certificates are prioritized to accommodate disabled persons. Establishing a category of Section 8 vouchers exclusively for disabled persons would help address this problem. Strategies to improve the quality of public housing are hard to identify, but might include creating more mixed public housing that accommodates seniors, disabled persons, and others.

- **Mental Health Services for Parents.** Counties can use CalWORKs allocations to fund therapy and other behavioral health services for CalWORKs clients, including some clients who transition to SSI. Many study respondents qualified for SSI on the basis (in part, at least) of their mental illness, and many had been able to take advantage of CalWORKs-funded mental health therapy, which helped establish the medical record that substantiated their need for SSI.

Once on SSI, some clients were cut off from the therapy and other mental health supports they needed to care for their children and manage their lives. A strategy to enable these clients to continue with the same therapists after transferring to SSI would be very useful.

- **Early Childhood Education, Child Care, and Educational Support**. The high rates of behavioral problems among school-aged children of SSI parents may stem in part from impoverished early childhood environments. The young children of SSI recipients need priority access to high-quality child care and preschool settings, including Head Start and Early Head Start. With the respite that child care offers, disabled parents may have more energy to engage with and supervise their children when they are at home.

Some of the children in these families would benefit from mental health services, whether provided directly or in the context of child care that is informed by a mental health perspective. For example, San Francisco's comprehensive Early Childhood Mental Health

Consultation program advises staff in some child care centers and child care homes serving low-income populations. If possible, children of SSI parents who have been identified as needing extra support should be placed in these settings.

- **Support for Successful Parenting.** The numerous CPS contacts among respondents suggest that many of them have difficulties in parenting. Since these families are still connected to CalWORKs, program staff with responsibility for their cases might explore ways to foster community and mutual aid among the disabled parents. For example, they could inform disabled parents of targeted programs and support groups through which parents could meet others with similar disabilities.[13] Advocates, clinicians and parents could collaborate to design a parenting curriculum or a resource handbook for disabled parents to be shared through peer-based mentoring.

Child Protective Services resources can be used to support families and prevent foster placement. This type of assistance is important especially when parents have physical or mental health disabilities; these parents might even benefit from services along the lines of IHSS, but targeted to parenting support. Collaboration between IHSS, CalWORKs and CPS might lead to an enriched program of in-home support for clients already receiving IHSS

**WE CONCLUDE THIS POLICY BRIEF** with a vision for a broader system of support for all families, in which parents on SSI could find resources, health services, therapy, child care, and peer support. Other countries have systems of family resource centers to support families in communities: Britain, for example, has created the system of Sure Start Children's Centres.[14] Were California to adapt its own system from this and other models, all vulnerable families could gain access to the social support, mental health, and referral services discussed in this brief, no matter how they have been labeled in the public assistance system.

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## ENDNOTES

1 This simple measure is highly correlated with specific illnesses and with overall longevity, and so is routinely used in surveys. Idler, E.L. and S.V. Kasl.1995. Self-Ratings of Health: Do They Also Predict Change in Functional Ability? Journals of Gerontology, Series B: Psychological Sciences and Social Sciences 50(6), S344-S353.

2 Most of the respondents with learning disabilities (all except four) also reported a work-limiting mental health problem.

3 Being unable to perform ADLs or IADLs, or needing help with them, is considered a measure of "severe disability" in disability research. See Public Policy Institutes of the American Association of Retired Persons. 2004. Disability: Federal Survey Definitions, Measurements and Estimates. <http://www.aarp.org/money/budgeting-saving/info-2004/aresearch-import-890.html>; and Steinmetz, E. 2002. Americans With Disabilities: 2002. Household Economic Studies, Current Population Reports P70-107. <http://www.census.gov/hhes/www/disability/sipp/disab02/ds02f1.pdf>

4 Early Release of Selected Estimates Based on Data From the January-September 2009 National Health Interview Survey. National Center for Health Statistics, General health status (3/2010). <http://www.cdc.gov/nchs/data/nhis/earlyrelease/earlyrelease201003.pdf>

5 IHSS is partially funded with federal Medicaid dollars in order to help seriously disabled people live independently in their homes. Applicants' abilities in ADLs and IADLs are indicators of need for IHSS services.

6 None of those needing help with three or fewer of the eight physical ADLs (bathing, personal care, housework, laundry, cooking, shopping for and carrying groceries, going up or down stairs) received IHSS services.

7 By design, two-parent families were effectively excluded from this study because in families with one parent on SSI and one non-disabled parent the children would not be on child-only CalWORKs. CalWORKs families with two parents on SSI are rare, and none are in this sample.

8 Section 8 participants receive a voucher for a substantial rental subsidy on any qualifying unit, in any neighborhood. The percentage of families in this study who had Section 8 is unexpectedly high, given the difficulty of acquiring these vouchers; many municipalities have closed their waiting lists to new applicants.

9 This statement is based on a comparison of our survey data to the national statistics reported in Case, A. and C. Paxson. 2000. Children's Health and Social Mobility. The Future of Children. <http://www.jstor.org/stable/3844795?seq=3>

10 Some respondents were splitting rent with housemates or renting rooms in houses.

11 Statewide in California in 2009, allegations of child maltreatment were recorded for fewer than 5% of children. Entries into the child welfare system took place for 7% of allegations. Needell, B. et al. 2010. Child Welfare Services Reports for California. <http://cssr.berkeley.edu/ucb_childwelfare>

12 The parent's portion of a CalWORKs grant ($216 monthly in one-child families, $133 in two-child families, with $174 the average of the two) is comparable to the state's share of the SSI/SSP benefit ($169), so state (General Fund) spending on public assistance changes little when a parent transfers from CalWORKs to SSI. Letters from the U.S. Department of Health and Human Services, Office of Family Assistance, and the California Department of Social Services describe the $47.7 million penalty amount levied against California for FY 2008 and the state's planned appeal. <http://www.dss.cahwnet.gov/lettersnotices/entres/getinfo/acin/2010/I-45_10.pdf>

13 Examples include Through the Looking Glass, a national support and advocacy group for disabled parents, and disability support groups such as those sponsored by the Depression and Bipolar Support Alliance. <http://www.lookingglass.org> and <http://www.dbsalliance.org>

14 Sure Start Children's Centres are service hubs where children under five years old and their families can receive seamless integrated services and information. By 2010, every British community will be served by a Sure Start Children's Centre, offering permanent universal provision across the country. <http://www.dcsf.gov.uk/everychildmatters/earlyyears/surestart/surestartchildrenscentres/childrenscentres/>