

CHAPTER 6: BASIC NEEDS



INTRODUCTION

Immigrants and refugees do not receive the support they need to meet their basic needs, primarily because public assistance programs are built not to include everyone who requires assistance, but to exclude certain people from consideration, regardless of their needs.

Despite the United States' commitment to refugee protection, the United States makes scant public benefit provisions for refugees and asylum seekers. Refugees are eligible for basic services, but face strict time limits and complications if they relocate. Asylum seekers receive no support upon their arrival in the United States and face a waiting period for work authorization after applying for asylum.

Many other immigrants face a host of barriers to accessing services to meet their basic needs. Communication around public benefits suffers from the paradoxical problem of both not enough information and “information overload” driven by the complexity of the benefits eligibility system. Language barriers and cultural differences create an additional challenge to communicating with clients about their benefits. Service providers also noted the problematic design of the U.S. public assistance system, which is built on addressing individuals' “deficiencies,” instead of their strengths.

The health care system contains additional barriers. Many immigrants are simply unable to access services due to exorbitant health care costs. Health care professionals also face serious challenges in communicating with their patients due to language, literacy, and cultural barriers. This challenge is particularly acute in the mental health care field, which faces a severe lack of culturally appropriate providers.

Eligibility for most public benefits hinges on immigration status, and confusing and complex rules lead to denial of benefits to qualified immigrants or family members. Some immigrants fear accessing the system at all due to their immigration status or the fear of being labeled a “public charge.” Finally, the categorical exclusion of undocumented immigrants from almost all public benefits and recent cuts to state-funded programs denies basic human rights to many people.

HUMAN RIGHTS AND BASIC NEEDS

Full participation in a community can only take place once basic human needs, such as food, health, shelter, and economic subsistence, have been fulfilled. The absence of any one of these creates dysfunction and imbalance in a person's life and inequity in society. Securing and protecting access to these foundational human rights for all must be of primary importance to governments. Article 25 of the Universal Declaration of Human Rights states, “Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of

unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.”⁹⁷⁰ Article 11 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) declares that everyone has the right to an adequate standard of living and that everyone has the right to be free from hunger.⁹⁷¹ Likewise, according to Article 12 of the ICESCR, “Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health.”⁹⁷² Thus, any discrimination in access to these basic human rights constitutes a violation of international human rights standards and a threat to one’s survival.

BACKGROUND ON ELIGIBILITY

The access and use of public assistance benefits by newcomers to the United States is determined by federal eligibility rules combined with state and local rules and policies.⁹⁷³ Federal rules governing public assistance benefits fall in two categories: pre- and post-1996, when Congress enacted the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), commonly known as welfare reform. Before PRWORA, legal immigrants enjoyed eligibility to public benefits similar to U.S. citizens.⁹⁷⁴ PRWORA categorized immigrants as “qualified” or “nonqualified” to determine their eligibility for benefits.⁹⁷⁵ That same year, Congress passed a new immigration law requiring that people immigrating through family-based petitions demonstrate that they are not likely to become public charges by submitting a legally binding affidavit of support from a sponsor. These laws combined to exclude most legally residing low-income immigrants from public benefit support.⁹⁷⁶ For those who remain eligible for benefits, participation rates have declined. The worst impact was on citizen children in families with mixed immigration status, where parents who are not eligible for benefits did not access benefits for their children who are eligible.⁹⁷⁷

⁹⁷⁰ Universal Declaration of Human Rights (UDHR), Art. 25(1).

⁹⁷¹ International Covenant on Economic, Social and Cultural Rights (ICESCR), Art. 11

⁹⁷² ICESCR, Art. 12.

⁹⁷³ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Overview of Immigrants’ Eligibility for SNAP, TANF, Medicaid, and CHIP* (Mar. 2012), <http://aspe.hhs.gov/hsp/11/ImmigrantAccess/Eligibility/ib.shtml>.

⁹⁷⁴ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Barriers to Immigrants’ Access to Health and Human Services Programs*, Krista M. Pereira, Robert Crosnoe, Karina Fortuny, Juan Manuel Pedroza, Kjersti Ulvestad, Christina Weiland, and Hirokazu Yoshikawa (May 2012), <http://aspe.hhs.gov/hsp/11/ImmigrantAccess/Barriers/rb.shtml>.

⁹⁷⁵ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Barriers to Immigrants’ Access to Health and Human Services Programs*, Krista M. Pereira, Robert Crosnoe, Karina Fortuny, Juan Manuel Pedroza, Kjersti Ulvestad, Christina Weiland, and Hirokazu Yoshikawa (May 2012), <http://aspe.hhs.gov/hsp/11/ImmigrantAccess/Barriers/rb.shtml>.

⁹⁷⁶ Tanya Broder and Jonathan Blazer, *Overview of Immigrant Eligibility for Federal Programs*, National Immigration Law Center, (Oct. 2011), <http://www.nilc.org/overview-immeligfedprograms.html>.

⁹⁷⁷ Karina Fortuny and Ajay Chaudry, *A Comprehensive Review of Immigrant Access to Health and Human Services*, Urban Institute (Jun. 2011), <http://www.urban.org/UploadedPDF/412425-Immigrant-Access-to-Health-and-Human-Services.pdf>.

DEFINITIONS

Qualified Immigrants include:

- Lawful permanent residents (LPRs) (green card holders)
- Persons granted asylum
- Refugees
- Parolees (paroled into the United States for a period of at least one year)
- Noncitizens granted withholding of deportation by the Department of Homeland Security (DHS)
- Conditional entrants
- Cuban and Haitian entrants
- Certain battered immigrant spouses and children
- Certain victims of trafficking

Nonqualified Immigrants include all other immigrants, including undocumented immigrants and many lawfully present immigrants in the United States.⁹⁷⁸

To offset the gaps in eligibility, Minnesota opted to use state money to provide some immigrants who are not eligible for federally funded programs with limited access to state benefits. Despite good intentions, these state-funded programs have been vulnerable to budget cuts and other challenges,⁹⁷⁹ leaving some Minnesotans at risk of not having their basic needs met.

MINNESOTA PUBLIC BENEFIT PROGRAMS

Minnesota Family Investment Program (MFIP): MFIP is Minnesota's welfare-to-work program for low-income families with children and pregnant women and contains both cash and food assistance. Families can only receive MFIP benefits for a maximum of 60 months.⁹⁸⁰ To be eligible for MFIP, families have to meet program income and asset limits and either be a U.S. citizen or have a qualified immigrant status.⁹⁸¹

cont. on next page

⁹⁷⁸ Tanya Broder and Jonathan Blazer, *Overview of Immigrant Eligibility for Federal Programs*, National Immigration Law Center, (Oct. 2011), <http://www.nilc.org/overview-immeligfedprograms.html>.

⁹⁷⁹ Tanya Broder and Jonathan Blazer, *Overview of Immigrant Eligibility for Federal Programs*, National Immigration Law Center, (Oct. 2011), <http://www.nilc.org/overview-immeligfedprograms.html>.

⁹⁸⁰ Laura Melnick, *Summary Guide to Minnesota Government Benefit Programs, 2014 Update* Minnesota Continuing Legal Education, Inc., 2014.

⁹⁸¹ Benefits.gov, "Minnesota Family Investment Program (MFIP)", (accessed Feb 21, 2014), <http://www.benefits.gov/benefits/benefit-details/1666>.

Supplemental Nutrition Assistance Program (SNAP): SNAP helps low-income individuals and families obtain food that promotes healthy nutrition.⁹⁸² To be eligible for SNAP, households must meet program income limits and have a qualifying immigration status.⁹⁸³

Refugee Cash Assistance (RCA) and Refugee Medical Assistance (RMA): Refugee families with minor children in Minnesota qualify for the same cash and medical assistance programs as other low-income eligible families. Refugees who do not have minor children in their home can receive RCA and RMA for the first eight months after their arrival.⁹⁸⁴

Supplemental Security Income (SSI): SSI provides cash benefits to adults and children who are blind or disabled, and to people 65 or older who do not have disabilities.⁹⁸⁵ Individuals must meet strict income and asset limits and have a specific immigration status to qualify for SSI.⁹⁸⁶ SSI has a seven-year eligibility limit for refugees and asylees.⁹⁸⁷

Medical Assistance (MA):⁹⁸⁸ Federally funded MA pays for medical care for low-income people who cannot otherwise meet their health care needs.⁹⁸⁹ To qualify for MA, an immigrant must be in a qualified status and must have been in this status for at least five years. Minnesota has recently eliminated its state-funded MA program⁹⁹⁰

cont. on next page

⁹⁸² Minnesota Department of Human Services, “Supplemental Nutrition Assistance Program (SNAP) and Food Assistance Programs,” (accessed Feb 21, 2014), www.dhs.state.mn.us/id_002555

⁹⁸³ Laura Melnick, *Summary Guide to Minnesota Government Benefit Programs, 2014 Update* Minnesota Continuing Legal Education, Inc., 2014.

⁹⁸⁴ Minnesota Department of Human Services, “Refugee Assistance”, (accessed Feb 21, 2014) http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_004115.

⁹⁸⁵ Social Security Administration, “Supplemental Security Income (SSI) Program”, (accessed Feb 21, 2014), <http://www.ssa.gov/pgm/ssi.htm>.

⁹⁸⁶ Laura Melnick, *Summary Guide to Minnesota Government Benefit Programs, 2014 Update* Minnesota Continuing Legal Education, Inc., 2014.

⁹⁸⁷ Social Security Administration, “Supplemental Security Income (SSI) for Noncitizens,” (Dec. 2012), <http://www.socialsecurity.gov/pubs/EN-05-11051.pdf>.

⁹⁸⁸ Participants did not discuss the Affordable Care Act (ACA), mainly because the research period preceded the implementation of health insurance coverage under the ACA. However, it is important to note that under the ACA, a larger percentage of legally residing immigrants and non-immigrants will be able to receive health coverage. [Randall Chun, *Medical Assistance*, Minnesota House of Representatives Research Department, (Oct. 2013), <http://www.house.leg.state.mn.us/hrd/pubs/medastib.pdf>; Fatema Haji-Taki, *Access to Health Coverage for immigrants in Minnesota: CLE for American Immigration Lawyers Association Minnesota/Dakotas Chapter*, Mar. 6, 2014].

⁹⁸⁹ Minnesota Department of Health, “Guide to Minnesota’s Public Health Care Programs”, (accessed Feb 21, 2014), <http://www.health.state.mn.us/clearinghouse/public.htm>.

⁹⁹⁰ Laura Melnick, *Summary Guide to Minnesota Government Benefit Programs, 2014 Update*, Minnesota Continuing Legal Education, Inc., 2014.

Minnesota Care (MN Care): MN Care is a health care program for low income Minnesotans who are ineligible for MA due to their income being over MA limits and do not have other health coverage. MN Care is also health coverage program for those who cannot get MA due to immigration status⁹⁹¹

Emergency Medical Assistance (EMA): EMA mainly covers medical emergency services in emergency rooms for the duration of the emergency need.⁹⁹²

FAILURE TO MEET THE BASIC NEEDS OF REFUGEES AND ASYLUM SEEKERS

The United States has committed itself to the principle that everyone has the right to seek and enjoy asylum from persecution.⁹⁹³ Nonetheless, refugees face strict limitations on services to meet their basic needs, and asylum seekers receive no support upon their arrival in the United States.

REFUGEE RESETTLEMENT

Minnesota has an especially large refugee population, representing one in five immigrants to the state.⁹⁹⁴ Some of Minnesota's largest immigrant groups initially arrived as refugees, including Somalis, Hmong, Ethiopians, Cambodians, Karen, Liberians, and residents of the former Soviet Union.⁹⁹⁵ Nearly half of all Minnesotans receiving permanent resident status are refugees or individuals who have been granted asylum.⁹⁹⁶

Refugee resettlement to the United States is governed by federal law.⁹⁹⁷ The resettlement reception and placement program provides support to newly arrived refugees and their families.⁹⁹⁸

⁹⁹¹ Laura Melnick, *Summary Guide to Minnesota Government Benefit Programs, 2014 Update*, Minnesota Continuing Legal Education, Inc., 2014.

⁹⁹² Laura Melnick, *Summary Guide to Minnesota Government Benefit Programs, 2014 Update*, Minnesota Continuing Legal Education, Inc., 2014.

⁹⁹³ UDHR, Art. 14(1). International refugee protection is governed by the 1951 Convention and the 1967 Protocol relating to the Status of Refugees. The United States acceded to the 1957 Protocol in 1968 and in 1980 the U.S. Congress passed the Refugee Act executing its obligations under the Protocol. In addition to guaranteeing the right to seek asylum, the Refugee Act created the refugee resettlement system that continues to govern the identification, adjudication, and resettlement in the United States of those refugees who can neither be repatriated to their homelands nor locally integrated into the countries of first asylum.

⁹⁹⁴ The Minneapolis Foundation, *A New Age of Immigrants: Making Immigration Work for Minnesota*, (Aug. 2010), 2.

⁹⁹⁵ Minnesota Department of Health, "Cumulative Refugee Arrival Data, 1979-2012", (accessed Feb. 14, 2014), www.health.state.mn.us/divs/idepc/refugee/stats/refcummm.pdf.

⁹⁹⁶ The Minneapolis Foundation, *A New Age of Immigrants: Making Immigration Work for Minnesota*, (Aug. 2010), 2.

⁹⁹⁷ 8 U.S.C. §§1157, 1521 (2013).

In Minnesota, resettlement services are coordinated by the state’s Resettlement Program Office⁹⁹⁹ and voluntary agencies that provide direct services to new arrivals. One local resettlement agency describes the scope of services: “Resettlement services include welcoming families at the airport when they first arrive, addressing medical needs, finding housing, helping them apply for Social Security cards, economic assistance, school registration and English Language classes, and explaining social adjustment and acculturation issues.”¹⁰⁰⁰

Federal regulations outline program requirements for the Refugee Cash Assistance and Refugee Medical Assistance programs, as well as requirements for employability and social adjustment services.¹⁰⁰¹ Rigid rules governing refugee assistance programs pose challenges to ensuring that all refugees receive the assistance they need.¹⁰⁰² For example, almost all professionals working with refugee populations¹⁰⁰³ identified the short time period that refugees can qualify for services and benefits as a major barrier for their wellbeing.¹⁰⁰⁴

Core services, such as food, housing, clothing, employment services, and follow-up medical care, are provided only during the first one to three months after a refugee's arrival.¹⁰⁰⁵ Eligibility for cash and medical assistance extends to eight months, but refugees are then expected to be self-sufficient.

One provider described the various time limits on available services:

*We do refugee resettlement, which is a 90-day program. We assist clients in finding housing, getting their Social Security card, and applying for public assistance benefits. Refugee cash assistance program is a public-private partnership with the city for people who have been in the United States for less than 18 months with no dependents. They can apply for cash and food assistance here at the agency. We also have a Matching Grant Program and an accelerated employment program for the first six months in United States, and a refugee cash assistance coordinator can refer clients to an employment counselor to find work for up to eight months.*¹⁰⁰⁶

⁹⁹⁸ 8 U.S.C. §1522; 45 C.F.R. §400 (2013).

⁹⁹⁹ Interview 115; Interview 145.

¹⁰⁰⁰ World Relief Minnesota, “What We Do: Refugee Resettlement,” (accessed Mar. 21, 2014), <http://www.worldreliefmn.org/about/what-we-do/refugee-resettlement-services/>.

¹⁰⁰¹ 45 C.F.R. §400.

¹⁰⁰² 45 C.F.R. §400.1(b) (stating “[i]t is the purpose of this program to provide for the effective resettlement of refugees and to assist them to achieve economic self-sufficiency as quickly as possible).

¹⁰⁰³ People who are inspected and admitted as “refugees” under 8 U.S.C. §1157.

¹⁰⁰⁴ Interview 115; Interview 145; Conversation 7; Conversation 16; conversation 18; Interview 119.

¹⁰⁰⁵ Refugee Council USA, “Post Arrival Assistance and Benefits,” (accessed Mar. 21, 2014), <http://www.rcusa.org/index.php?page=post-arrival-assistance-and-benefits>.

¹⁰⁰⁶ Interview 145.

BASIC NEEDS

A social service provider said, “We see refugee clients for three months until the resettlement services contract is done. It used to be 180 days allotted for someone to be fully integrated or be self-sufficient, which was barely adequate. Now it has dropped to three months; cut in half. For someone to have a bank account, have children in school, and find work in three months isn’t at all realistic.”¹⁰⁰⁷

“There are times when we are closing a 90 day case and the person has not even been given employment counseling.”

Others working in the field agreed that three months are insufficient to provide all the necessary services and orientation and to be able to assess their clients’ wellbeing, integration, and stability in the community.¹⁰⁰⁸ A health professional stated, “I don’t think the United States really helps refugees like they

should. They kind of just let them go.”¹⁰⁰⁹

Resettlement workers and other service providers noted the challenge of achieving true self-sufficiency in 90 days. One refugee resettlement expert also noted that the focus of the refugee resettlement program has shifted from holistic integration services to getting refugees into jobs.¹⁰¹⁰ Given the limited English proficiency many refugees have upon arrival, this often drives refugees into low-wage jobs.¹⁰¹¹

In addition to the limited period of initial resettlement services, refugee applicants sometimes face a long waiting period for eligibility determination and approval for public benefits. Professionals working with refugees identified this as a major problem for their clients. One advocate said: “One of the major challenges we see, is when someone is referred to MFIP, the actual processing time can take up to 30 days and during this time, the person cannot be referred to a job counselor. There are times when we are closing a 90 day case and the person has not even been given employment counseling.”¹⁰¹²

The long wait time for benefits approval can also have health implications. An advocate mentioned that some services do not accept Medical Assistance while approval is pending.¹⁰¹³ She added that accessing health insurance was not the problem, but the long wait time created a hardship for clients.¹⁰¹⁴

¹⁰⁰⁷ Interview 115.

¹⁰⁰⁸ Interview 115.

¹⁰⁰⁹ Conversation 10.

¹⁰¹⁰ Interview 145.

¹⁰¹¹ Interview 145.

¹⁰¹² Interview 97.

¹⁰¹³ Interview 97.

¹⁰¹⁴ Interview 97.

Adding to the problem is that refugee resettlement agencies get all of their refugee clients at the same time. According to the social service providers, this creates an influx of requests to county agencies for benefits and services flooding the system. One social service provider stated: “We all need to jump on what’s available and compete,” adding, “some counties are better equipped to handle it than others. Ramsey County does a great job!”¹⁰¹⁵

One community member reflected that even services prior to arrival have been cut: “Refugees come with little to no English skills or cultural orientation. In the past, many had intensive language classes for months before arrival; that no longer exists,”¹⁰¹⁶ increasing the burden on post-arrival services to help refugees achieve self-sufficiency.

SECONDARY RESETTLEMENT

Resettlement service providers cited the increasing mobility of the refugee population as a significant challenge to providing services. The resettlement system was designed for planned refugee arrivals to designated communities, but advocates noted that a lack of jobs and affordable family housing often drove refugees to move away from the community in which they initially were resettled, a process often referred to as “secondary resettlement.”¹⁰¹⁷ Minnesota communities in the southern and western part of the state reported influxes of secondary refugees in the past few years, particularly by refugees seeking employment in the meatpacking industry.¹⁰¹⁸ Resettlement providers in the Twin Cities confirmed this trend.¹⁰¹⁹ One community in greater Minnesota reported that men come to work during the week, but return to their families in the Twin Cities on the weekends, breaking up families and contributing to a lack of community engagement.¹⁰²⁰

Unfortunately, refugees who move away from where they are initially resettled risk losing assistance under the refugee resettlement program.¹⁰²¹ Interviewees expressed concern that refugees in smaller communities do not have access to resettlement services once they relocate. One resettlement worker noted:

When they decide to move to Windom, Marshall, or Worthington (places with no refugee resettlement services), we can set up the health screening, but we cannot provide any other services. They do get their money [refugee cash assistance]. But when they refuse to stay here, they are on their own. We use translators to make sure they understand the risk and responsibilities of moving to areas that do not have refugee resettlement services. If there

¹⁰¹⁵ Interview 115.

¹⁰¹⁶ Conversation 18.

¹⁰¹⁷ Interview 80.

¹⁰¹⁸ Interview 145.

¹⁰¹⁹ Interview 145; Conversation 2; Interview 80; Interview 105.

¹⁰²⁰ Interview 80; Conversation 2.

¹⁰²¹ Interview 145.

BASIC NEEDS

*are refugee resettlement services in the areas they move to, they can be transferred if they are within the 90-day period. Case managers will have these conversations with every family.*¹⁰²²

One agency secured funding outside the refugee resettlement program for immigration services and case managers for secondary migrants,¹⁰²³ but because the agency is limited to working with refugees who live within 100 miles of their office,¹⁰²⁴ some the refugees simply fall outside the agency's service area.¹⁰²⁵

ASYLUM SEEKERS

Although lawfully present in the United States, asylum seekers in Minnesota are barred both from employment and from virtually all forms of government assistance, including assistance for refugees.

One man described his struggle to survive while seeking asylum: "Before I got asylum it was terrible. I did not get any assistance whatsoever apart from legal services. They literally leave you out to die. It was so bad. I think the government does it that way so that people get frustrated and go home. You put them in a six-month period where they cannot work and you are not giving them any assistance at all. How do you expect them to survive?"¹⁰²⁶ Another asylum seeker reported myriad struggles during his first year in the country, including having to rely on friends for food and a place to live, and not having money for bus fare.¹⁰²⁷

As the interviewee opined, the policy denying work permission to asylum seekers was, in fact, a deliberate attempt to deter asylum claims. In 1994, federal regulations changed to prohibit asylum seekers from receiving employment authorization until their asylum applications had been pending for at least 180 days.¹⁰²⁸ In promulgating the rule, the government noted that the rule was being changed to deter the filing of unmeritorious claims and that asylum seekers should be dependent on their own savings and the charity of friends and family.¹⁰²⁹ The government downplayed the

¹⁰²² Interview 115.

¹⁰²³ Interview 145.

¹⁰²⁴ Interview 145; Interview 115.

¹⁰²⁵ Interview 115; Interview 145.

¹⁰²⁶ Interview 9.

¹⁰²⁷ Interview 8.

¹⁰²⁸ Congress subsequently codified this change as part of the Illegal Immigration and Immigrant Responsibility Act of 1996. 8 U.S.C. §1158(d)(2); Legal Action Center, Penn State Dickinson School of Law Center for Immigrants' Rights, *Up Against the Asylum Clock: Fixing the Broken Employment Authorization Asylum Clock*, 2010, 6-8. http://law.psu.edu/_file/Immigrants/Asylum_Clock_Paper.pdf.

¹⁰²⁹ 59 Fed. Reg. at 62290-91.

expected hardship to asylum seekers, noting that concurrent policy changes were expected to shrink asylum adjudication times to 60 days.¹⁰³⁰

The government's expectation of case adjudication times proved to be wildly inaccurate. The Advocates for Human Rights, which represents hundreds of asylum seekers in the upper Midwest, notes an average case processing time of more

“Before I got asylum it was terrible. I did not get any assistance whatsoever apart from legal services. They literally leave you out to die.”

than two years before the Chicago Asylum Office. The Bloomington Immigration Court currently is scheduling hearings for 2016. While in many cases asylum seekers facing these delays do receive employment authorization after their cases have been pending for 180 days, complicated rules relating to the “asylum clock” mean that some asylum seekers never become eligible for employment authorization.¹⁰³¹

Being ineligible both for employment and for public assistance leaves asylum seekers in Minnesota especially vulnerable. One attorney recalled a particularly difficult case:

*My client, a young woman who had fled horrific persecution as a ‘bush wife’ during the war in Sierra Leone, was completely destitute when she arrived in Minnesota. We were trying to prepare her for her upcoming asylum interview, which was a really painful process for her. But what she found really difficult was her living situation. She was staying on someone’s couch, and he was forcing her to pose for pornographic photographs in exchange for staying there. When I contacted her social worker to see about housing assistance, their response was that housing was so tight, she was lucky to have anywhere to live at all.*¹⁰³²

LIMITS AND BARRIERS TO RECEIVING BENEFITS

INSUFFICIENT BENEFIT LEVELS

Stagnant rates of public benefits keep benefit recipients in poverty and unable to meet their basic needs. A service provider described the problem: “Public assistance rates have not increased since 1986, but as you know, housing rates have risen steadily. This poses a huge challenge to setting families up in housing that they can sustain.”¹⁰³³ Indeed, the Minnesota Family Investment Program (the state version of the federal Temporary Assistance to Needy Families program) rates were set in

¹⁰³⁰ 59 Fed. Reg. at 62290-91.

¹⁰³¹ Legal Action Center, Penn State Dickinson School of Law Center for Immigrants’ Rights, *Up Against the Asylum Clock: Fixing the Broken Employment Authorization Asylum Clock*, 2010, 6-8. http://law.psu.edu/_file/Immigrants/Asylum_Clock_Paper.pdf.

¹⁰³² Interview 184.

¹⁰³³ Interview 145.

BASIC NEEDS

1986 and have not increased since that time (providing just \$437 for a household of two, \$532 for a household of three, and \$621 for a household of four.) As a result, recipients of food and cash assistance live well below federal poverty guidelines.¹⁰³⁴

LACK OF INFORMATION

Accessing public benefits for which they are eligible is made more difficult for low-income immigrants because of a lack of information. Some professionals in the social and human services stated that the lack of information and outreach from public agencies to low-income immigrant populations both is a deterrent to accessing services and creates gaps that are laced with a sense of mistrust. For many immigrants who come from cultures and places where support to meet basic needs is provided by community-based entities, the concepts and processes of public benefit programs may not be well understood, making the availability of accurate information even more important.

Community members also identified the lack of information about benefits as a major barrier. As one participant mentioned, there is a “lack of a central place for vital information.”¹⁰³⁵ Another community member stated that there is a “lack of awareness about the government support system.”¹⁰³⁶ The consequences of not having access to information can create undue hardship on people. For example, one respondent said, “a lady’s husband was deported; she now has to take care of her child alone, and it was hard because she did not know where to find resources that were necessary.”¹⁰³⁷ Others also expressed frustration about the lack of accurate information and the negative impact it had on them. A community member remarked: “Information should be easier for people to get. I know a person who got sick and he could not find health resources, so he had to leave and go back to his home country.”¹⁰³⁸ Respondents also mentioned that information is only available in limited venues; an interviewee said, “Churches give information about organization and resources. But that should exist beyond churches.”¹⁰³⁹ As one interviewee stated, outreach efforts are even more important to “people who are a little more cautious of government assistance.”¹⁰⁴⁰

The lack of information combined with a fear and mistrust of government entities helps create what an advocate called a “hidden population.”¹⁰⁴¹ Members of this group are too afraid to seek services and may not get their information from reliable sources, which pushes them further away from the

¹⁰³⁴ Laura Melnick, *Eligibility for Cash Assistance Programs*, Southern Minnesota Regional Legal Services, Inc., (Oct. 2013), http://www.mfsrc.org/Conferences_files/2013_handouts/MAXIS_HANDOUT.pdf.

¹⁰³⁵ Conversation 21.

¹⁰³⁶ Conversation 21.

¹⁰³⁷ Conversation 22.

¹⁰³⁸ Conversation 24.

¹⁰³⁹ Conversation 21.

¹⁰⁴⁰ Interview 40.

¹⁰⁴¹ Interview 108.

support they need to meet their basic needs. A social worker commented, “I have had a few times when immigrants did not know they were eligible for services. I will tell them, ‘Your children do have a documented status, so you can apply for SNAP.’”¹⁰⁴² Research also found that while some immigrants had access to community-based organizations and to information that facilitated their access to services, others who did not belong to established communities served by community-based organizations had limited information and substantially more difficulties connecting with services.¹⁰⁴³

In order to minimize barriers and the information gap, public agencies should form partnerships with nonprofit organizations and community-based entities that have existing trusting and lasting relationships with their clients. These organizations have the ability to reach out to various communities and channel information in a culturally sensitive manner. According to one advocate, most immigrants, especially those who are undocumented, “only trust their churches, grocery stores, and nonprofits.”¹⁰⁴⁴ As such, most professionals in the field recommended the use of nonprofit organizations that are community-based as a way to create more “connectedness” with immigrant communities, “especially for those who may be wary of coming to a government office.”¹⁰⁴⁵ Community-based and nonprofit organizations should use existing resources, such as Bridges to Benefits, a web-based tool developed by the Children’s Defense Fund-Minnesota that helps families and individuals safely determine if they are eligible for public benefit programs, without requiring any identifying information, and links them to services.¹⁰⁴⁶ United Way’s 2-1-1 similarly provides confidential information about health and social services.¹⁰⁴⁷

INFORMATION OVERLOAD

The complex and confusing public benefit eligibility rules resulting from PRWORA have created a highly difficult system to navigate. This complexity has become a substantial barrier to access and participation. Individuals seeking benefits feel discouraged by the sheer number of required documentations. According to the Office of the Assistant Secretary for Planning and Evaluation of the U.S. Department of Health and Human Services, “these barriers were even more acute for immigrant families, in part because the specific policies and requirements related to immigrant

¹⁰⁴² Interview 108.

¹⁰⁴³ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Barriers to Immigrants’ Access to Health and Human Services Programs*, by Krista M. Pereira, Robert Crosnoe, Karina Fortuny, Juan Manuel Pedroza, Kjersti Ulvestad, Christina Weiland, and Hirokazu Yoshikawa (May 2012), <http://aspe.hhs.gov/hsp/11/ImmigrantAccess/Barriers/rb.shtml>.

¹⁰⁴⁴ Interview 147.

¹⁰⁴⁵ Interview 40.

¹⁰⁴⁶ Children’s Defense Fund, “Bridge to Benefits,” (accessed Mar. 21, 2014), <http://mn.bridgetobenefits.org/Home2>.

¹⁰⁴⁷ United Way 2-1-1, “About 2-1-1,” (accessed Mar. 21, 2014), <http://www.211unitedway.org/>.

BASIC NEEDS

eligibility and verification changed rapidly, differed across programs, and added greatly to an already high level of complexity.”¹⁰⁴⁸

Many advocates and social service professionals who assist people with the application and re-certification processes identified the process as being time-consuming and complex. A community worker stated that “access is difficult because of having too much paperwork to fill out and not knowing how to do it correctly.”¹⁰⁴⁹ Another social service provider commented: “It is a difficult and complicated process for someone who speaks the language, let alone for someone who doesn’t speak the language and doesn’t understand or is new to the system.”¹⁰⁵⁰

As one advocate reported, “there is an information overload on our clients; every county office is full of bureaucracy, full of paperwork. The process is driven by government rules that are very methodical and cold.”¹⁰⁵¹ She added that within this complex system, “keeping everything straight is difficult for most of our clients; so we help explain and make things more manageable.”¹⁰⁵² One participant who experienced difficulties stated, “[the process was] very difficult because they ask for one paper, then ask for another paper. When I brought what they asked, they said that I needed to bring more documentation; they told me come back with the other papers.”¹⁰⁵³

Many advocates and workers indicated that in addition to the mounds of paperwork and bureaucracy, the unclear concepts and terminologies of the eligibility rules compound immigrants’

“A client with limited English proficiency regularly came to the agency with a bag full of correspondence and notices from government agencies, seeking help to decipher the vast amount of information contained in those papers. A staff member from the organization would sit with him for a couple of hours, sort through the bag, and read each piece of mail.”

confusion when trying to access the public benefit system. To some immigrants, the concept of public assistance may be new. Many find themselves baffled by terms such as “head of household” or “responsible party” that may not readily translate into their languages or cultures. This is even more challenging to those with

¹⁰⁴⁸ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Barriers to Immigrants’ Access to Health and Human Services Programs*, by Krista M. Pereira, Robert Crosnoe, Karina Fortuny, Juan Manuel Pedroza, Kjersti Ulvestad, Christina Weiland, and Hirokazu Yoshikawa (May 2012), <http://aspe.hhs.gov/hsp/11/ImmigrantAccess/Barriers/rb.shtml>.

¹⁰⁴⁹ Interview 147.

¹⁰⁵⁰ Interview 106.

¹⁰⁵¹ Interview 119.

¹⁰⁵² Interview 119.

¹⁰⁵³ Interview 15.

limited education and literacy. It is also a system that is increasingly becoming computerized, making it necessary for applicants to have some computer skills.

A social worker remembers a client with limited English proficiency, who regularly came to a social service agency with a bag full of correspondence and notices from government agencies, seeking help to decipher the vast amount of information contained in those papers. A staff member from the organization would sit with him for a couple of hours, sort through the bag, read each piece of mail, and help him understand its content.¹⁰⁵⁴

Similarly, navigating insurance and billing in the U.S. health care system is just as overwhelming and creates a great deal of confusion for immigrant individuals and families, even for those who are not on public assistance. An advocate reflected that “one of the biggest barriers is navigating the health care system, knowing how to access it, and understanding the billing and collection components. These are so complex that some elect not to receive health care.”¹⁰⁵⁵

LANGUAGE ACCESS: A CONTINUING CHALLENGE

In addition to the problems with the overwhelming complexity of the benefits system, service providers, advocates, and health care professionals reported serious challenges in communicating with their clients and patients because of language and cultural barriers. In addition to interpretation and translation, people noted that conveying accurate information depends on understanding the context as well as the language. In a state where more than 230 languages¹⁰⁵⁶ are spoken, service providers, health care institutions, and government agencies can never ensure that interpreters for all languages are readily on hand, but resources continue to be needed to provide language access.

Many human and social service agencies in Minnesota work with immigrants and refugees who are English learners. Although many efforts to address language access have been implemented, language issues still present barriers to receiving essential services and benefits. For people seeking public assistance or medical care, access to interpretation and translation of paperwork is essential. A public agency professional mentioned that clients face “lots of confusion, mounds of paperwork, lack of language access, difficulties with terminology and concepts.”¹⁰⁵⁷

Title VI of the Civil Rights Act states that no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be

¹⁰⁵⁴ Interview 185.

¹⁰⁵⁵ Interview 141.

¹⁰⁵⁶ Minnesota Department of Education, Division of Student Support, *English Learner Education in Minnesota: 2013*, 12.

¹⁰⁵⁷ Interview 119.

BASIC NEEDS

subjected to discrimination under any program or activity receiving federal financial assistance.¹⁰⁵⁸ This requirement applies to states¹⁰⁵⁹ and to private agencies receiving federal funding.¹⁰⁶⁰ Minnesota law provides additional requirements for language access, including the employment of bilingual employees in certain state agencies, translation of materials explaining agency services, and provision of translated materials for certain local offices.¹⁰⁶¹ In addition, Minnesota law governs interpreter services for recipients of MN Care¹⁰⁶² and Medicaid.¹⁰⁶³

Despite both federal and state legal requirements, there are few uniform policies or protocols for public service agencies to respond to the needs of Minnesotans with limited English proficiency.¹⁰⁶⁴ Those agencies that have developed plans for English learners differ substantially in how they have addressed the need, even among areas with similar populations.¹⁰⁶⁵ There is no central reporting system or enforcement protocol for violations of Title VI mandates by agencies receiving federal funds.¹⁰⁶⁶

Although Minnesota law requires the commissioner of administration to determine the application of Minnesota’s bilingual staff and translation requirements for each state agency in consultation with many partners, including the Council on Affairs of Chicano/Latino People, groups representing other non-English-speaking individuals, and the head of the agency,¹⁰⁶⁷ information about each agency’s status under this law is not readily available.

“Services tailored to your culture in your own language help make you feel welcome.”

Advocates and professionals noted that certain immigrants have better access to language services, as well as to services provided in their languages and in a culturally appropriate manner. One professional noted that access for large or more established populations often is in place: “for Somalis, at the county they have Somali speakers, which helps. Services tailored to your culture in your own language help make you feel welcome.”¹⁰⁶⁸

¹⁰⁵⁸ 42 U.S.C. §2000d.

¹⁰⁵⁹ 42 U.S.C. §2000d-7.

¹⁰⁶⁰ Exec. Order No. 13,166, 65 Fed. Reg. 50121 (Aug. 16, 2000).

¹⁰⁶¹ Minn. Stat. §15.441 (2013).

¹⁰⁶² Minn. Stat. §256L.03 (2013).

¹⁰⁶³ Minn. Stat. §256B.0625, subd. 18a (2013).

¹⁰⁶⁴ Interview 173.

¹⁰⁶⁵ Minnesota Advocates for Human Rights, *The Government Response to Domestic Violence Against Refugee and Immigrant Women in the Minneapolis/St. Paul Metropolitan Area: A Human Rights Report* (Dec. 2004), 41.

¹⁰⁶⁶ Interview 173.

¹⁰⁶⁷ Minn. Stat. §15.441, subd. 1 (2013).

¹⁰⁶⁸ Interview 115.

Other groups of immigrants and refugees, however, struggle to access services and information in their languages. One advocate observed of his community, “Older people feel frustrated when they go to Social Security or benefits offices and there isn’t someone there who speaks their language. They often do not know to ask for an interpreter and leave without being served. They will call our organization to have someone go with them.”¹⁰⁶⁹ One advocate observed the difficulty of meeting the needs of such a diverse community, even with the best of efforts: “In my organization we provide interpreters, we serve the community and don’t turn anyone away. Although we have staff representing various cultures, we do not have all the cultures covered; I believe we should, since we get our funding to serve them and we owe it to them to have representation.”¹⁰⁷⁰ Others echoed the statement, observing that language barriers remain a challenge. A service provider in a community-based organization talked about the financial resources needed to meet language needs, noting that her organization wants to be a primary resource for language and other language and culture specific services for immigrants, but they do not have the necessary funding and support.¹⁰⁷¹

Language barriers are exacerbated by the shortage of qualified interpreters. One person noted that “if an interpreter is provided, often the ‘interpreter’ is a staff member of the agency who works in a different area and happens to speak the language – not a dedicated interpreter.”¹⁰⁷² Another advocate remarked on the risks of using interpreters from the community rather than professionals: “We have people in here who know the medical terms and HIPPA policy, unlike untrained interpreters. For example, when a doctor asks a patient, ‘what happened to your eye?’ the untrained interpreter will say to her, ‘you better not tell that your husband beat you.’”¹⁰⁷³ As required by state law, the Commissioner of Health maintains a voluntary statewide roster of spoken language health care interpreters.¹⁰⁷⁴

Most troubling is when people must rely on their children to interpret. Using children as interpreters presents a number of problems. Children may be unable to understand concepts or vocabulary. They may be exposed to information that could cause them undue harm and stress. And, in some cases, children who interpret for their parents assume power over their parents that can result in role reversal and instability in the family.

Problems may arise even when a qualified interpreter is available. An attorney cited a case where her client sought medical attention: “The clinic knew about his language needs and was ready with

¹⁰⁶⁹ Interview 146.

¹⁰⁷⁰ Interview 133.

¹⁰⁷¹ Interview 137.

¹⁰⁷² Interview 146.

¹⁰⁷³ Interview 129.

¹⁰⁷⁴ Minn. Stat. §144.058 (2013).

BASIC NEEDS

an interpreter from his own country. What the clinic did not know was that the client, an asylum seeker, was deeply afraid that his government would learn that he was in Minnesota. When he saw the interpreter from his own country, he walked out of the appointment.”¹⁰⁷⁵

Translation of written information also poses challenges. Both the public benefits and the health care systems rely on written explanations and forms, and the sheer amount of paperwork can deter immigrants and refugees with limited English literacy skills from seeking help. Even when materials are translated into various languages, context and concepts can be lost in translation. Most print materials assume high literacy levels and familiarity with complex concepts and languages that are difficult to understand even for native English speakers. As one advocate stated, “people often need help with the ‘combined application’ for public benefits. It is difficult people who do not speak English, especially for those who may not be literate in their own languages.” Another advocate noted, “The language needs to be adjusted to the level of people being served.”

Service providers also recognized language as a key ingredient to a welcoming and culturally appropriate and sensitive practice. They acknowledged that providing services in the clients’ language or at the very least providing access to language lines went a long way in creating a trusting and lasting relationship with their clients. Not only does language accessibility allow the service provider to do her job effectively, it also offers clients a “sense of belonging and acceptance” and demonstrates sensitivity to and validation of their cultures and their stories. In addition to the benefits to the clients, it helps professionals in the field steer clear of stereotypes, develop their cultural knowledge base, and attribute value to the enrichment it provides.

BEST PRACTICE:

One social service agency implemented a creative solution to addressing the language and cultural barriers their clients face. An advocate from the agency stated:

*When hiring staff, we are not looking for degrees or previous work experience. We hire people who have passion and want to see their communities not just survive but thrive. Clients are served by people who are like them, share the same experiences and speak their language; the focus is on respect and dignity. We are one small entity within a wider government entity not known for its friendliness. Our clients are treated with dignity and respect, and we celebrate culture. When people come here they need to see someone who understands them, someone who is a bridge from where they are to where they are going.*¹⁰⁷⁶

¹⁰⁷⁵ Interview 184.

¹⁰⁷⁶ Interview 119

PROGRAMS THAT FAIL TO RECOGNIZE CLIENTS' STRENGTHS

In addition to all the barriers that arise from communication difficulties, the design of public benefit programs puts more focus on the limitations of families and individuals than their strengths, hurting service provision. Respondents indicated that there is a tendency in the human services sector to view those who are seeking services, especially immigrants who face language and other barriers, as “deficient.” An advocate declared: “There is a problem on the part of professionals who think they are doing service to immigrants by being ‘nice’ and not factual. They treat them as if they were incapable.”¹⁰⁷⁷

Community-based organizations were identified as being more likely to elicit their clients’ existing strengths and further empower them to gain the knowledge and confidence they need to navigate the various systems with which they may come in contact. One service provider said, “My own family used public benefits for a small time when we came here, but my family’s goal was to get off assistance and get established. That is the goal for our program participants too. To eventually get them established and independent.”¹⁰⁷⁸ Referring to their clients’ strengths, one advocate said, “We work with [refugees], a population that is resilient, hard working and determined. It is an honor and a privilege to work with this population.”¹⁰⁷⁹ Another advocate reiterated the statement by saying, “They are very resourceful. If you point them to the resources, they will get them, especially if they have access to an interpreter or language access at county phone lines.”¹⁰⁸⁰

However, continued insufficient funding and resources present challenges to these organizations. A professional in the field said, “There are many established communities and organizations that can do the work but are unable to do so because of lack of funding; the work requires resources!”¹⁰⁸¹

Furthermore, the assumption that all immigrants have similar needs can lead to culturally insensitive practices that can adversely affect eligible immigrants. As one advocate remarked, “everyone is supposed to be treated equally with the assumption that everyone has equal needs. Clients get very frustrated.”¹⁰⁸² An interviewee stated that people have a tendency to put immigrants, refugees, and asylees in the same category. He recommends that more education be given to professionals in this regards.¹⁰⁸³ In concurrence, a service provider stated, “Data collection needs to look at different communities instead of lumping them together. Acquisition of

¹⁰⁷⁷ Interview 114.

¹⁰⁷⁸ Interview 106.

¹⁰⁷⁹ Interview 115.

¹⁰⁸⁰ Interview 123.

¹⁰⁸¹ Interview 130.

¹⁰⁸² Interview 119.

¹⁰⁸³ Conversation 7.

BASIC NEEDS

information needs to be done in a culturally sensitive way.”¹⁰⁸⁴ However, at the moment this practice is not yet in place.

BARRIERS TO HEALTH CARE: COSTS AND CULTURE

HEALTH CARE COSTS

Human rights standards state that everyone has the right to “the highest attainable standard of physical and mental health,”¹⁰⁸⁵ which includes being able to access needed health care. However, immigrants and refugees reported having trouble receiving adequate health care because of high costs and cultural barriers. The significant cost of health care and health insurance is one of the main deterrents to immigrants seeking care. Social service providers, advocates, and members of the community discussed at length the damaging effect of steep health care costs. An advocate stated, “The two biggest fears that stop people from seeking health care are fear of being deported and the fear of the cost.”¹⁰⁸⁶ Another advocate echoed the statement by saying, “It is really sad, but I have heard some people say, ‘I would rather just die.’”¹⁰⁸⁷

According to advocates, high costs force many individuals and families to do without health insurance. Research found that even if immigrants, especially those with limited English language proficiency, are employed, they tend to mostly be employed by industries that opt not to offer insurance at all.¹⁰⁸⁸ For those who decide to have it, often times the premiums are very high. A respondent reported, “health insurance is frustrating; it is expensive if you cannot get it from employment. It is too expensive for me, so I do not have it. I just applied for Minnesota Care for just my son; I have to pay over \$400 that I do not have. In other words, here if you get sick and do not have money you either die or face a bill that is thousands of dollars.”¹⁰⁸⁹ Research indicates that coverage is worse for immigrant communities in Minnesota than for citizens. In 2011, roughly 32 percent of noncitizens stated they were uninsured, as opposed to 7.7 percent of citizens.¹⁰⁹⁰

For immigrants without insurance, visiting a doctor and other kinds of health care are financially out of reach. An interviewee stated, “Health is a huge issue and now it is getting worse. People feel like they cannot go to the doctor, because they do not get insurance benefits at their jobs and they

¹⁰⁸⁴ Conversation 24.

¹⁰⁸⁵ ICESCR, Art. 12.

¹⁰⁸⁶ Interview 136.

¹⁰⁸⁷ Interview 136.

¹⁰⁸⁸ Henry J. Kaiser Family Foundation, “Overview of Health Coverage for Individuals with Limited English Proficiency,” (Aug. 2012), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8343.pdf>.

¹⁰⁸⁹ Interview 44.

¹⁰⁹⁰ State Health Access Data Assistance Center, “Health Insurance Coverage Estimates, ACS, All Ages, All Poverty Levels, Minnesota: Calendar Year 2011,” (accessed Mar. 21, 2014). <http://www.shadac.org/datacenter/tables/tables/id/0734ed0c-0fd6-461f-9107-56cadd94faec>.

cannot afford a doctor. They feel the system is unfair because their hard work does not get them the same treatment as [others].¹⁰⁹¹ Other interviewees also expressed their concerns and frustration about the exorbitant costs associated with health care. A respondent stated, “I am very concerned about my medication. I need to take daily medications. The idea of not having a job and not having insurance to help pay for my medications is very concerning.”¹⁰⁹² Interviewees observed that the cost of health insurance is too high to afford even when they are working. One said, “Sometimes half of what families are making is being spent on health care.”¹⁰⁹³

“It is really sad, but I have heard some people say, ‘I would rather just die’ than try to get health care.”

Despite steep costs for both health insurance and health care, fear of becoming a “public charge” discourages lawfully present immigrants who wish to obtain permanent residency from accessing public health coverage. A “public charge” is a person who is dependent on the state for income, and while health care programs are not categorized as support under this policy,¹⁰⁹⁴ there is immense concern in immigrant communities about being perceived as a public charge and jeopardizing their future immigration status, which inhibits otherwise eligible families from enrolling in public insurance.¹⁰⁹⁵

CULTURAL UNDERSTANDING AND EFFECTIVE SERVICE DELIVERY

In addition to cost, health care providers noted that cultural differences can impede effective communication and limit the ability of immigrants and refugees to get the care they need. A worker in the field explained, “Even in places that have lots of services, the biggest issues are cultural misunderstandings and unwillingness to be open to the others.”¹⁰⁹⁶

An advocate observed that, “due to language barriers and cultural differences, the relationship between patients and doctors is not strong.” She added, “maybe because [some immigrant] patients tend to be more animated in their body language, doctors sometimes assume that what patients are saying is exaggerated or untrue. Some patients tell stories, but the doctors want to hurry up and get to the point and want symptoms described exactly. Unfortunately, most of the issues tend to be lost in the conversation.”¹⁰⁹⁷ Another person gave the following insight, “the

¹⁰⁹¹ Interview 139.

¹⁰⁹² Interview 147.

¹⁰⁹³ Interview 147.

¹⁰⁹⁴ National Immigration Law Center, *Public Charge: An Overview*, (Oct. 2013).

¹⁰⁹⁵ Henry J. Kaiser Family Foundation, *Connecting Eligible Immigrant Families to Health Coverage and Care: Key Lessons from Outreach and Enrollment Workers* (Oct. 2011).

¹⁰⁹⁶ Interview 110.

¹⁰⁹⁷ Interview 133.

BASIC NEEDS

system here is different from what people are used to back home. In our culture, it is more about building a relationship. But, there is not the time to do that here. Doctor's visits are 15-20 minutes long, which makes it difficult to chat and get to know each other."¹⁰⁹⁸

Cultural taboos also present obstacles to health care access. According to professionals in the field, topics such as sexual partners and pregnancy test are difficult to discuss, even when communicating through interpreters to address language barriers. An advocate stated, "Providers try to help the best they can, but sex is not a normal conversation topic in most cultures and this becomes a health care barrier. Sometimes the right information is not being translated correctly."¹⁰⁹⁹ Another advocate stated, "Some women don't want to see a male doctor and men don't want to see a female doctor. That is hard for people."¹¹⁰⁰

To address the needs of immigrants who may face language and cultural barriers, the Minnesota Department of Human Services and Department of Health contract with various cultural and ethnic organizations to assist immigrants, many of which focus on specific cultural or linguistic groups.¹¹⁰¹ These organizations however, are small in number, they often experience shortages in funding and resources, and they tend to be mainly concentrated in the metro area.

According to a health care worker: "In theory we are welcoming; for example we have a 'welcome' sign in every language, but we still have a way to go to make it really welcoming."¹¹⁰² Another person observed: "Most immigrants try to avoid going to clinics if possible because they don't feel comfortable; there is a kind of mistrust. It is hard to explain it but they feel uncomfortable."¹¹⁰³ A health professional observed, "People who come here find the system strange and hard to access – they only go in when they are really sick and they usually end up in urgent care or the Emergency Room, so the government has to then spend more money. We have the ability to go out and educate the community but there is no funding for our work."¹¹⁰⁴ A social service professional indicated that in general, "the health care message is often unwelcoming and not tailored to

¹⁰⁹⁸ Interview 136.

¹⁰⁹⁹ Interview 147.

¹¹⁰⁰ Interview 136.

¹¹⁰¹ Minnesota Legislature, Legislative Coordinating Commission, Ethnic Heritage and New American Working Group, "Health Care Services Offered to Immigrants and Refugees," (Sep. 28, 2010), (accessed Mar. 21, 2014), http://www.lcc.leg.mn/inactive/ehwg/meetings/09282010_DHS_Services.pdf; Minnesota Department of Human Services, "Contact Numbers," (accessed Mar. 21, 2014), http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dDocName=id_006296&RevisionSelectionMethod=LatestReleased, ("contact a navigator. A navigator is a person or group that gives free application help").

¹¹⁰² Interview 133.

¹¹⁰³ Conversation 3.

¹¹⁰⁴ Conversation 10.

specific communities.”¹¹⁰⁵ The provider added that Minnesota’s health care system often fails to address the needs of survivors of torture, war trauma, or other violence, or of those needing culturally sensitive mental health services. “These are people who need to be understood and strongly supported.”¹¹⁰⁶ Another advocate noted, “When I think about health, I think about access to medical services. But when a group of refugees was asked about health, they talked about so much more.”¹¹⁰⁷ The challenge for the health care system is how to address that holistic concept of health.

One advocate spoke about the missed opportunity to engage health care professionals from other parts of the world due to difficulties they face in becoming licensed in Minnesota: “There are culturally and linguistically competent professionals able to provide support to the communities and there are large immigrant populations here that need physicians who can understand and help them, physicians who know the cultural nuances and know how to ask appropriate questions. This would alleviate so many biases and trust issues. People who have to communicate through interpreters may not say everything. Competent doctors who are from their patients’ cultures’ will be better equipped to provide culturally sensitive service and the government would have to spend less on health care.”¹¹⁰⁸ One health professional gave an example of the nuances of communication needed to get and convey accurate information, “for example if doctors ask patients if they eat a lot of salt, they say ‘no.’ But when doctors ask if they eat particular foods that are popular in their culture and very high in sodium, they can give a more accurate answer.”¹¹⁰⁹

ACUTE SHORTAGE OF MENTAL HEALTH CARE

Mental health service providers stress the critical need for community outreach and educating community members on the benefits of receiving mental health services. The need for culturally sensitive service is most acute in the mental health field, particularly in light of Minnesota’s high proportion of refugees.¹¹¹⁰ Studies corroborate that refugees are more at risk for conditions related to “exposure to deprivation, violence, and forced migration.”¹¹¹¹ The shortage of “culturally appropriate and competent assessments”¹¹¹² and “the misperceptions that exist on both sides

¹¹⁰⁵ Interview 137.

¹¹⁰⁶ Interview 137.

¹¹⁰⁷ Interview 184.

¹¹⁰⁸ Conversation 10.

¹¹⁰⁹ Conversation 10.

¹¹¹⁰ The Minneapolis Foundation, *A New Age of Immigrants: Making Immigration Work for Minnesota*, (Aug. 2010)

¹¹¹¹ Katherine Fennelly, “The ‘Healthy Migrant’ Effect,” *Healthy Generations: Immigrant and Refugee Health*, University of Minnesota School of Public Health, Maternal & Child Health Program, Feb. 2005, http://www.epi.umn.edu/mch/resources/hg/hg_immi.pdf.

¹¹¹² Interview 185.

BASIC NEEDS

about mental health services for refugees¹¹¹³ often stand in the way of delivery of appropriate mental health services.

“We have a need for interpreters for therapeutic sessions, but we need a diagnosis first to get the funding for the interpreter. It is a catch-22.”

One professional in the field observed a general “increase in manifestation of mental health issues.”¹¹¹⁴ One service provider stated, “The problem that we see is that mostly the clients think the mental health issues are not pertinent; they think

that they are situational. Even if they have access to mental health care they do not identify as needing those services. Sometimes police have to be called and the client is sent to the hospital.”¹¹¹⁵ Another provider noted that “because mental health is considered very taboo, patients will come in talking about physical pain. It is really hard to get them to therapy, to deal with the issues. A lot of people rely on religious resolutions and other remedies.”¹¹¹⁶ Concurring, a respondent said, “There are no mental health services that are culturally appropriate. In our culture, the way people see mental health is not the way people in this country see it. Often, the issues have escalated before they are clearly noticeable. And psychiatrists and therapists are very expensive.”¹¹¹⁷ A service provider reported, “Community stigma is still attached to mental health and it is very hard for people to reach out for help, because there is such a pressure to hide it.”¹¹¹⁸

People interviewed identified the need for culturally sensitive practices, training for mainstream health professionals, and recruitment of bicultural and bilingual professionals who have a strong grasp of their communities’ health care needs.¹¹¹⁹ As within the entire health care field, people also noted the failure to capitalize on the resource of foreign-trained professionals who may have both the skills and the ability to serve the health needs of refugees and immigrants.¹¹²⁰

In addition to the daunting cultural barriers, mental health service provision is hampered by rigid and complex program requirements. A professional in the field stated, “We have a need for interpreters for therapeutic sessions, but we need a diagnosis first to get the funding for the interpreter. It is a catch-22.”¹¹²¹ This unfortunately increases the likelihood for misdiagnosis or under-diagnosis of mental illness and the implementation of incorrect interventions. Additionally,

¹¹¹³ Interview 145.

¹¹¹⁴ Interview 110.

¹¹¹⁵ Interview 145.

¹¹¹⁶ Interview 123.

¹¹¹⁷ Interview 130.

¹¹¹⁸ Interview 105.

¹¹¹⁹ Conversation 10.

¹¹²⁰ Conversation 10.

¹¹²¹ Interview 144.

even though Medical Assistance and MN Care cover mental health care programs and prescriptions,¹¹²² the steps and requirements involved in accessing care can be daunting for most people, but more so to immigrants with language, literacy, and other barriers.

DENIAL OF THE RIGHT TO FAMILY UNITY: SPONSOR DEEMING

International law recognizes that “the family is the natural and fundamental group unit of society and is entitled to protection by society and the State.”¹¹²³ U.S. immigration policy also recognizes the principle of family unity, placing family-based immigration at the heart of U.S. immigration policy. Nonetheless, U.S. immigration law, which excludes persons deemed likely to become a “public charge,”¹¹²⁴ denies this fundamental right to low-income people.

A person immigrating to the United States must establish that he is not likely to become a public charge. For those immigrating through family-based petitions, a legally binding affidavit of support must be completed by a sponsor in the United States who promises to financially support the new immigrants. For the purpose of public assistance programs, the sponsor is financially responsible for the immigrant until the immigrant becomes a U.S. citizen or accumulates 40 qualifying quarters of employment.¹¹²⁵ The public charge ground of exclusion means that low-income families struggle with reunification because they must wait until they are financially able to support their family members before they can be together.

The impact of the sponsorship requirement continues even after the family is reunited in the United States. Immigrants and their sponsors may have trouble meeting their basic needs because of strict eligibility requirements. When assessing eligibility for federal public assistance programs, 100 percent of the income and assets of the sponsor and the sponsor’s spouse are counted or “deemed available” to the immigrant. As a result, sponsored immigrants are ineligible for many federal benefits and most state benefits, because they are income and asset ineligible.¹¹²⁶ In some cases sponsors may not fully understand the requirements associated with sponsorship and may not be aware of the ramifications of signing affidavits of support. In other cases, the requirement of financial support creates financial hardship for the sponsor as well as the sponsored individual or family member. Participants stated that “the state should educate sponsors to be better prepared to help bring new arrivals to the community. Agencies and government should do more to help [...]

¹¹²² Minnesota Department of Human Services, *Minnesota Health Care Programs: Summary of Coverage, Cost Sharing and Limits* (Jan. 2014).

¹¹²³ UDHR, Art. 16(3).

¹¹²⁴ 8 U.S.C. §1182(a)(4)(A)-(C).

¹¹²⁵ U.S. Department of Human and Health Services, “Immigrant Eligibility Restrictions Under Current Law,” (Feb. 25, 2009), <http://aspe.hhs.gov/hsp/immigration/restrictions-sum.shtml>.

¹¹²⁶ Interview 126.

BASIC NEEDS

and understand newcomers' needs."¹¹²⁷ According to an advocate, because these rules were previously applied more liberally, sponsor deeming was not a big obstacle, but recent budget and policy changes, have made access to public benefits more difficult.¹¹²⁸

EXCLUSION BECAUSE OF IMMIGRATION STATUS

Despite human rights standards that give everyone, regardless of citizenship status, the "right to a standard of living adequate for the health and wellbeing of himself and his family,"¹¹²⁹ state and federal law exclude undocumented people from virtually all access to vital public assistance.

Respondents identified these exclusionary policies and practices as threatening to their survival. Many interviewees expressed their frustration about the "nonexistent" access to services to nonqualified immigrants, which includes both undocumented people and some documented immigrants. Those who sought help talked about the fruitless and endless cycles of referrals from one service to another that are unable to provide the help they need. A participant stated, "I have tried, I have consulted some places, but they told me that since I don't have Social Security card, I'm not eligible."¹¹³⁰ Another said, "I also found some resources online, but my ambiguous immigration status made it difficult for people to help me. There are so many barriers when you are in that gap."¹¹³¹ Some immigrants' inability to obtain driver's licenses makes these tasks even more challenging by limiting their movements and ability to seek assistance.¹¹³²

BARRIERS FOR MIXED-STATUS FAMILIES

Because eligibility for most public benefits rests on immigration status, the public benefits system expends an enormous effort on determining and verifying applicants' immigration status. Most undocumented immigrants assume that members of their families do not qualify for benefits and support, so they do not ask for them. Undocumented immigrants who are aware that their citizen children are eligible for benefits may seek them for their children, but many remain skeptical of the system.¹¹³³ Undocumented immigrants fear, sometimes with good reason, that seeking public assistance can lead to deportation.

Advocates reported that many immigrants fear that accessing a government agency for services will trigger involvement from immigration authorities. Based on this fear, many make the decision not to access services altogether. One advocate stated, "There is an underlying fear that the system will

¹¹²⁷ Conversation 24.

¹¹²⁸ Interview 126.

¹¹²⁹ UDHR, Art. 25(1).

¹¹³⁰ Interview 8.

¹¹³¹ Interview 9.

¹¹³² Conversation 22.

¹¹³³ Interview 133.

separate them from their children, which makes them more protective; they have a very real underlying fear that they will be deported or their kids taken away.”¹¹³⁴ Another advocate remembers one of her clients stating, “Even if my child is eligible, I am afraid of applying, because once my name, as the head of household on the application form, goes in a government computer, it will be accessible to everyone and I can get deported.”¹¹³⁵ This sentiment of fear and mistrust drives some immigrants to “stay away from any government places and people as much as possible.”¹¹³⁶ A social worker stated, “I think part of the reason why I don’t work with undocumented persons is because they’re scared to seek services. I sit in a government office building, so there can be a perception that I could turn someone in.”¹¹³⁷ Similarly, other community based-professionals find themselves tasked with reassuring clients that they are not “government” workers and will not divulge immigration status information to immigration authorities.

The U.S. Department of Health and Human Services recently confirmed the same trend nationally. Many immigrant parents who do not qualify for public benefits failed to realize that their children who were born in the United States were eligible for services and benefits. Even if they realized that their children were eligible, they feared that attempting to access services on behalf of their children would put them in danger of deportation.¹¹³⁸

The fear and mistrust that immigrants feel are often based on actual examples where attempts to access services have triggered deportation. An advocate remembered the case of a woman in her 70s whose public benefits application triggered a response from Immigration and Customs Enforcement (ICE):

*Previously the woman had a Temporary Protection from Deportation status. Over time, her status had expired and she had neglected to renew it, ending up with an Order for Deportation. Due to her severe health issues, she started the process of applying for Medical Assistance, so she could obtain medical care. However, verification of her immigration status by the public benefits worker revealed the Order of Deportation, at which point she was reported to ICE. Sometime later, ICE agents went to her house under the guise of helping her complete her Medical Assistance application and took the woman into custody. She ended up spending one month in jail and was eventually deported.*¹¹³⁹

¹¹³⁴ Interview 110.

¹¹³⁵ Interview 185.

¹¹³⁶ Interview 45.

¹¹³⁷ Interview 108.

¹¹³⁸ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Barriers to Immigrants’ Access to Health and Human Services Programs*, Krista M. Pereira, Robert Crosnoe, Karina Fortuny, Juan Manuel Pedroza, Kjersti Ulvestad, Christina Weiland, and Hirokazu Yoshikawa (May 2012), <http://aspe.hhs.gov/hsp/11/ImmigrantAccess/Barriers/rb.shtml>.

¹¹³⁹ Interview 184.

EXCLUSION FROM EMERGENCY MEDICAL ASSISTANCE

Foreign-born Minnesota residents account for eight percent of Minnesota's population, yet they make up about twenty-four percent of all uninsured people.¹¹⁴⁰ Although there are numerous contributing factors, budget cuts to benefits programs were described as major barriers to accessing health care. For instance, the Minnesota legislature recently passed funding changes that eliminated the state-funded Medical Assistance (MA) program, causing the loss of health care to noncitizen immigrants who met financial eligibility requirements but were not eligible for federally funded MA. Also, recent cuts to Emergency Medical Assistance (EMA), a program that previously offered broad coverage of chronic and acute conditions for those ineligible for MA,¹¹⁴¹ have had significantly negative impacts on noncitizen immigrant individuals and families.

An advocate stated, "The Minnesota cutback in Medical Assistance (MA) and Emergency Medical Assistance (EMA) eligibility has had a huge impact."¹¹⁴² She added, "It used to be that we could get people on EMA in some situations; now we cannot, [some people] are no longer eligible. [The categories] used to include asylum applicants and U-visa applicants. This also forced a lot of people who had been on MA to move to the MN Care program, but MN Care does not cover personal or home care, which impacted a number of disabled clients."¹¹⁴³

Another advocate explained that "the 2011 session ended with dramatic changes to whom we would provide emergency health care funding. It restricted access to chemotherapy and dialysis. It affected mostly undocumented people, but also some documented people within their first five years of residence. 2,500 people were notified that their coverage was to be terminated. For families of individuals who have green cards, it was sort of unfathomable that a state would do this: deny chemotherapy to someone who would die without it. This is an unbelievable level of state-sponsored neglect."¹¹⁴⁴

A community health professional reported "the negative impact to the safety net caused by the policy changes in EMA affects all [beneficiaries], including our patients. We need to ensure that health care policy recognizes that various populations will always be here and will have continued need for assistance."¹¹⁴⁵ An advocate gave an example of an individual who was a victim of this change in policy. "An elderly woman with chronic conditions had her benefits cut. She has a cardiac

¹¹⁴⁰ Minnesota Department of Health, *Health Insurance Coverage in Minnesota: Early Results from the 2011 Minnesota Health Access Survey*, Jessie Kemmick-Pintor and Stefan Gildemeister (Mar. 2012), <http://mn.gov/health-reform/images/TaskForce-2012-07-12-AccessWG-Health-Access-Survey-Results.pdf>.

¹¹⁴¹ Laura Melnick, *Summary Guide to Minnesota Government Benefit Programs, 2014 Update* Minnesota Continuing Legal Education, Inc., 2014.

¹¹⁴² Interview 126.

¹¹⁴³ Interview 126.

¹¹⁴⁴ Interview 121.

¹¹⁴⁵ Interview 141.

issue and has colon cancer that is quiescent – but the funds do not cover her medications for diabetes. There are some limited EMA exceptions for dialysis and chemotherapy, but only if a doctor says, ‘without this, they will die within 48 hours.’ For this woman, it was all chronic conditions so she could not get on EMA.”¹¹⁴⁶

A lawsuit by the Immigrant Law Center of Minnesota made it possible to get the cutoff date of EMA postponed. After long negotiations with the Department of Human Services, a process was created so that no one can be cut off without a doctor’s guarantee that there would be no immediate harm to the patient. The goal was to give doctors the decision-making power in regards to who needs emergency care, not legislators.¹¹⁴⁷

RECOMMENDATIONS

Finding: Federal refugee resettlement services are inadequate in their scope and duration and focus mainly on employment.

Recommendations

- The 90-day period of initial refugee resettlement services should be extended to a minimum of 180 days in order to allow an adequate transition period for refugees coming to the United States. Furthermore, the five-year period for initial refugee resettlement services should be restored.
- Refugee resettlement organizations need funding beyond federal requirements to expand their scope to include robust and comprehensive integration services, including case management, that promote the wellbeing and stability of refugees in their new communities.
- To facilitate the integration of refugees in the United States, the orientation period allotted for refugees abroad should be sufficient to ready them for arrival and should include services such as intensive English language classes.
- Resettlement grants to refugees should be increased in order to adequately meet the demands refugees face in meeting their basic needs.

¹¹⁴⁶ Interview 126.

¹¹⁴⁷ Interview 121.

Finding: Refugees face a long waiting period for eligibility determination and approval for public benefits.

Recommendation

- Expedite the eligibility determination and approval period for public benefits for refugees in order to address their needs within the limited time allotted for refugee resettlement services.

Finding: Secondary migration by refugees results in disconnection from refugee services.

Recommendations

- Refugee services should be decoupled from the designated resettlement locations and follow the refugee through secondary migration to the extent possible.
- County agencies should create a point of contact for partnering with refugee resettlement organizations to provide resettlement services to refugees who relocate to areas outside of the coverage of the designated refugee resettlement organizations, ensuring uninterrupted delivery of services.

Finding: Although asylum seekers flee their countries and face similar issues as refugees, they are ineligible for public benefit assistance and are barred from employment.

Recommendations

- State and federal public benefits eligibility rules should expand the “qualified immigrant” category to include asylum seekers, an especially vulnerable population, in order to grant them access to public assistance benefits and reduce hardship while they are waiting to be granted asylum.
- Shorten the wait for asylum seekers to receive work authorization, in order to allow them to be gainfully employed and reduce their need for public assistance.

Finding: Public benefit rates that have been stagnant since 1986 keep benefit recipients in poverty and unable to meet their basic needs.

Recommendations

- Congress should increase funding for public assistance grants and adjust them to meet the current costs of basic needs.

Finding: Insufficient or incorrect information about available benefits creates barriers to services for those who are eligible.

Recommendations

- Public benefit agencies should partner with community-based organizations to conduct outreach and provide information about benefit programs and eligibilities at safe venues outside of government offices.
- Increase public funding for community-based and nonprofit organizations that serve immigrant communities in order to increase capacity and immigrants' access to information and basic needs services.

Finding: The complexity of public benefits programs and compliance requirements deter immigrants from accessing services.

Recommendations

- Forms and written communication should be drafted in simple language to assure they reach a wide range of readers with various literacy levels.
- Written communication should be streamlined and coordinated to indicate only the most current and timely information.
- Automated communications should be clear, simple, and concise, as well as include visual cues to flag levels of importance and the need for an urgent response from participants.
- Participants in public benefits programs should have access to a single worker who handles their cases in order to build rapport and receive coordinated service delivery.

Finding: Language, literacy, and cultural barriers, as well as inadequate interpreters and translation, stand in the way of effective service delivery.

Recommendations

- Public benefit agencies and other social service agencies should recruit and hire more individuals from within the communities they serve in order to build capacity around language access and cultural understanding and to develop a more trusting relationship with immigrant clients.
- Increase access to language lines and interpreters.
- Increase funding for interpretation and translation training and services.
- Recruit more individuals from within the communities served to be trained and certified as interpreters and translators.
- Ensure continued access to training for public benefits staff on appropriate use of interpreters.
- Minnesota's Commissioner of Administration should clarify which agencies are required to provide meaningful access to services under state law, either through bilingual staff or translation, and information about these requirements should be readily accessible.

Finding: Public benefits programs focus on complicated eligibility rules and restrictions, rather than ensuring that basic needs are met.

Recommendations

- Public benefit services should focus more on meeting families' and individuals' specific needs and focus less on eligibility criteria that are complex and may not best address the issues expressed by recipients.
- Public benefit application forms should reflect a program design that addresses specific needs by asking applicants to state their needs and the issues they face.

Finding: The cost of health care deters people from seeking medical treatment and preventative care.

Recommendation

- Immigration status should not determine access to health subsidies under the Affordable Care Act.

Finding: Inadequate bilingual and bicultural health and mental health care create major barriers to immigrants' access to health care services.

Recommendations

- Engage foreign-trained health professionals who are culturally and linguistically competent in health and mental health care delivery.
- Support and train individuals from immigrant communities to become health care professionals.
- Provide ongoing cultural proficiency training to all health care staff at all levels.
- Train and empower patients to make informed health decisions on their own and their families' behalf.
- Increase the use of interpreter services and language lines.

Finding: Immigrants, especially those from mixed- status families, fear that accessing public benefits may result in deportation or becoming a "public charge."

Recommendations

- If immigration status is not a legal condition for accessing a service or benefit, service providers should not ask about status and should conduct outreach to make clear that they are not connected to immigration authorities.
- Public benefits application forms should clearly indicate that Social Security numbers or other identifying information are not required for parents and guardians applying on behalf of minor children who are eligible for public benefits.
- Nonprofit and community-based organizations should make use of existing resources such as the Bridges to Benefits website and United Way's 2-1-1 to safely

BASIC NEEDS

and confidentially determine eligibility for benefits and search for appropriate social and health services.

- Public agencies should clearly delineate the specific public benefit programs that will result in a person becoming a “public charge,” as defined by federal immigration law, and make this information widely accessible.
- Public benefits workers should receive training on basic immigration laws that affect benefit recipients.

Finding: Requiring sponsors to financially support immigrating family members results in a denial of the right to family unity and hinders the ability of immigrants to meet their basic needs.

Recommendation

- Federal law should eliminate the requirement that a family sponsor’s income be included in public benefits eligibility determinations.
- The public charge ground for exclusion should not apply when it would prevent family reunification.

Finding: State and federal laws exclude many noncitizens in Minnesota from accessing benefits and services to meet their basic needs.

Recommendations

- Public benefits assistance should be accessible to all those who are not able to meet their basic needs in order to comply with international human rights standards.