

WASHINGTON HEALTH FACILITIES: GUIDANCE AND MODEL POLICIES TO ASSIST IN THE IMPLEMENTATION OF THE KEEP WASHINGTON WORKING ACT



Washington State Office
of the Attorney General
BOB FERGUSON

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- We will conduct ourselves with integrity, professionalism, civility, and transparency.
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Letter from the Attorney General



Dear Washingtonians:

Washington strives to be a welcoming place for immigrants and refugees to work and live. To support this goal, in 2019 the Washington State Legislature passed the Keep Washington Working Act (KWW) to establish statewide practices regarding the enforcement of federal immigration laws by state and local agencies and provide improved support of economic opportunities for all Washingtonians, regardless of their immigration or citizenship status.

KWW also directed the Office of the Attorney General to develop and publish model guidance “for limiting immigration enforcement to the fullest extent possible consistent with federal and state law” at public schools, publicly operated health facilities, courthouses, and shelters, “to ensure they remain safe and accessible to all Washington residents, regardless of immigration or citizenship status.” Under this legislative directive, the Office of the Attorney General engaged with state and local stakeholders to develop the required model policies.

This publication is specific to Washington health facilities operated by the state or subdivisions of the state. Its guidance includes model policies, training and best practices recommendations intended to assist health facility administrators and personnel in these institutions with understanding and implementing policies consistent with the new law. Indeed, the role of health facilities is essential to the function and achievement of all our communities.

Every day, health facility personnel bear the awesome task of healing and minimizing harm, helping create a more resilient, healthy population. I thank the wide network of health facility personnel, and the local governmental and community leaders who support them, for their leadership ensuring full and fair access to health care for all. Effective implementation of the model policies, training recommendations, and guidance set forth in this publication will meet this obligation.

Sincerely,

A handwritten signature in blue ink that reads "Bob Ferguson". The signature is fluid and cursive, with a long, sweeping underline.

Bob Ferguson
Washington State Attorney General
May 21st, 2020

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PART I: HOW TO USE THIS PUBLICATION

A. Understanding the Keep Washington Working Act and Development of the Attorney General's Guidance

The Washington State Legislature passed the Keep Washington Working Act (KWW) to support the State's interest "in ensuring the state of Washington remains a place where the rights and dignity of all residents are maintained and protected in order to keep Washington working."¹ In furtherance of this goal, KWW makes numerous changes to state law addressing the extent to which state and local agencies may participate in the enforcement of federal immigration laws.² The Legislature further declared passage of KWW as an emergency, expeditiously establishing a statewide policy supporting Washington State's economy and immigrants' role therein.³

The Legislature also mandated that the Office of the Attorney General (AGO) publish model policies to assist local and state entities in the implementation of KWW. Specifically, KWW requires the AGO publish model policies for a number of public entities, including Washington health facilities, for "limiting immigration enforcement to the fullest extent possible consistent with federal and state law . . . to ensure [health facilities] remain accessible to all Washington residents, regardless of immigration or citizenship status."⁴ Under this legislative directive, Attorney General Bob Ferguson created a Keep Washington Working Team of staff to receive input from hospital administrators, community health organizations, and stakeholders across the state.

The model policies and guidance included in this publication is specific to the Washington health facilities operated by the state or political subdivision of the state, and is intended to assist health care administrators and hospital personnel in understanding the new law to help to ensure that all residents, regardless of citizenship status, have full and fair access to the Washington health care system.

B. Adoption of Model Policies and Guidance

The model policies in this publication include guidance regarding collection and transmission of patient information, response and reporting of immigration enforcement activity, and ensuring safe access to health facilities for all persons in need of care. To the extent that health facilities have existing policies that are aligned with or provide greater protections than those provided here, those set forth in this publication are not intended to displace those policies. However, KWW requires all publicly operated Washington health facilities to (1) adopt policies consistent with those published here,⁵ or (2) notify the AGO that they are not adopting the necessary changes, state the reasons why they are not doing so, and provide the AGO with a copy of the agency's policies that ensure compliance with KWW.⁶ To submit copies of an agency's policies, please visit www.atg.wa.gov/publications.

1 Laws of 2019, ch. 440, § 1(3) (codified as a note following RCW 43.17.425). The full text of the KWW law is in Appendix A.

2 See, e.g., RCW 10.93.160; RCW 43.10.310, .315; RCW 43.17.425.

3 Effective Date—2019 c 440 (3) in RCW 43.17.425.

4 RCW 43.10.310.

5 *Id.*

6 RCW 43.10.315(2).

The model policies include placeholders for each facility to insert its name. The placeholders “[health facility],” “[health facility personnel],” and “[designated facility administrator]” should be filled with the proper terms or titles of the specific health facility and personnel who will be responsible for those provisions of the policy. This publication also includes definitions that should accompany adoption of any of the guidance herein.

Finally, all health facilities should implement an expeditious review process of this publication such that adoption of the model policies, and training and best practices recommendations may be initiated immediately. The Legislature declared an emergency when passing KWW, putting the law into immediate effect.⁷ The AGO recognizes the additional strain on resources many state and local entities are facing due to the impacts of the COVID-19 outbreak in the United States. (U.S.). However, prompt review of the included guidance and adoption of model policies, training and best practices recommendations will help ensure the requirements established in the law are met.

Questions or comments regarding KWW may be addressed to KKW@atg.wa.gov.

C. Legal Overview and Recommendations for Training & Best Practices

The AGO’s training recommendations, best practices, and legal overview are aids to guide and assist health facilities with implementing the model policies. Appropriate training is essential for compliance with the model policies, KWW’s provisions, and other laws governing health facilities. While some training on these issues currently exists, consistent training across the state will best ensure that the requirements in KWW are met.

D. Appendix

This publication contains references to several official forms and documents, including types of federal administrative requests, court orders, and warrants. Documents referenced appear in the appendix of this publication.

⁷ Effective date—2019 c 440 in RCW 43.17.425.

PART II: APPLICABLE DEFINITIONS

The following definitions should be adopted with the model policies herein. These definitions are based on the definitions provided in KWW⁸ and other relevant statutory provisions.⁹

- “Civil immigration warrant” means any warrant for a violation of federal civil immigration law issued by a federal immigration authority. A “civil immigration warrant” includes, but is not limited to, administrative warrants entered in the national crime information center database, warrants issued on U.S. Immigration and Customs Enforcement (ICE) Form I-200 (Warrant for Arrest of Alien)¹⁰, Form I-205 (ICE Administrative Warrant), or prior or subsequent versions of those forms, which are not court orders.¹¹
- “Court order” and “judicial warrant” mean a directive issued by a judge or magistrate under the authority of article III of the United States Constitution or article IV of the Washington Constitution. A “court order” includes, but is not limited to, judicially authorized warrants and judicially enforced subpoenas. Such orders and warrants do not include civil immigration warrants, or other administrative orders, warrants or subpoenas that are not signed or enforced by a judge or magistrate as defined in this section.
- “De-identified” means health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.
- “Federal immigration authority” means any on-duty officer, employee, or person otherwise paid by or acting as an agent of the United States Department of Homeland Security (DHS) including, but not limited to, its sub-agencies, Immigration and Customs Enforcement (ICE), Customs and Border Protection (CBP), United States Citizenship and Immigration Services (USCIS), and any present or future divisions thereof charged with immigration enforcement. “Federal immigration authority” includes, but is not limited to, the Enforcement & Removal Operations (ERO) and Homeland Security Investigations (HSI) of ICE, or any person or class of persons authorized to perform the functions of an immigration officer as defined in the Immigration and Nationality Act.
- “Health care” means any care, service, or procedure provided by a health care provider: (a) to diagnose, treat, or maintain a patient’s physical or mental condition or (b) that affects the structure or any function of the human body.

8 RCW 43.17.420; Laws of 2020 ch. 37 § 2.

9 *See, e.g.*, RCW 7.98.010, 19.270.010, 19.375.010, 19.255.005, 42.56.230, 42.56.640, 42.56.010, 70.175.020, 70.02.010; 45 CFR 160.103.

10 Example of Form I-200 is in Appendix B.

11 Example of Form I-205 is in Appendix C.

- “Health care provider” means a person who is licensed, certified, registered, or otherwise authorized by the law of this state to provide health care in the ordinary course of business or practice of a profession.
- “Health facility” and “health care facility” mean any land, structure, system, machinery, equipment, or other real or personal property or appurtenances useful for or associated with delivery of inpatient or outpatient health care service or support for such care or any combination thereof which is operated or undertaken in connection with a hospital, clinic, health maintenance organization, diagnostic or treatment center, extended care facility, substance abuse facility, or any facility providing or designed to provide therapeutic, convalescent or preventive health care services.
- “Health care information” means any information, whether oral or recorded in any form or medium, that identifies or can readily be associated with the identity of a patient and that directly relates to the patient’s health care. The term includes any required accounting of disclosures of health care information.
- “HIPAA” means the Health Insurance Portability and Accountability Act of 1996, which required the Secretary of the U.S. Department of Health and Human Services to develop regulations protecting the privacy and security of certain health information.
- “Hold request” or “immigration detainer request” means a request from a federal immigration authority, without a court order, that a state or local law enforcement agency maintain custody of an individual currently in its custody beyond the time he or she would otherwise be eligible for release in order to facilitate transfer to a federal immigration authority. A “hold request” or “immigration detainer request” includes, but is not limited to, DHS Form I-247A or prior or subsequent versions of Form I-247.¹²
- “Immigration or citizenship status” means such status as has been established to such individual under the Immigration and Nationality Act.
- “Language services” includes but is not limited to translation, interpretation, training, or classes. “Translation” means written communication from one language to another while preserving the intent and essential meaning of the original text. “Interpretation” means transfer of an oral communication from one language to another.
- “Law enforcement agency” or “LEA” means any agency of the state of Washington (State) or any agency of a city, county, special district, or other political subdivision of the State that is a general authority Washington law enforcement agency, as defined by RCW 10.93.020, or that is authorized to operate jails or maintain custody of individuals in jails; or to operate juvenile detention facilities or to maintain custody of individuals in juvenile detention facilities; or to monitor compliance with probation or parole conditions.
- “Local government” means any governmental entity other than the state, federal agencies, or an operating system established under chapter 43.52 RCW. It includes, but is not limited to, cities, counties, school districts, and special purpose districts. It does not include sovereign tribal governments.

¹² An example of the currently used Form I-247A, as well as the Guidance ICE uses to complete the form are in Appendix D.

- “Necessary to perform duties” means that, after following appropriate procedures to verify a course of action, no reasonably effective alternative appears to exist that would enable the performance of one’s legal duties and obligations.
- “Notice to appear” or “NTA” means the charging document issued by ICE, CBP, or the USCIS seeking to commence formal removal proceedings against an individual before a federal immigration court (reflected in DHS Form I-862).
- “Notification request” means a federal immigration authority’s request for affirmative notification from a state or local law enforcement agency of an individual’s release from the LEA’s custody. “Notification request” includes, but is not limited to, oral or written requests, including DHS Form I-247A, Form I-247N, or prior or subsequent versions of those forms.
- “Personal information” means names, date of birth, addresses, Global Positioning System (GPS) coordinates or location, telephone numbers, email addresses, social media handles or screen names, social security numbers, driver’s license numbers, parents’ or affiliates’ names, biometric data, or other personally identifying information. “Personal information” does not include immigration or citizenship status.
- “Patient” means an individual who receives or who has received health care. The term includes a deceased individual who has received health care.
- “Protected health information” or “PHI” means individually identifiable health information that is a subset of health information, including demographic information collected from an individual and: (1) is created or received by a health care provider, health plan, employer, or health care clearing house and (2) relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) that identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
- “Secretary” means the Secretary of the Department of Health.
- “Sensitive location” refers to the 2011 ICE and 2013 CBP policies which categorize certain locations as sensitive locations that should generally be avoided for immigration enforcement purposes. Accordingly, “sensitive location” includes health facilities, places of worship, and schools.
- “State agency” has the same meaning as provided in RCW 42.56.010.

Part III: Model Policies

Pursuant to RCW 43.10.310(2), all Washington health facilities operated by the state or political subdivision of the state must either (a) adopt policies consistent with the following model policies, or (b) notify the AGO that the facility is not adopting the model policies, state the reasons why it is not adopting them, and provide the AGO with a copy of its policies that ensure compliance with the Keep Washington Working Act, chapter 440, Laws of 2019. Prior to adoption, health facilities should consult with their respective legal counsel to ensure that their policies are in compliance with state and federal law.

The applicable definitions set forth in Section II to this publication should be adopted in conjunction with the adoption of the model policies.

A. Access to [Health Facility] & Nondiscrimination of Services

1. The Washington health care system is founded upon the fundamental principle that health care is accessible to all persons in need. [Health facility] is committed to helping the people it serves get access to health care, regardless of immigration or citizenship status.
2. [Health facility] shall not exclude those eligible for care because of their race, color, national origin, or citizenship or immigration status, sex, sexual orientation, disability, veteran or military status, use of a trained dog guide or service animal by a person with a disability, or creed, or on any other basis prohibited by federal, state, or local law. [Health facility] policies and obligations regarding charity care shall be followed regardless of a patient's immigration or citizenship status.
3. All areas of [health facility] premises are private spaces, except for the [main lobby, reception/information desk, waiting areas, gift shop, parking garages] or other areas specifically designated as open to the public. Access to the private spaces of [health facility] shall be limited to staff, persons receiving care and authorized guests, and individuals with approved access.
4. [Health facility]'s policies prohibiting participation or aid in immigration enforcement shall generally apply for enforcement activity against patients and their visitors, staff, and volunteers.
5. [Health facility] does not grant permission for immigration enforcement to be conducted on its premises or permit access to the private spaces of the facility without permission from [Health facility security or designated facility administrator] or without a court order or judicial warrant requiring such access.
6. [Health facility] personnel shall presume that activities by federal immigration authorities, including surveillance, constitute immigration enforcement.

7. If a law enforcement officer or federal immigration authority orders [health facility] personnel to provide immediate access to facilities and presents lawful authority to do so, personnel should comply with the officer's orders and not attempt to interfere. Personnel shall immediately contact [health facility security or designated facility administrator].
8. [Health facility] recognizes that many of the people it serves may speak a primary language other than English. [Health facility] shall assist with providing treatment and communications using language services, including qualified interpreters and translated written information to patients or family members. [Health facility] personnel shall not use federal immigration authorities to provide any language services.

B. Immigration Enforcement at [Health Facility]

1. [Designated senior facility administrator] shall be [health facility]'s lead point of contact on all immigration related issues, which shall include any law enforcement activities by any person engaging in, or intending to engage in, immigration enforcement, including federal immigration authorities, such as requests for information, access to the facility, arrests or detention of persons receiving care or their guests, or any related issues. All [health facility] personnel shall presume federal immigration authorities on official business are engaged in immigration enforcement.
2. The [designated facility administrator] shall be responsible for ensuring that [health facility] personnel and volunteers are properly trained and in compliance with the requirements set forth in the policies herein.
3. All [health facility] personnel shall contact the [designated facility administrator] immediately upon receipt of any request (including subpoenas, petitions, complaints, warrants, court orders, notification request or other administrative notifications) by any person engaging, or intending to engage, in immigration enforcement, including federal immigration authorities, regarding access to the facility, access to a patient or patient visitor, request for the review of [health facility] documents or patient records, or any other type of immigration enforcement requests or activity, to determine the appropriate course of action.
4. The [designated facility administrator] shall collect and maintain records regarding all such immigration enforcement requests or activity, including requests to access non-public areas within [health facility] or persons at the facility. At minimum, [designated facility administrator] shall record the person's name, badge number or other identifying information, agency, date, time, specific law enforcement purpose, and the proposed law enforcement action to be taken.
5. [Health facility] shall not aid or support any person being subject to arrest or having their freedom restricted or hindered for immigration enforcement purposes, except (a) by valid court order or judicial warrant, (b) when it is necessary to secure the immediate safety of facility personnel or the public, or (c) where circumstances otherwise permit warrantless arrest pursuant to RCW 10.31.100.
6. [Health facility] does not grant permission to any person engaged, or intending to engage, in immigration enforcement to access any person receiving care within the facility or their visitors without a court order or judicial warrant requiring that such access is authorized or unless [health facility] obtains the person's written permission. [Health facility] personnel who receive any such requests for access by federal immigration authorities shall immediately contact [designated facility administrator] to determine the appropriate course of action.

7. Before authorizing any access, the [designated facility administrator] shall confirm that the court order is issued and signed by a U.S. District Court Judge or Magistrate Judge and authorizes access to the specific individual by:
 - a. Obtaining a copy of the court order;
 - b. Confirming that a U.S. District Court Judge or Magistrate signed the court order;
 - c. Confirming that the court order identifies the individual for whom the access is sought by name; and
 - d. Verifying that the court order has a valid date or is not otherwise expired or has not previously been executed.

C. Gathering Information Related to Immigration or Citizenship Status

1. [Health facility] personnel have no general obligation to collect or inquire into the immigration or citizenship status of a person receiving care or their visitors.
2. [Health facility] personnel shall not inquire, request, or collect information regarding the immigration or citizenship status, or place of birth of any person accessing services provided by [health facility], unless doing so is (1) necessary to properly provide health care to the person, (2) necessary to determine eligibility (or ineligibility) for state or federal programs, or (3) otherwise required by law. [Health facility] personnel shall consider information other than immigration or citizenship status, or place of birth, such as recent travel activities when ascertaining geographically specific exposure.

D. Protecting Patient Information & Responding to Requests for Information

1. Protecting the medical and health information of all [health facility] patients is a fundamental priority. HIPAA and the HIPAA Privacy Rules require [health facility] to protect the confidentiality of patients' Protected Health Information (PHI), with certain exceptions.
2. As provided by law, health care information is private and must be protected. [Health facility] will treat the PHI or other health care information equally, no matter the patient's immigration or citizenship status, or place of birth.
3. [Health facility] shall not provide any person engaged, or intending to engage, in immigration enforcement, including federal immigration authorities any personal information, except as required to do so by law.
4. [Health facility] shall not require personnel to answer questions or provide information to any person engaged, or intending to engage, in immigration enforcement, including federal immigration authorities, absent a court order or judicial warrant. [Health facility] personnel shall not provide personal information to any person or entity for immigration enforcement purposes unless required to do so by law.
5. [Health facility] personnel reasonably likely to receive requests from or interact with persons engaged, or intending to engage, in immigration enforcement, including federal immigration authorities, shall complete training to become familiar with the types of federal documents

used in immigration enforcement, including those used by federal immigration authorities, and how to respond to those requests.

6. When in receipt of any requests for personal information by any person engaging in, or intending to engage in, immigration enforcement, including federal immigration authorities, [health facility] personnel shall contact [designated facility administrator] to determine an appropriate course of action. [Designated facility administrator] shall collect and record the following information from the requesting official: name, badge number or other identifying information, agency, date, time, specific law enforcement purpose, and the proposed law enforcement action to be taken.
7. If [Health facility] is required to make a disclosure of personal information, without the person's authorization, to any person engaged, or intending to engage, in immigration enforcement, including federal immigration authorities, to comply with a court order or judicial warrant, then [health facility] personnel shall document the disclosure and the reason disclosure was required. Disclosures to any person engaging in, or intending to engage in, immigration enforcement, including federal immigration authorities, like all law enforcement agencies, shall be submitted in accordance with the accounting-of-disclosures requirement under HIPAA.

PART IV: OVERVIEW OF KWW AND RELEVANT STATE AND FEDERAL HEALTH CARE LAWS

While the Keep Washington Working Act, chapter 440, Laws of 2019, requires publically operated health facilities to adopt the model policies in order to promote safe and secure access to their services by limiting participation in immigration enforcement, exceptions apply where federal, state, or local laws require otherwise. This section provides an overview of KWW and other laws that health facilities should consider when adopting the model policies. Health facility administrators should also consult with their legal counsel to ensure that their policies are in compliance with state and federal law before adopting or implementing their policies.

A. Federal Law Relating to Sharing Immigration Status Information

KWW prohibits state agencies from collecting, using, or disclosing information for immigration enforcement purposes except as required by state or federal law or as a necessary condition of federal funding to the state. Under 8 U.S.C. § 1373, which governs “Communication between government agencies and the Immigration and Naturalization Service,” state and local governments may not bar their officials from sharing information regarding “citizenship or immigration status” with federal immigration authorities or “maintaining” information regarding “immigration status.” Section 1373 limits state and local agencies as follows:

(a) In general

Notwithstanding any other provision of Federal, State, or local law, a Federal, State, or local government entity or official may not prohibit, or in any way restrict, any government entity or official from sending to, or receiving from, the Immigration and Naturalization Service information regarding the citizenship or immigration status, lawful or unlawful, of any individual.

(b) Additional authority of government entities

Notwithstanding any other provision of Federal, State, or local law, no person or agency may prohibit, or in any way restrict, a Federal, State, or local government entity from doing any of the following with respect to information regarding the immigration status, lawful or unlawful, of any individual:

- (1) Sending such information to, or requesting or receiving such information from, the Immigration and Naturalization Service.
- (2) Maintaining such information.
- (3) Exchanging such information with any other Federal, State, or local government entity.

In short, Section 1373 prohibits state and local governments from barring staff from sending immigration or citizenship status information to, or receiving that information from, federal immigration authorities, or “maintaining” such information. However, by Section 1373’s own language, these restrictions apply only to information regarding an individual’s “citizenship or immigration status.”¹³ Washington law defines “immigration or citizenship status” as “such status has been established to such individual under the Immigration and Nationality Act.”¹⁴ Therefore, speculation about a person’s citizenship or immigration status and information that supports such speculation would not constitute “information regarding the citizenship or immigration status” covered under Section 1373.

State and local policies limiting use of local law enforcement and other resources to enforce federal law are supported by the Tenth Amendment to the U.S. Constitution. The Tenth Amendment provides that “powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people.”¹⁵

Specifically, the Tenth Amendment’s “anti-commandeering doctrine” limits the federal government’s ability to mandate particular action by states and localities, including in the area of federal immigration law enforcement and investigations.¹⁶ Under this doctrine, the federal government cannot “compel the States to enact or administer a federal regulatory program,”¹⁷ or compel state employees to participate in the administration of a federally enacted regulatory scheme.¹⁸

Especially relevant here, in *United States v. California*, the United States Court of Appeals for the Ninth Circuit held that where federal law provides state and localities the option, rather than a mandate, to assist with federal immigration law, a state’s decision to enact a policy to refrain from providing such assistance is permissible under the anti-commandeering doctrine.¹⁹ The Ninth Circuit held “the federal government was free to expect” cooperation between state and federal immigration authorities, but it could “not require California’s cooperation without running afoul of the Tenth Amendment.”²⁰

As *California* illustrates, state and local agencies adopting the model policies are protected under the Tenth Amendment’s anti-commandeering doctrine. Indeed, *California* clarified that federal law cannot mandate that states and local agencies assist with federal immigration enforcement efforts, and KWW’s provisions affirming Washington’s choice to refrain from such participation are protected by the Tenth Amendment.²¹

13 Similarly, 8 U.S.C. § 1644 (Section 1644) provides that “no State or local government entity may be prohibited, or in any way restricted, from sending to or receiving from the Immigration and Naturalization Service information regarding the immigration status, lawful or unlawful, of an alien in the United States.”

14 RCW 43.17.420(7); Laws of 2020 ch. 37 § 2(7).

15 U.S. Const., amend. X.

16 *United States v. California*, 921 F.3d 865, 889 (9th Cir. 2019), *petition for cert. filed*, 2019 WL 5448580 (U.S. Oct. 22, 2019) (No. 19-532) (stating under the Tenth Amendment anti-commandeering rule that “Congress cannot issue direct orders to state legislatures” or put into its service the police of all 50 states, and that states are permitted to refuse to adopt preferred federal policies) (internal quotations omitted).

17 *New York v. United States*, 505 U.S. 144, 188 (1992) (federal statutory requirement that States enact legislation providing for the disposal of their radioactive waste invalid).

18 *Printz v. United States*, 521 U.S. 898, 935 (1997) (Brady Handgun Violence Prevention Act’s requirement that state and local law enforcement officers perform background checks on prospective firearm purchasers invalid). *See also New York*, 505 U.S. at 903-04.

19 *California*, 921 F.3d at 891.

20 *Id.*

21 *Id.* at 890.

Additionally, Section 1373 only restricts agencies from prohibiting their staff to share or receive information about what a person's citizenship or immigration status is with federal immigration authorities,²² and KWW does not conflict with that prohibition. Rather, KWW's provisions are expressly subject to requirements under federal law.²³

B. Federal Immigration Authority "Sensitive Location" Policies

In 2011 and 2013, respectively, ICE and CBP each issued policies (DHS policies) limiting immigration enforcement activity at or around "sensitive" locations," including health facilities.²⁴ Under these DHS policies, ICE and CBP must avoid enforcement activities at health facilities²⁵ and other "sensitive locations" unless a specific set of prerequisites are met. Thus, enforcement activities by ICE and CBP may only take place when (1) an officer has received prior approval from an appropriate level supervisory director or (2) "exigent circumstances" exist such that immediate action is required. Exigent circumstances exist when:

- the enforcement action involves a national security or terrorism matter;
- there is imminent risk of death, violence, or physical harm to a person or property;
- enforcement action involves the immediate arrest or pursuit of a dangerous felon, terrorist suspect, or other individual posing an imminent danger to public safety; or
- there is an imminent risk of destruction of evidence material to an ongoing criminal case.²⁶

Given these DHS policies, enforcement actions by federal immigration authorities at Washington health facilities should generally be limited. However, health facilities should be mindful that these policies are not binding legal requirements and therefore can be amended or revoked at any time.²⁷ Additionally, the DHS policies only cover immigration enforcement actions, including arrests, interviews, searches, and surveillance of individuals for immigration enforcement purposes by ICE and CBP. They expressly do not include efforts by these agencies to obtain records, documents, or similar materials; providing notice to officials or employees; serving subpoenas; or participating in official functions or community meetings.²⁸ Therefore, the AGO's model policies may be more protective than these DHS policies.

22 *Id.* at 892.

23 Construction—2019 c 440, Conflict with federal requirements—2019 c 440 in RCW 43.17.425.

24 See Morton, ICE, Enforcement Actions at or Focused on Sensitive Locations, Oct. 24, 2011, available online at <https://www.ice.gov/doclib/ero-outreach/pdf/10029.2-policy.pdf> (last visited May 18, 2020) and in Appendix E; ICE, FAQs on Sensitive Locations and Courthouse Arrests, available online at <https://www.ice.gov/ero/enforcement/sensitive-loc> (last visited May 18, 2020); CBP, U.S. Customs and Border Protection Enforcement Actions at or Near Certain Community Locations, Jan. 18, 2013, available online at https://foiarr.cbp.gov/docs/Policies_and_Procedures/2013/826326181_1251/1302211111_CBP_Enforcement_Actions_at_or_Near_Certain_Community_Locations_%7BSigned_M.pdf (last visited May 18, 2020) and in Appendix F;.

25 Both policies address enforcement activities at "hospitals," which would include health facilities as defined in KWW and this guidance.

26 The ICE guidance further provides that when officers proceed with an enforcement action under exigent circumstances, they "must conduct themselves as discretely as possible, consistent with officer and public safety, and make every effort to limit the time at or focused on the sensitive location."

27 In light of this, some counties have already established guides for public health sites, like King County. King County's 2017 Guidance for Public Health Site Staff is in Appendix G.

28 CBP's policy does not apply to agency operations conducted at or near the international border or that bear a "nexus" to the border.

C. Compliance with HIPAA and Washington State Health Care Laws

Adoption of the model policies must be done in consideration of compliance with the federal and state requirements to protect patients' health information from disclosure. The model policies in this publication are meant to compliment those requirements. All Washington health facilities are required to comply with HIPAA, which protects use and disclosure of PHI.²⁹

Washington State laws also protect PHI from disclosure. Initially, the Washington Constitution includes a right not to be disturbed in one's "private affairs"³⁰ and several state statutes specifically govern release of patient information.³¹ The Washington State Uniform Health Care Information Act (HCIA),³² the primary state law protecting PHI, directs health care providers, facilities, patients, insurance providers, and others regarding access to medical records.³³ Like HIPAA, the HCIA applies to healthcare providers, health insurers, and individuals or businesses they contract with that have access to medical information.³⁴ Finally, unlike HIPAA, the HCIA provides an individual private right of action.³⁵

Under these provisions, Washington health facilities have no affirmative obligation to inquire into a patient's immigration or citizenship status. Indeed, both HIPAA and Washington State laws protect PHI from disclosure, unless a specific exception applies.³⁶ Although immigration and citizenship status are not specifically included within the definition of PHI under HIPAA or HCIA, both laws protect information that "identifies or can readily be associated with the identity" of a patient.³⁷ Such information can include a person's name, address, date of birth, or social security number.³⁸ Information pertaining to a patient's immigration or citizenship status should therefore also be considered a protected identifier if included as part of a record of medical care.

D. Collection of Immigration and Citizenship Status Information to Determine Eligibility for Public Benefits

Although publicly operated health facilities have no general obligation to inquire into a patient's immigration or citizenship status, such information may be used to determine eligibility for certain public health benefits. This includes benefits provided under the Affordable Care Act (ACA), and Medicaid and Medicare laws.

- 29 HIPAA defines "protected health information" as individually identifiable health information transmitted or maintained by a covered entity or its business associates in any form or medium. 45 C.F.R. 160.103. The definition exempts a small number of categories of individually identifiable health information, such as individually identifiable health information found in employment records held by a covered entity in its role as an employer.
- 30 Wash. Const., art. I, § 7.
- 31 Where state law related to privacy of health information is stricter than HIPAA, health facilities must adhere to state law. *Youngs v. Peacehealth*, 179 Wn.2d 645, 665 n.9 (2014) (stating while HIPAA generally supersedes contrary state law, it does not do so where the state law relates to privacy of individually identifiable health information) (citing 42 U.S.C. § 1320d-7(a)(2)(B)).
- 32 Chapter 70.02 RCW.
- 33 The HCIA applies to "health care information," defined as "any information, whether oral or recorded in any form or medium, that identifies or can readily be associated with the identity of a patient and directly relates to the patient's health care, including a patient's deoxyribonucleic acid and identified sequence of chemical base pairs." RCW 70.02.010 (19), (44).
- 34 RCW 70.02.170.
- 35 45 C.F.R. § 160.103.
- 37 RCW 70.02.010(17); 45 C.F.R. § 160.103.
- 38 Guidance Regarding Methods for De-identification of Protected Health Information in Accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, available online at <https://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html#protected> (last visited April 8, 2020); 45 C.F.R. §§ 160.103, 164.514 (b)(2)(I)(R) (listing as items to be removed to ensure deidentification "[a]ny other unique identifying number, characteristic, or code [...]").

For example, the Washington Health Care Authority (HCA) is required under federal law to verify citizenship or immigration status for almost all individuals who apply for Apple Health, the state-run Medicaid program that provides health coverage for individuals under certain income levels. Some immigrant residents qualify only after five years of residence in Washington, including lawful permanent residents.³⁹ Others are exempt from the five year bar, including those admitted to the U.S. as a refugee or those granted asylum.⁴⁰ If qualified, these immigrants, like any other beneficiary, must meet certain eligibility requirements, such as income limits and Washington residency. Adults with certain immigration status and children (without regard to immigration status) may qualify for full Apple Health coverage. Undocumented adults or certain individuals who have not yet met the 5-year immigration bar may currently qualify for a more limited range of services (emergencies and pregnancy-related) under the Alien Emergency Medical (AEM) program.⁴¹

The HCA is required to report certain data that it collects, including demographic information and immigration status, to the federal government. The information, however, cannot be used for immigration enforcement purposes.⁴² If a health facility assists someone in applying for Apple Health, the facility may become aware of an individual's immigration status. However, pursuant to KWW, Washington health facilities should not otherwise ask for information regarding immigration or citizenship status.⁴³

Similarly, individuals must provide information regarding their immigration status to determine their eligibility for the Children's Health Insurance Program (CHIP).⁴⁴ Individuals applying for benefits under the Hospital Presumptive Eligibility (HPE) program, administered in Washington by the HCA, must also attest to meeting citizenship and state residency requirements.⁴⁵

The ACA also requires individuals applying for insurance coverage through the Washington Health Benefits Exchange to provide information about their immigration status.⁴⁶ The individual must be lawfully present in the United States to purchase coverage or to be eligible for certain healthcare subsidies. Applicants who attest to eligibility based on immigration status, rather than citizenship, must provide their social security numbers (if applicable) and "such identifying information with respect to the enrollee's immigration status as

39 WAC 182-503-0535.

40 *Id.*

41 Washington State Health Care Authority, Noncitizens, available online at <https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/non-citizens> (last visited May 18, 2020). The Apple Health Care Eligibility Overview Program Manual is in Appendix H. A toolkit from the American Academy of Pediatrics regarding treatment and resources available for immigrant children is also available in Appendix I.

42 Washington Healthplanfinder, Immigrants, available online at <https://www.wahealthplanfinder.org/content/immigrants.html> (last visited May 18, 2020).

43 RCW 43.17.425(a).

44 See Overview of Immigrants' Eligibility for SNAP, TANF, MEDICAID, and CHIP, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services, available online at <https://aspe.hhs.gov/basic-report/overview-immigrants-eligibility-snap-tanf-medicaid-and-chip> (last visited May 18, 2020).

45 See Washington State Health Care Authority, Overview of Hospital Presumptive Eligibility in Washington, available online at https://www.hca.wa.gov/assets/free-or-low-cost/HPE_Overview_12-367.pdf (last visited May 18, 2020).

46 42 U.S.C. § 18081(b)(2).

the Secretary [of Health and Human Services], after consultation with the Secretary of Homeland Security, determines appropriate.”⁴⁷ The Washington Healthplanfinder, which administers the program, collects information regarding immigration status of only the individual applying for coverage, and not of family members unless they are also applying for coverage. Additionally, personal information provided by applicants is used only to confirm eligibility for the program.⁴⁸

E. Emergency Medical Services for Immigrants

The Emergency Medical Treatment and Labor Act,⁴⁹ requires health facilities that have emergency rooms and receive Medicare funds to ensure public access to emergency services regardless of immigration or citizenship status, or ability to pay. The facility must screen the patient to determine if an emergency medical condition exists and, if it does, stabilize the condition or transfer the patient to a hospital better equipped to stabilize the condition. Facilities with specialized capabilities must also accept transfer patients if they have the capacity.

In addition, Washington’s Charity Care statute, requires health facilities to provide charity care, defined as “necessary hospital health care rendered to indigent persons, to the extent that the persons are unable to pay for the care[.]”⁵⁰ Whether an individual qualifies as an “indigent person” is based on income and ability to pay amounts required by a third-party payor; immigration and citizenship status are not referenced.⁵¹ The state Department of Health (DOH) reviews health facilities’ charity care policies for approval and does not approve policies that exclude care to otherwise eligible patients on the basis of legal residency or visa status.

F. The “Public Charge” Rule

“Public charge” is a term in immigration law referring to a person who has or is likely to use certain government benefits or assistance programs for a certain amount of time.⁵² If immigration officials deem a person a public charge, they may deny an immigration application or re-entry petition or designate the person for deportation.⁵³ While immigration officials consider whether a person is a public charge to evaluate applications for lawful permanent residency (green cards) or admission to the United States, they do not consider public charge to evaluate green card renewals or citizenship or naturalization applications. Nor do they consider public charge for individuals applying for or who have already applied for Temporary Protected Status (TPS) (for those who cannot return to their country of origin due to ongoing armed conflict, natural disaster or other extraordinary reason), including U or T visas (for certain survivors of crime or human trafficking), asylum or refugee status, or Special Immigrant Juvenile Status (SIJS) (for minors who have been abused, abandoned, or neglected).⁵⁴ The public charge considerations include the “totality of circumstances,” including a person’s income, age, education or skills (including English language skills), health, affidavits of support or contracts from a person’s sponsor in addition to whether they have used public programs.⁵⁵

47 42 U.S.C. § 18081(a)(2)(B).

48 Washington Health Plan Finder, U.S. Citizens and Lawfully Present Immigrants are Eligible for Coverage, available online at https://www.wahealthplanfinder.org/_content/immigrants.html (last visited May 18, 2020).

49 42 U.S.C. § 1395dd.

50 RCW 70.170.020(4).

51 WAC 246-453.

52 8 C.F.R. § 212.21 (a)-(c).

53 8 C.F.R. § 212.22.

54 8 U.S.C. § 1182 (a)(4)(E).

55 8 C.F.R. § 212.22; *see In re Perez*, 15 I. & N. Dec. 136, 137 (B.I.A. 1974) (citing Foreign Affairs Manual, Part III, Vol. 9, Note 1 to 22 CFR § 42.91(a)(15)); *see also* Adjustment of Status for Certain Aliens, 53 Fed. Reg. 43986-01, 43996 (1988) (in making public charge determination, financial responsibility of immigrant based on

In August of 2019, DHS published a new rule expanding the definition of public charge. Under this expanded definition, immigration officials will now consider if a person has used Federal Public Housing and Section 8 Assistance, Apple Health/Medicaid (except for emergency services, Apple Health for kids under 21, and services for pregnant women and new mothers), Supplemental Nutritional Assistance Programs (SNAP) including Electronic Benefits Transfer (EBT) or Food Stamps, Cash Assistance Programs (such as Supplemental Security Income [SSI], Temporary Assistance for Needy Families [TANF], or other general assistance), or long-term care in facilities like nursing homes at government expense.⁵⁶ Other services, like the nutrition program for Women, Infants and Children (WIC), CHIP, school lunches, food banks, shelters, state or local health care programs are not considered as part of the public charge evaluation.⁵⁷

“totality of the alien’s circumstances” at the time of application), *codified at* 8 C.F.R. § 245a.3(g)(4)(i); U.S. Dep’t of Justice, Final Rule: Adjustment of Status for Certain Aliens, 54 Fed. Reg. 29442-01 (July 12, 1989), *codified in relevant part at* 8 C.F.R. §§ 245a.2(k)(4), 245a.3(g)(4)(iii), 245a.4(b)(1)(iv)(C) (financial responsibility determined based on “totality of the alien’s circumstances” at the time of application).

56 8 C.F.R. § 212.21(b).

57 See Public Charge Fact Sheet, *supra* n. 39; Changes to Public Charge, Protecting Immigrant Families, available online at https://docs.google.com/document/d/1zHLRaciDqIZfkI_icRGVJWKWcinP6cAwvkuAeac8eog/edit (last visited May 18, 2020).

PART V: TRAINING RECOMMENDATIONS & BEST PRACTICES GUIDANCE

Under Washington law, Washington health facilities have a responsibility to provide safe and secure access to health care, regardless of immigration status. In addition to the model policies mandated by KWW, this section provides recommendations and proactive approaches health facilities may use (or in some cases, that health facilities are already using), to increase access for all members of the community.

A. Training for Health Facility Personnel

The AGO recommends that Washington health facility personnel be fully trained to understand and carry out the model policies and practices adopted by their respective facilities. At a minimum, training should be required for senior administrators, security personnel, personnel working at public information and help stations, including public-facing nurses in specific departments, and those responsible for maintaining medical records and other protected health information. Such training is particularly important for the frontline staff responsible for answering patients' and their visitors' questions regarding the policies maintained by the facility. To the extent that health facilities have already developed and/or adopted curricula equal to or greater than those outlined below, this guidance is not intended to displace those efforts. Instead, these training areas reflect a baseline of information that relevant health facility personnel should have in order to adequately implement the model policies within this guide. Each facility may wish to include additional topics.

1. Responding to Immigration Enforcement Activities

Training in responding to and documenting immigration enforcement activity at Washington health facilities is a priority. Certain facility personnel must also be prepared to determine the appropriate response for any request for disclosure of patient information, including personnel's ability to communicate as emerging incidents occur and assistance is needed. Health facility personnel should develop working knowledge of the different types of documents that may be presented for the purpose of immigration enforcement. In particular, training programs should educate health facility personnel on the following:

- a. The ability to determine the appropriate response for any potential request for information, including personnel's ability to communicate with the appropriate [health facility designee, counsel] authority as emerging incidents occur and as assistance is needed;
- b. The ability to identify all nonpublic, restricted locations within the health facility property, as well as who may access those restricted locations;
- c. The ability to differentiate between administrative warrants and judicial warrants signed by a judge or magistrate judge;
- d. The ability to differentiate between administrative and judicial subpoenas;
- e. The procedure for responding to any warrant, subpoena, or order issued in connection with immigration enforcement activities; and

- f. The procedure for documenting any immigration enforcement activity, inquiry, or incident within the health facility.

2. Identification of Federal Documents

Without expressing consent, health facility personnel should respond to requests for personal information according to the requirements set forth in the presented documentation. If the presented document is:

- a. Civil immigration warrant: Personnel should refer the official and provide the document to their designated facility administrator as soon as possible.
- b. Administrative request: An administrative request is issued by a federal or state agency or law enforcement official, rather than a court of law. Such requests include administrative subpoenas or summons signed by someone other than a judge or magistrate. Personnel should forward these requests to their designated health facility administrator.
- c. A judicial warrant or court order: Immediate compliance is usually required, but, where feasible, personnel should consult with their security personnel and designated facility administrator.
- d. A subpoena for production of records or other items: Personnel should refer the requestor and provide the document to their designated facility administrator as soon as possible.
- e. A notice to appear: This document is likely not directed at the health facility. Health facility personnel are under no obligation to deliver or facilitate service of this document to those receiving care from the facility. Personnel should provide a copy of the notice to the designated facility administrator as soon as possible.

B. Fostering a Welcoming Environment within the Health Facility

To ensure patients feel confident that they will receive the health care services that they need, regardless of their immigration or citizenship status, it is critical for facilities to create a welcoming environment. Health facilities already provide patients with information regarding their privacy policies, which explain how their personal information will be used, who will see that information, and where to file a complaint if those rights have been violated. Health facilities should include in these explanations their policies specific to releasing immigration or citizenship status, or place of birth. Health facilities should also develop written materials and post signage within the property that welcomes community members to access the full range of the facility's services. Such materials could include:

- “All are Welcome” signs to remind patients that the facility is open to everyone in the community, regardless of immigration or citizenship status;
- Educational information, such as “Know Your Rights” pamphlets and related materials, including the right to access health care and public benefit programs, without fear of immigration enforcement activity; and
- Documents outlining the facility's information-sharing policies.

Meeting Washington residents' diverse languages needs is also critical to ensure equal access to healthcare and full access to services within health facilities. Health facilities should provide access to privacy notices in multiple languages to reach those whose primary languages are not English. To the extent possible, health facilities should translate all materials and programs in multiple languages. Finally, health facilities should be prepared with interpreter resources in order to communicate with their clients. Since KWW specifically discourages the use of federal immigration authorities for language services, health facility personnel should know what resources are available to them should it become necessary on short notice.

**PART VI:
APPENDIX**

Appendixes begin on next page.

CERTIFICATION OF ENROLLMENT

ENGROSSED SECOND SUBSTITUTE SENATE BILL 5497

Chapter 440, Laws of 2019

66th Legislature
2019 Regular Session

IMMIGRANTS--STATEWIDE POLICY

EFFECTIVE DATE: May 21, 2019

Passed by the Senate April 24, 2019
Yeas 27 Nays 21

CYRUS HABIB

President of the Senate

Passed by the House April 12, 2019
Yeas 57 Nays 38

FRANK CHOPP

Speaker of the House of Representatives

Approved May 21, 2019 1:39 PM

JAY INSLEE

Governor of the State of Washington

CERTIFICATE

I, Brad Hendrickson, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **ENGROSSED SECOND SUBSTITUTE SENATE BILL 5497** as passed by the Senate and the House of Representatives on the dates hereon set forth.

BRAD HENDRICKSON

Secretary

FILED

May 21, 2019

**Secretary of State
State of Washington**

ENGROSSED SECOND SUBSTITUTE SENATE BILL 5497

AS AMENDED BY THE HOUSE

Passed Legislature - 2019 Regular Session

State of Washington 66th Legislature 2019 Regular Session

By Senate Ways & Means (originally sponsored by Senators Wellman, Nguyen, Hasegawa, Kuderer, Frockt, Das, Keiser, Saldaña, Mullet, McCoy, Randall, Cleveland, Hunt, Lias, Conway, and Darneille)

READ FIRST TIME 03/01/19.

1 AN ACT Relating to establishing a statewide policy supporting
2 Washington state's economy and immigrants' role in the workplace;
3 adding new sections to chapter 43.17 RCW; adding a new section to
4 chapter 43.330 RCW; adding a new section to chapter 43.10 RCW; adding
5 a new section to chapter 10.93 RCW; creating new sections; repealing
6 RCW 10.70.140 and 10.70.150; and declaring an emergency.

7 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

8 NEW SECTION. **Sec. 1.** (1) The legislature finds that Washington
9 state has a thriving economy that spans both east and west, and
10 encompasses agriculture, food processing, timber, construction,
11 health care, technology, and the hospitality industries.

12 (2) The legislature also finds that Washington employers rely on
13 a diverse workforce to ensure the economic vitality of the state.
14 Nearly one million Washingtonians are immigrants, which is one out of
15 every seven people in the state. Immigrants make up over sixteen
16 percent of the workforce. In addition, fifteen percent of all
17 business owners in the state were born outside the country, and these
18 business owners have a large impact on the economy through innovation
19 and the creation of jobs. Immigrants make a significant contribution
20 to the economic vitality of this state, and it is essential that the

1 state have policies that recognize their importance to Washington's
2 economy.

3 (3) In recognition of this significant contribution to the
4 overall prosperity and strength of Washington state, the legislature,
5 therefore, has a substantial and compelling interest in ensuring the
6 state of Washington remains a place where the rights and dignity of
7 all residents are maintained and protected in order to keep
8 Washington working.

9 NEW SECTION. **Sec. 2.** A new section is added to chapter 43.17
10 RCW to read as follows:

11 The definitions in this section apply throughout this section and
12 sections 3 through 9 of this act unless the context clearly requires
13 otherwise.

14 (1) "Civil immigration warrant" means any warrant for a violation
15 of federal civil immigration law issued by a federal immigration
16 authority. A "civil immigration warrant" includes, but is not limited
17 to, administrative warrants issued on forms I-200 or I-203, or their
18 successors, and civil immigration warrants entered in the national
19 crime information center database.

20 (2) "Court order" means a directive issued by a judge or
21 magistrate under the authority of Article III of the United States
22 Constitution or Article IV of the Washington Constitution. A "court
23 order" includes but is not limited to warrants and subpoenas.

24 (3) "Federal immigration authority" means any officer, employee,
25 or person otherwise paid by or acting as an agent of the United
26 States department of homeland security including but not limited to
27 its subagencies, immigration and customs enforcement and customs and
28 border protection, and any present or future divisions thereof,
29 charged with immigration enforcement.

30 (4) "Health facility" has the same meaning as the term "health
31 care facility" provided in RCW 70.175.020, and includes substance
32 abuse treatment facilities.

33 (5) "Hold request" or "immigration detainer request" means a
34 request from a federal immigration authority, without a court order,
35 that a state or local law enforcement agency maintain custody of an
36 individual currently in its custody beyond the time he or she would
37 otherwise be eligible for release in order to facilitate transfer to
38 a federal immigration authority. A "hold request" or "immigration
39 detainer request" includes, but is not limited to, department of

1 homeland security form I-247A or prior or subsequent versions of form
2 I-247.

3 (6) "Immigration detention agreement" means any contract,
4 agreement, intergovernmental service agreement, or memorandum of
5 understanding that permits a state or local law enforcement agency to
6 house or detain individuals for federal civil immigration violations.

7 (7) "Immigration or citizenship status" means as such status has
8 been established to such individual under the immigration and
9 nationality act.

10 (8) "Language services" includes but is not limited to
11 translation, interpretation, training, or classes. Translation means
12 written communication from one language to another while preserving
13 the intent and essential meaning of the original text. Interpretation
14 means transfer of an oral communication from one language to another.

15 (9) "Local government" means any governmental entity other than
16 the state, federal agencies, or an operating system established under
17 chapter 43.52 RCW. It includes, but is not limited to, cities,
18 counties, school districts, and special purpose districts.

19 (10) "Local law enforcement agency" means any agency of a city,
20 county, special district, or other political subdivision of the state
21 that is a general authority Washington law enforcement agency, as
22 defined by RCW 10.93.020, or that is authorized to operate jails or
23 to maintain custody of individuals in jails; or to operate juvenile
24 detention facilities or to maintain custody of individuals in
25 juvenile detention facilities; or to monitor compliance with
26 probation or parole conditions.

27 (11) "Notification request" means a request from a federal
28 immigration authority that a state or local law enforcement agency
29 inform a federal immigration authority of the release date and time
30 in advance of the release of an individual in its custody.
31 "Notification request" includes, but is not limited to, the
32 department of homeland security's form I-247A, form I-247N, or prior
33 or subsequent versions of such forms.

34 (12) "Physical custody of the department of corrections" means
35 only those individuals detained in a state correctional facility but
36 does not include minors detained pursuant to chapter 13.40 RCW, or
37 individuals in community custody as defined in RCW 9.94A.030.

38 (13) "Public schools" means all public elementary and secondary
39 schools under the jurisdiction of local governing boards or a charter

1 school board and all institutions of higher education as defined in
2 RCW 28B.10.016.

3 (14) "School resource officer" means a commissioned law
4 enforcement officer in the state of Washington with sworn authority
5 to uphold the law and assigned by the employing police department or
6 sheriff's office to work in schools to ensure school safety. By
7 building relationships with students, school resource officers work
8 alongside school administrators and staff to help students make good
9 choices. School resource officers are encouraged to focus on keeping
10 students out of the criminal justice system when possible and not
11 impose criminal sanctions in matters that are more appropriately
12 handled within the educational system.

13 (15) "State agency" has the same meaning as provided in RCW
14 42.56.010.

15 (16) "State law enforcement agency" means any agency of the state
16 of Washington that:

17 (a) Is a general authority Washington law enforcement agency as
18 defined by RCW 10.93.020;

19 (b) Is authorized to operate prisons or to maintain custody of
20 individuals in prisons; or

21 (c) Is authorized to operate juvenile detention facilities or to
22 maintain custody of individuals in juvenile detention facilities.

23 NEW SECTION. **Sec. 3.** A new section is added to chapter 43.330
24 RCW to read as follows:

25 (1) A keep Washington working statewide work group is established
26 within the department. The work group must:

27 (a) Develop strategies with private sector businesses, labor, and
28 immigrant advocacy organizations to support current and future
29 industries across the state;

30 (b) Conduct research on methods to strengthen career pathways for
31 immigrants and create and enhance partnerships with projected growth
32 industries;

33 (c) Support business and agriculture leadership, civic groups,
34 government, and immigrant advocacy organizations in a statewide
35 effort to provide predictability and stability to the workforce in
36 the agriculture industry; and

37 (d) Recommend approaches to improve Washington's ability to
38 attract and retain immigrant business owners that provide new
39 business and trade opportunities.

1 (2) The work group must consist of eleven representatives, each
2 serving a term of three years, representing members from
3 geographically diverse immigrant advocacy groups, professional
4 associations representing business, labor organizations with a
5 statewide presence, agriculture and immigrant legal interests, faith-
6 based community nonprofit organizations, legal advocacy groups
7 focusing on immigration and criminal justice, academic institutions,
8 and law enforcement. The terms of the members must be staggered.
9 Members of the work group must select a chair from among the
10 membership. The work group must meet at least four times a year and
11 hold meetings in various locations throughout the state. Following
12 each meeting, the work group must report on its status, including
13 meeting minutes and a meeting summary to the department. The
14 department must provide a report to the legislature annually.

15 (3) In addition to the duties and powers described in RCW
16 43.330.040, it is the director's duty to provide support to the work
17 group.

18 (4) The definitions in section 2 of this act apply to this
19 section.

20 NEW SECTION. **Sec. 4.** A new section is added to chapter 43.10
21 RCW to read as follows:

22 (1) The attorney general, in consultation with appropriate
23 stakeholders, must publish model policies within twelve months after
24 the effective date of this section for limiting immigration
25 enforcement to the fullest extent possible consistent with federal
26 and state law at public schools, health facilities operated by the
27 state or a political subdivision of the state, courthouses, and
28 shelters, to ensure they remain safe and accessible to all Washington
29 residents, regardless of immigration or citizenship status.

30 (2) All public schools, health facilities either operated by the
31 state or a political subdivision of the state, and courthouses must:

32 (a) Adopt necessary changes to policies consistent with the model
33 policy; or

34 (b) Notify the attorney general that the agency is not adopting
35 the changes to its policies consistent with the model policy, state
36 the reasons that the agency is not adopting the changes, and provide
37 the attorney general with a copy of the agency's policies.

1 (3) All other organizations and entities that provide services
2 related to physical or mental health and wellness, education, or
3 access to justice, are encouraged to adopt the model policy.

4 (4) Implementation of any policy under this section must be in
5 accordance with state and federal law; policies, grants, waivers, or
6 other requirements necessary to maintain funding; or other agreements
7 related to the operation and functions of the organization, including
8 databases within the organization.

9 (5) The definitions in section 2 of this act apply to this
10 section.

11 NEW SECTION. **Sec. 5.** A new section is added to chapter 43.17
12 RCW to read as follows:

13 (1) Except as provided in subsection (3) of this section, no
14 state agency, including law enforcement, may use agency funds,
15 facilities, property, equipment, or personnel to investigate,
16 enforce, cooperate with, or assist in the investigation or
17 enforcement of any federal registration or surveillance programs or
18 any other laws, rules, or policies that target Washington residents
19 solely on the basis of race, religion, immigration, or citizenship
20 status, or national or ethnic origin. This subsection does not apply
21 to any program with the primary purpose of providing persons with
22 services or benefits, or to RCW 9.94A.685.

23 (2) Except as provided in subsection (3) of this section, the
24 state agencies listed in subsections (5) and (6) of this section
25 shall review their policies and identify and make any changes
26 necessary to ensure that:

27 (a) Information collected from individuals is limited to the
28 minimum necessary to comply with subsection (3) of this section;

29 (b) Information collected from individuals is not disclosed
30 except as necessary to comply with subsection (3) of this section or
31 as permitted by state or federal law;

32 (c) Agency employees may not condition services or request
33 information or proof regarding a person's immigration status,
34 citizenship status, or place of birth; and

35 (d) Public services are available to, and agency employees shall
36 serve, all Washington residents without regard to immigration or
37 citizenship status.

38 (3) Nothing in subsection (1) or (2) of this section prohibits
39 the collection, use, or disclosure of information that is:

- 1 (a) Required to comply with state or federal law;
2 (b) In response to a lawfully issued court order;
3 (c) Necessary to perform agency duties, functions, or other
4 business, as permitted by statute or rule, conducted by the agency
5 that is not related to immigration enforcement;
6 (d) Required to comply with policies, grants, waivers, or other
7 requirements necessary to maintain funding; or
8 (e) In the form of deidentified or aggregated data, including
9 census data.

10 (4) Any changes to agency policies required by this section must
11 be made as expeditiously as possible, consistent with agency
12 procedures. Final policies must be published.

13 (5) The following state agencies shall begin implementation of
14 this section within twelve months after the effective date of this
15 section and demonstrate full compliance by December 1, 2021:

- 16 (a) Department of licensing;
17 (b) Department of labor and industries;
18 (c) Employment security department;
19 (d) Department of revenue;
20 (e) Department of health;
21 (f) Health care authority;
22 (g) Department of social and health services;
23 (h) Department of children, youth, and families;
24 (i) Office of the superintendent of public instruction;
25 (j) State patrol.

26 (6) The following state agencies may begin implementation of this
27 section by December 1, 2021, and must demonstrate full compliance by
28 December 1, 2023:

- 29 (a) Department of agriculture;
30 (b) Department of financial institutions;
31 (c) Department of fish and wildlife;
32 (d) Department of natural resources;
33 (e) Department of retirement systems;
34 (f) Department of services for the blind;
35 (g) Department of transportation.

36 NEW SECTION. **Sec. 6.** A new section is added to chapter 10.93
37 RCW to read as follows:

38 (1) The definitions contained in section 2 of this act apply to
39 this section.

1 (2) The legislature finds that it is not the primary purpose of
2 state and local law enforcement agencies or school resource officers
3 to enforce civil federal immigration law. The legislature further
4 finds that the immigration status of an individual or an individual's
5 presence in, entry, or reentry to, or employment in the United States
6 alone, is not a matter for police action, and that United States
7 federal immigration authority has primary jurisdiction for
8 enforcement of the provisions of Title 8 U.S.C. dealing with illegal
9 entry.

10 (3) School resource officers, when acting in their official
11 capacity as a school resource officer, may not:

12 (a) Inquire into or collect information about an individual's
13 immigration or citizenship status, or place of birth; or

14 (b) Provide information pursuant to notification requests from
15 federal immigration authorities for the purposes of civil immigration
16 enforcement, except as required by law.

17 (4) State and local law enforcement agencies may not:

18 (a) Inquire into or collect information about an individual's
19 immigration or citizenship status, or place of birth unless there is
20 a connection between such information and an investigation into a
21 violation of state or local criminal law; or

22 (b) Provide information pursuant to notification requests from
23 federal immigration authorities for the purposes of civil immigration
24 enforcement, except as required by law.

25 (5) State and local law enforcement agencies may not provide
26 nonpublicly available personal information about an individual,
27 including individuals subject to community custody pursuant to RCW
28 9.94A.701 and 9.94A.702, to federal immigration authorities in a
29 noncriminal matter, except as required by state or federal law.

30 (6)(a) State and local law enforcement agencies may not give
31 federal immigration authorities access to interview individuals about
32 a noncriminal matter while they are in custody, except as required by
33 state or federal law, a court order, or by (b) of this subsection.

34 (b) Permission may be granted to a federal immigration authority
35 to conduct an interview regarding federal immigration violations with
36 a person who is in the custody of a state or local law enforcement
37 agency if the person consents in writing to be interviewed. In order
38 to obtain consent, agency staff shall provide the person with an oral
39 explanation and a written consent form that explains the purpose of
40 the interview, that the interview is voluntary, and that the person

1 may decline to be interviewed or may choose to be interviewed only
2 with the person's attorney present. The form must state explicitly
3 that the person will not be punished or suffer retaliation for
4 declining to be interviewed. The form must be available at least in
5 English and Spanish and explained orally to a person who is unable to
6 read the form, using, when necessary, an interpreter from the
7 district communications center "language line" or other district
8 resources.

9 (7) An individual may not be detained solely for the purpose of
10 determining immigration status.

11 (8) An individual must not be taken into custody, or held in
12 custody, solely for the purposes of determining immigration status or
13 based solely on a civil immigration warrant, or an immigration hold
14 request.

15 (9) (a) To ensure compliance with all treaty obligations,
16 including consular notification, and state and federal laws, on the
17 commitment or detainment of any individual, state and local law
18 enforcement agencies must explain in writing:

19 (i) The individual's right to refuse to disclose their
20 nationality, citizenship, or immigration status; and

21 (ii) That disclosure of their nationality, citizenship, or
22 immigration status may result in civil or criminal immigration
23 enforcement, including removal from the United States.

24 (b) Nothing in this subsection allows for any violation of
25 subsection (4) of this section.

26 (10) A state and local government or law enforcement agency may
27 not deny services, benefits, privileges, or opportunities to
28 individuals in custody, or under community custody pursuant to RCW
29 9.94A.701 and 9.94A.702, or in probation status, on the basis of the
30 presence of an immigration detainer, hold, notification request, or
31 civil immigration warrant, except as required by law or as necessary
32 for classification or placement purposes for individuals in the
33 physical custody of the department of corrections.

34 (11) No state or local law enforcement officer may enter into any
35 contract, agreement, or arrangement, whether written or oral, that
36 would grant federal civil immigration enforcement authority or powers
37 to state and local law enforcement officers, including but not
38 limited to agreements created under 8 U.S.C. Sec. 1357(g), also known
39 as 287(g) agreements.

1 (12) (a) No state agency or local government or law enforcement
2 officer may enter into an immigration detention agreement. All
3 immigration detention agreements must be terminated no later than one
4 hundred eighty days after the effective date of this section, except
5 as provided in (b) of this subsection.

6 (b) Any immigration detention agreement in effect prior to
7 January 1, 2019, and under which a payment was made between July 1,
8 2017, and December 31, 2018, may remain in effect until the date of
9 completion or December 31, 2021, whichever is earlier.

10 (13) No state or local law enforcement agency or school resource
11 officer may enter into or renew a contract for the provision of
12 language services from federal immigration authorities, nor may any
13 language services be accepted from such for free or otherwise.

14 (14) The department of corrections may not give federal
15 immigration authorities access to interview individuals about federal
16 immigration violations while they are in custody, except as required
17 by state or federal law or by court order, unless such individuals
18 consent to be interviewed in writing. Before agreeing to be
19 interviewed, individuals must be advised that they will not be
20 punished or suffer retaliation for declining to be interviewed.

21 (15) Subsections (3) through (6) of this section do not apply to
22 individuals who are in the physical custody of the department of
23 corrections.

24 (16) Nothing in this section prohibits the collection, use, or
25 disclosure of information that is:

26 (a) Required to comply with state or federal law; or

27 (b) In response to a lawfully issued court order.

28 NEW SECTION. **Sec. 7.** To ensure state and law enforcement
29 agencies are able to foster the community trust necessary to maintain
30 public safety, within twelve months of the effective date of this
31 section, the attorney general must, in consultation with appropriate
32 stakeholders, publish model policies, guidance, and training
33 recommendations consistent with this act and state and local law,
34 aimed at ensuring that state and local law enforcement duties are
35 carried out in a manner that limits, to the fullest extent
36 practicable and consistent with federal and state law, engagement
37 with federal immigration authorities for the purpose of immigration
38 enforcement. All state and local law enforcement agencies must
39 either:

- 1 (1) Adopt policies consistent with that guidance; or
 2 (2) Notify the attorney general that the agency is not adopting
 3 the guidance and model policies, state the reasons that the agency is
 4 not adopting the model policies and guidance, and provide the
 5 attorney general with a copy of the agency's policies to ensure
 6 compliance with this act.

7 NEW SECTION. **Sec. 8.** No section of this act is intended to
 8 limit or prohibit any state or local agency or officer from:

- 9 (1) Sending to, or receiving from, federal immigration
 10 authorities the citizenship or immigration status of a person, or
 11 maintaining such information, or exchanging the citizenship or
 12 immigration status of an individual with any other federal, state, or
 13 local government agency, in accordance with 8 U.S.C. Sec. 1373; or
 14 (2) Complying with any other state or federal law.

15 NEW SECTION. **Sec. 9.** If any part of this act is found to be in
 16 conflict with federal requirements that are a prescribed condition to
 17 the allocation of federal funds to the state, the conflicting part of
 18 this act is inoperative solely to the extent of the conflict and with
 19 respect to the agencies directly affected, and this finding does not
 20 affect the operation of the remainder of this act in its application
 21 to the agencies concerned. Rules adopted under this act must meet
 22 federal requirements that are a necessary condition to the receipt of
 23 federal funds by the state.

24 NEW SECTION. **Sec. 10.** The following acts or parts of acts are
 25 each repealed:

- 26 (1) RCW 10.70.140 (Aliens committed—Notice to immigration
 27 authority) and 1992 c 7 s 29 & 1925 ex.s. c 169 s 1; and
 28 (2) RCW 10.70.150 (Aliens committed—Copies of clerk's records)
 29 and 1925 ex.s. c 169 s 2.

30 NEW SECTION. **Sec. 11.** If specific funding for the purposes of
 31 this act, referencing this act by bill or chapter number, is not
 32 provided by June 30, 2019, in the omnibus appropriations act, this
 33 act is null and void.

34 NEW SECTION. **Sec. 12.** This act is necessary for the immediate
 35 preservation of the public peace, health, or safety, or support of

1 the state government and its existing public institutions, and takes
2 effect immediately.

Passed by the Senate April 24, 2019.

Passed by the House April 12, 2019.

Approved by the Governor May 21, 2019.

Filed in Office of Secretary of State May 21, 2019.

--- END ---

U.S. DEPARTMENT OF HOMELAND SECURITY

Warrant for Arrest of Alien

File No. _____

Date: _____

To: Any immigration officer authorized pursuant to sections 236 and 287 of the Immigration and Nationality Act and part 287 of title 8, Code of Federal Regulations, to serve warrants of arrest for immigration violations

I have determined that there is probable cause to believe that _____ is removable from the United States. This determination is based upon:

- the execution of a charging document to initiate removal proceedings against the subject;
- the pendency of ongoing removal proceedings against the subject;
- the failure to establish admissibility subsequent to deferred inspection;
- biometric confirmation of the subject's identity and a records check of federal databases that affirmatively indicate, by themselves or in addition to other reliable information, that the subject either lacks immigration status or notwithstanding such status is removable under U.S. immigration law; and/or
- statements made voluntarily by the subject to an immigration officer and/or other reliable evidence that affirmatively indicate the subject either lacks immigration status or notwithstanding such status is removable under U.S. immigration law.

YOU ARE COMMANDED to arrest and take into custody for removal proceedings under the Immigration and Nationality Act, the above-named alien.

(Signature of Authorized Immigration Officer)

(Printed Name and Title of Authorized Immigration Officer)

Certificate of Service

I hereby certify that the Warrant for Arrest of Alien was served by me at _____
(Location)

on _____ on _____, and the contents of this
(Name of Alien) (Date of Service)

notice were read to him or her in the _____ language.
(Language)

Name and Signature of Officer

Name or Number of Interpreter (if applicable)

DEPARTMENT OF HOMELAND SECURITY
U.S. Immigration and Customs Enforcement

WARRANT OF REMOVAL/DEPORTATION

File No: _____

Date: _____

To any immigration officer of the United States Department of Homeland Security:

(Full name of alien)

who entered the United States at _____ on _____
(Place of entry) (Date of entry)

is subject to removal/deportation from the United States, based upon a final order by:

- an immigration judge in exclusion, deportation, or removal proceedings
 a designated official
 the Board of Immigration Appeals
 a United States District or Magistrate Court Judge

and pursuant to the following provisions of the Immigration and Nationality Act:

I, the undersigned officer of the United States, by virtue of the power and authority vested in the Secretary of Homeland Security under the laws of the United States and by his or her direction, command you to take into custody and remove from the United States the above-named alien, pursuant to law, at the expense of:

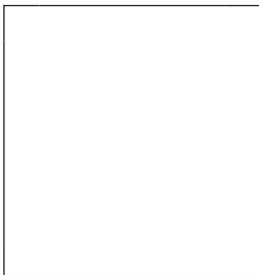
(Signature of immigration officer)

(Title of immigration officer)

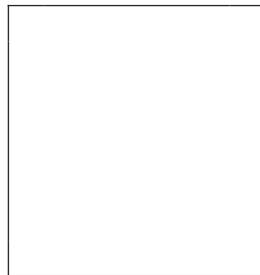
(Date and office location)

To be completed by immigration officer executing the warrant: Name of alien being removed:

Port, date, and manner of removal: _____



Photograph of alien removed



Right index fingerprint of alien removed

(Signature of alien being fingerprinted)

(Signature and title of immigration officer taking print)

Departure witnessed by: _____
(Signature and title of immigration officer)

If actual departure is not witnessed, fully identify source or means of verification of departure:

If self-removal (self-deportation), pursuant to 8 CFR 241.7, check here.

Departure Verified by: _____
(Signature and title of immigration officer)

DEPARTMENT OF HOMELAND SECURITY
IMMIGRATION DETAINER - NOTICE OF ACTION

Subject ID:
Event #:

File No:
Date:

TO: (Name and Title of Institution - OR Any Subsequent Law Enforcement Agency)

FROM: (Department of Homeland Security Office Address)

MAINTAIN CUSTODY OF ALIEN FOR A PERIOD NOT TO EXCEED 48 HOURS

Name of Alien: _____

Date of Birth: _____ Nationality: _____ Sex: _____

THE U.S. DEPARTMENT OF HOMELAND SECURITY (DHS) HAS TAKEN THE FOLLOWING ACTION RELATED TO THE PERSON IDENTIFIED ABOVE, CURRENTLY IN YOUR CUSTODY:

- Determined that there is reason to believe the individual is an alien subject to removal from the United States. The individual (*check all that apply*):
- has a prior a felony conviction or has been charged with a felony offense;
 - has three or more prior misdemeanor convictions;
 - has a prior misdemeanor conviction or has been charged with a misdemeanor for an offense that involves violence, threats, or assaults; sexual abuse or exploitation; driving under the influence of alcohol or a controlled substance; unlawful flight from the scene of an accident; the unlawful possession or use of a firearm or other deadly weapon, the distribution or trafficking of a controlled substance; or other significant threat to public safety;
 - has been convicted of illegal entry pursuant to 8 U.S.C. § 1325;
 - has illegally re-entered the country after a previous removal or return;
 - has been found by an immigration officer or an immigration judge to have knowingly committed immigration fraud;
 - otherwise poses a significant risk to national security, border security, or public safety; and/or
 - other (specify): _____.
- Initiated removal proceedings and served a Notice to Appear or other charging document. A copy of the charging document is attached and was served on _____ (date).
- Served a warrant of arrest for removal proceedings. A copy of the warrant is attached and was served on _____ (date).
- Obtained an order of deportation or removal from the United States for this person.

This action does not limit your discretion to make decisions related to this person's custody classification, work, quarter assignments, or other matters. DHS discourages dismissing criminal charges based on the existence of a detainer.

IT IS REQUESTED THAT YOU:

- Maintain custody of the subject for a period **NOT TO EXCEED 48 HOURS**, excluding Saturdays, Sundays, and holidays, beyond the time when the subject would have otherwise been released from your custody to allow DHS to take custody of the subject. This request derives from federal regulation 8 C.F.R. § 287.7. For purposes of this immigration detainer, **you are not authorized to hold the subject beyond these 48 hours**. As early as possible prior to the time you otherwise would release the subject, please notify DHS by calling _____ during business hours or _____ after hours or in an emergency. If you cannot reach a DHS Official at these numbers, please contact the ICE Law Enforcement Support Center in Burlington, Vermont at: (802) 872-6020.
- Provide a copy to the subject of this detainer.
- Notify this office of the time of release at least 30 days prior to release or as far in advance as possible.
- Notify this office in the event of the inmate's death, hospitalization or transfer to another institution.
- Consider this request for a detainer operative only upon the subject's conviction.
- Cancel the detainer previously placed by this Office on _____ (date).

(Name and title of Immigration Officer)

(Signature of Immigration Officer)

TO BE COMPLETED BY THE LAW ENFORCEMENT AGENCY CURRENTLY HOLDING THE SUBJECT OF THIS NOTICE:

Please provide the information below, sign, and return to DHS using the envelope enclosed for your convenience or by faxing a copy to _____. You should maintain a copy for your own records so you may track the case and not hold the subject beyond the 48-hour period.

Local Booking/Inmate #: _____ Latest criminal charge/conviction: _____ (date) Estimated release: _____ (date)

Last criminal charge/conviction: _____

Notice: Once in our custody, the subject of this detainer may be removed from the United States. If the individual may be the victim of a crime, or if you want this individual to remain in the United States for prosecution or other law enforcement purposes, including acting as a witness, please notify the ICE Law Enforcement Support Center at (802) 872-6020.

(Name and title of Officer)

(Signature of Officer)

NOTICE TO THE DETAINEE

The Department of Homeland Security (DHS) has placed an immigration detainer on you. An immigration detainer is a notice from DHS informing law enforcement agencies that DHS intends to assume custody of you after you otherwise would be released from custody. DHS has requested that the law enforcement agency which is currently detaining you maintain custody of you for a period not to exceed 48 hours (excluding Saturdays, Sundays, and holidays) beyond the time when you would have been released by the state or local law enforcement authorities based on your criminal charges or convictions. **If DHS does not take you into custody during that additional 48 hour period, not counting weekends or holidays, you should contact your custodian** (the law enforcement agency or other entity that is holding you now) to inquire about your release from state or local custody. **If you have a complaint regarding this detainer or related to violations of civil rights or civil liberties connected to DHS activities, please contact the ICE Joint Intake Center at 1-877-2INTAKE (877-246-8253). If you believe you are a United States citizen or the victim of a crime, please advise DHS by calling the ICE Law Enforcement Support Center toll free at (855) 448-6903.**

NOTIFICACIÓN A LA PERSONA DETENIDA

El Departamento de Seguridad Nacional (DHS) de EE. UU. ha emitido una orden de detención migratoria en su contra. Mediante esta orden, se notifica a los organismos policiales que el DHS pretende arrestarlo cuando usted cumpla su reclusión actual. El DHS ha solicitado que el organismo policial local o estatal a cargo de su actual detención lo mantenga en custodia por un período no mayor a 48 horas (excluyendo sábados, domingos y días festivos) tras el cese de su reclusión penal. **Si el DHS no procede con su arresto migratorio durante este período adicional de 48 horas, excluyendo los fines de semana o días festivos, usted debe comunicarse con la autoridad estatal o local que lo tiene detenido** (el organismo policial u otra entidad a cargo de su custodia actual) para obtener mayores detalles sobre el cese de su reclusión. **Si tiene alguna queja que se relacione con esta orden de detención o con posibles infracciones a los derechos o libertades civiles en conexión con las actividades del DHS, comuníquese con el Joint Intake Center (Centro de Admisión) del ICE (Servicio de Inmigración y Control de Aduanas) llamando al 1-877-2INTAKE (877-246-8253). Si usted cree que es ciudadano de los Estados Unidos o que ha sido víctima de un delito, infórmele al DHS llamando al Centro de Apoyo a los Organismos Policiales (Law Enforcement Support Center) del ICE, teléfono (855) 448-6903 (llamada gratuita).**

Avis au détenu

Le département de la Sécurité Intérieure [Department of Homeland Security (DHS)] a émis, à votre rencontre, un ordre d'incarcération pour des raisons d'immigration. Un ordre d'incarcération pour des raisons d'immigration est un avis du DHS informant les agences des forces de l'ordre que le DHS a l'intention de vous détenir après la date normale de votre remise en liberté. Le DHS a requis que l'agence des forces de l'ordre, qui vous détient actuellement, vous garde en détention pour une période maximum de 48 heures (excluant les samedis, dimanches et jours fériés) au-delà de la période à la fin de laquelle vous auriez été remis en liberté par les autorités policières de l'État ou locales en fonction des inculpations ou condamnations pénales à votre rencontre. **Si le DHS ne vous détient pas durant cette période supplémentaire de 48 heures, sans compter les fins de semaines et les jours fériés, vous devez contacter votre gardien** (l'agence des forces de l'ordre qui vous détient actuellement) pour vous renseigner à propos de votre libération par l'État ou l'autorité locale. **Si vous avez une plainte à formuler au sujet de cet ordre d'incarcération ou en rapport avec des violations de vos droits civils liées à des activités du DHS, veuillez contacter le centre commun d'admissions du Service de l'Immigration et des Douanes [ICE - Immigration and Customs Enforcement] [ICE Joint Intake Center] au 1-877-2INTAKE (877-246-8253). Si vous croyez être un citoyen des États-Unis ou la victime d'un crime, veuillez en aviser le DHS en appelant le centre d'assistance des forces de l'ordre de l'ICE [ICE Law Enforcement Support Center] au numéro gratuit (855) 448-6903.**

AVISO AO DETENTO

O Departamento de Segurança Nacional (DHS) emitiu uma ordem de custódia imigratória em seu nome. Este documento é um aviso enviado às agências de imposição da lei de que o DHS pretende assumir a custódia da sua pessoa, caso seja liberado. O DHS pediu que a agência de imposição da lei encarregada da sua atual detenção mantenha-o sob custódia durante, no máximo, 48 horas (excluindo-se sábados, domingos e feriados) após o período em que seria liberado pelas autoridades estaduais ou municipais de imposição da lei, de acordo com as respectivas acusações e penas criminais. **Se o DHS não assumir a sua custódia durante essas 48 horas adicionais, excluindo-se os fins de semana e feriados, você deverá entrar em contato com o seu custodiante** (a agência de imposição da lei ou qualquer outra entidade que esteja detendo-o no momento) para obter informações sobre sua liberação da custódia estadual ou municipal. **Caso você tenha alguma reclamação a fazer sobre esta ordem de custódia imigratória ou relacionada a violações dos seus direitos ou liberdades civis decorrente das atividades do DHS, entre em contato com o Centro de Entrada Conjunta da Agência de Controle de Imigração e Alfândega (ICE) pelo telefone 1-877-246-8253. Se você acreditar que é um cidadão dos EUA ou está sendo vítima de um crime, informe o DHS ligando para o Centro de Apoio à Imposição da Lei do ICE pelo telefone de ligação gratuita (855) 448-6903**

THÔNG BÁO CHO NGƯỜI BỊ GIAM GIỮ

Bộ Quốc Phòng (DHS) đã có lệnh giam giữ quý vị vì lý do di trú. Lệnh giam giữ vì lý do di trú là thông báo của DHS cho các cơ quan thi hành luật pháp là DHS có ý định tạm giữ quý vị sau khi quý vị được thả. DHS đã yêu cầu cơ quan thi hành luật pháp hiện đang giữ quý vị phải tiếp tục tạm giữ quý vị trong không quá 48 giờ đồng hồ (không kể thứ Bảy, Chủ nhật, và các ngày nghỉ lễ) ngoài thời gian mà lẽ ra quý vị sẽ được cơ quan thi hành luật pháp của tiểu bang hoặc địa phương thả ra dựa trên các bản án và tội hình sự của quý vị. **Nếu DHS không tạm giam quý vị trong thời gian 48 giờ bổ sung đó, không tính các ngày cuối tuần hoặc ngày lễ, quý vị nên liên lạc với bên giam giữ quý vị** (cơ quan thi hành luật pháp hoặc tổ chức khác hiện đang giam giữ quý vị) để hỏi về việc cơ quan địa phương hoặc liên bang thả quý vị ra. **Nếu quý vị có khiếu nại về lệnh giam giữ này hoặc liên quan tới các trường hợp vi phạm dân quyền hoặc tự do công dân liên quan tới các hoạt động của DHS, vui lòng liên lạc với ICE Joint Intake Center tại số 1-877-2INTAKE (877-246-8253). Nếu quý vị tin rằng quý vị là công dân Hoa Kỳ hoặc nạn nhân tội phạm, vui lòng báo cho DHS biết bằng cách gọi ICE Law Enforcement Support Center tại số điện thoại miễn phí (855) 448-6903.**

对被拘留者的通告

美国国土安全部 (DHS) 已发出对你的移民监禁令。移民监禁令是美国国土安全部用来通告执法当局, 表示美国国土安全部意图在你可能从当前的拘留被释放以后继续拘留你的通知单。美国国土安全部已经向当前拘留你的执法当局要求, 根据对你的刑事起诉或判罪的基础, 在本当由州或地方执法当局释放你时, 继续拘留你, 为期不超过 48 小时 (星期六、星期天和假日除外)。如果美国国土安全部未在不计周末或假日的额外 48 小时期限内将你拘留, 你应该联系你的监管单位 (现在拘留你的执法当局或其他单位), 询问关于你从州或地方执法单位被释放的事宜。如果你对于这项拘留或关于美国国土安全部的行动所涉及的违反民权或公民自由权有任何投诉, 请联系美国移民及海关执法局联合接纳中心 (ICE Joint Intake Center), 电话号码是 1-877-2INTAKE (877-246-8253)。如果你相信你是美国公民或犯罪被害人, 请联系美国移民及海关执法局的执法支援中心 (ICE Law Enforcement Support Center), 告知美国国土安全部。该执法支援中心的免费电话号码是 (855) 448-6903。

Policy Number: 10029.2
FEA Number: 306-112-002b

Office of the Director

U.S. Department of Homeland Security
500 12th Street, SW
Washington, D.C. 20536

OCT 24 2011



U.S. Immigration
and Customs
Enforcement

MEMORANDUM FOR: Field Office Directors
Special Agents in Charge
Chief Counsel

FROM: John Morton 
Director

SUBJECT: Enforcement Actions at or Focused on Sensitive Locations

Purpose

This memorandum sets forth Immigration and Customs Enforcement (ICE) policy regarding certain enforcement actions by ICE officers and agents at or focused on sensitive locations. This policy is designed to ensure that these enforcement actions do not occur at nor are focused on sensitive locations such as schools and churches unless (a) exigent circumstances exist, (b) other law enforcement actions have led officers to a sensitive location as described in the "Exceptions to the General Rule" section of this policy memorandum, or (c) prior approval is obtained. This policy supersedes all prior agency policy on this subject.¹

Definitions

The enforcement actions covered by this policy are (1) arrests; (2) interviews; (3) searches; and (4) for purposes of immigration enforcement only, surveillance. Actions not covered by this policy include actions such as obtaining records, documents and similar materials from officials or employees, providing notice to officials or employees, serving subpoenas, engaging in Student and Exchange Visitor Program (SEVP) compliance and certification visits, or participating in official functions or community meetings.

The sensitive locations covered by this policy include, but are not limited to, the following:

¹ Memorandum from Julie L. Myers, Assistant Secretary, U.S. Immigration and Customs Enforcement, "Field Guidance on Enforcement Actions or Investigative Activities At or Near Sensitive Community Locations" 10029.1 (July 3, 2008); Memorandum from Marcy M. Forman, Director, Office of Investigations, "Enforcement Actions at Schools" (December 26, 2007); Memorandum from James A. Puleo, Immigration and Naturalization Service (INS) Acting Associate Commissioner, "Enforcement Activities at Schools, Places of Worship, or at funerals or other religious ceremonies" HQ 807-P (May 17, 1993). This policy does not supersede the requirements regarding arrests at sensitive locations put forth in the Violence Against Women Act, see Memorandum from John P. Torres, Director Office of Detention and Removal Operations and Marcy M. Forman, Director, Office of Investigations, "Interim Guidance Relating to Officer Procedure Following Enactment of VAWA 2005 (January 22, 2007).

Enforcement Actions at or Focused on Sensitive Locations

Page 2

- schools (including pre-schools, primary schools, secondary schools, post-secondary schools up to and including colleges and universities, and other institutions of learning such as vocational or trade schools);
- hospitals;
- churches, synagogues, mosques or other institutions of worship, such as buildings rented for the purpose of religious services;
- the site of a funeral, wedding, or other public religious ceremony; and
- a site during the occurrence of a public demonstration, such as a march, rally or parade.

This is not an exclusive list, and ICE officers and agents shall consult with their supervisors if the location of a planned enforcement operation could reasonably be viewed as being at or near a sensitive location. Supervisors should take extra care when assessing whether a planned enforcement action could reasonably be viewed as causing significant disruption to the normal operations of the sensitive location. ICE employees should also exercise caution. For example, particular care should be exercised with any organization assisting children, pregnant women, victims of crime or abuse, or individuals with significant mental or physical disabilities.

Agency Policy

General Rule

Any planned enforcement action at or focused on a sensitive location covered by this policy must have prior approval of one of the following officials: the Assistant Director of Operations, Homeland Security Investigations (HSI); the Executive Associate Director (EAD) of HSI; the Assistant Director for Field Operations, Enforcement and Removal Operations (ERO); or the EAD of ERO. This includes planned enforcement actions at or focused on a sensitive location which is part of a joint case led by another law enforcement agency. ICE will give special consideration to requests for enforcement actions at or near sensitive locations if the only known address of a target is at or near a sensitive location (e.g., a target's only known address is next to a church or across the street from a school).

Exceptions to the General Rule

This policy is meant to ensure that ICE officers and agents exercise sound judgment when enforcing federal law at or focused on sensitive locations and make substantial efforts to avoid unnecessarily alarming local communities. The policy is not intended to categorically prohibit lawful enforcement operations when there is an immediate need for enforcement action as outlined below. ICE officers and agents may carry out an enforcement action covered by this policy without prior approval from headquarters when one of the following exigent circumstances exists:

- the enforcement action involves a national security or terrorism matter;
- there is an imminent risk of death, violence, or physical harm to any person or property;

Enforcement Actions at or Focused on Sensitive Locations

Page 3

- the enforcement action involves the immediate arrest or pursuit of a dangerous felon, terrorist suspect, or any other individual(s) that present an imminent danger to public safety; or
- there is an imminent risk of destruction of evidence material to an ongoing criminal case.

When proceeding with an enforcement action under these extraordinary circumstances, officers and agents must conduct themselves as discretely as possible, consistent with officer and public safety, and make every effort to limit the time at or focused on the sensitive location.

If, in the course of a planned or unplanned enforcement action that is not initiated at or focused on a sensitive location, ICE officers or agents are subsequently led to or near a sensitive location, barring an exigent need for an enforcement action, as provided above, such officers or agents must conduct themselves in a discrete manner, maintain surveillance if no threat to officer safety exists and immediately consult their supervisor prior to taking other enforcement action(s).

Dissemination

Each Field Office Director, Special Agent in Charge, and Chief Counsel shall ensure that the employees under his or her supervision receive a copy of this policy and adhere to its provisions.

Training

Each Field Office Director, Special Agent in Charge, and Chief Counsel shall ensure that the employees under his or her supervision are trained (both online and in-person/classroom) annually on enforcement actions at or focused on sensitive locations.

No Private Right of Action

Nothing in this memorandum is intended to and may not be relied upon to create any right or benefit, substantive or procedural, enforceable at law by any party in any administrative, civil, or criminal matter.

This memorandum provides management guidance to ICE officers exercising discretionary law enforcement functions, and does not affect the statutory authority of ICE officers and agents, nor is it intended to condone violations of federal law at sensitive locations.

1300 Pennsylvania Avenue, NW
Washington, DC 20229



**U.S. Customs and
Border Protection**

Deputy Commissioner

JAN 18 2013

MEMORANDUM FOR: See Distribution

FROM: David V. Aguilar 
Deputy Commissioner

SUBJECT: U.S. Customs and Border Protection Enforcement Actions at or
Near Certain Community Locations

The presence of U.S. Customs and Border Protection (CBP) Officers and Agents conducting enforcement activities at or near schools, places of worship, and certain other community locations has been a sensitive issue. Accordingly, careful consideration and planning must be undertaken, as outlined herein, in relation to enforcement actions conducted at or near these establishments.

The following establishments should be considered to be within the context of this policy:

- schools, including pre-schools, primary schools, secondary schools, post-secondary schools, vocational or trade schools, and colleges and universities;
- places of worship, including places where funerals, weddings, or other public religious ceremonies are taking place;
- community centers; and
- hospitals.

CBP personnel should consult their supervisors for guidance when an enforcement action is being contemplated or planned at or near a location not specifically listed above but that may be similar in nature, description, or function. In assessing the appropriateness of a proposed action, supervisors should consider alternative measures that could achieve the enforcement objective without causing significant disruption to the normal activities or operations at the identified location, including the importance of the enforcement objective in furthering CBP's mission.

When CBP enforcement actions or investigative activities are likely to lead to an apprehension at or near such locations, written approval by the Chief Patrol Agent, Director of Field Operations, Director of Air and Marine Operations or the Internal Affairs Special Agent in Charge is required. The Deputy to these offices may approve the inspection of records, preliminary investigative activities, and similar activities at these locations where apprehensions are not likely to be made.

This policy does not summarily preclude enforcement actions at the listed locations. When situations arise that call for enforcement actions at or near the above-mentioned establishments without prior written approval, Agents and Officers are expected to exercise sound judgment and

U.S. Customs and Border Protection Enforcement Action at or
Near Certain Community Locations

Page 2

common sense while taking appropriate action. Exigent circumstances, including matters related to national security, terrorism, or public safety, requiring an Agent or Officer to enter these establishments, must be reported immediately through the respective chain of command, as applicable.

This policy does not limit or otherwise apply to CBP operations that are conducted at or near the international border (including the functional equivalent of the border), or CBP operations that bear nexus to the border including, for example, but not limited to smuggling interdiction efforts that result in transportation to a hospital, custodial monitoring of injured aliens in CBP custody that require hospitalization, or a controlled delivery from the border that concludes in close proximity of one of the aforementioned locations.

This CBP policy guidance memorandum, which may be modified, superseded, or rescinded by CBP at any time without notice, is not intended to, does not, and may not be relied upon to create, any right or benefit, substantive or procedural, for any party.

Distribution: Assistant Commissioner, Office of Air and Marine
Assistant Commissioner, Office of Field Operations
Assistant Commissioner, Office of Internal Affairs
Chief, Office of Border Patrol
Chief Counsel

If federal immigration agents visit a Public Health site

Guidance for Managers, Supervisors, and other “Designated Leads”

June 2017



King County

Preface

All people should feel safe receiving the health services that they need. Unfortunately, the current levels of fear and stress among immigrant communities may be negatively impacting the willingness of some immigrant families to seek services. For many years, immigrants have arrived in King County looking for a better future: setting down roots, opening businesses, and helping with our vital economic growth. To remain that beacon of opportunity, we must ensure that immigrants have access to vital health, legal, and social services.

King County is providing tools to our employees, and to our health care clients, to ensure that immigrants can access health services without fear, while also remaining in compliance with federal laws.

The King County Office of Equity and Social Justice and Public Health—Seattle & King County worked together to create these materials.



King County²

Is it possible immigration agents might visit our clinics?

While there is a low likelihood that an enforcement action could occur at a health clinic – there have been reports nationally of immigration agents presence at health center parking lots and of agents arresting people near health clinics.

Federal Immigration & Customs Enforcement (ICE) agents have policies limiting when they may enter “sensitive locations” such as health facilities – but the rules do not forbid entry.

King County is training our employees to be prepared in case of a visit from immigration agents.

- The two keys to preparation: Designate “private areas,” and designate managers/supervisors to be leads



King County³

Overview

- Public Health department policy identifies Public Health Centers and clinics as “**private areas**” – only open to those who are authorized or seeking services provided at these facilities.
- Employees are **not** required to answer questions or provide information to immigration agents. Each site will identify “Designated Leads” to respond to agents, as described in the following pages.
- **Agents may not enter Public Health Centers and clinics (i.e. private areas) unless/until** the Designated Lead determines there is a valid warrant signed by a judge.
- All other employees should refer immigration agents to the Designated Leads.
- Front Desk/Reception staff are the most likely points of contact.
- Our employees are stewards & guardians of patient privacy.



What to say & do

- Once alerted by front desk or other staff, Designated Lead should say:
 - This is a sensitive health facility and King County does not permit unauthorized individuals, including law enforcement, to enter the facility without a signed judicial warrant.
- If the agents claim to have a warrant, Designated Lead must ask to see the warrant.
- The Designated Lead must determine if it is a signed judicial warrant, as opposed to an administrative arrest warrant issued by ICE or other agencies.

(see following slides for next steps)



What to say & do (continued)

If the immigration agents **do not have a judicial warrant** signed by a judge:

- Designated Lead should say:
 - Without a signed judicial warrant, I am not authorized to grant you access to the facility.
 - Please leave the facility and grounds so that there is minimal disruption to Public Health's mission to ensure access to health services.
- Ask for the agents' names and cards. Contact the Risk Manager in the Compliance Office to let them know, and immediately fax a copy of the warrant and/or business card to them.

[Risk Manager Terry McGuire: 206-263-8246; or Compliance hotline: 206-205-6191; full contact info on last page]



What to say & do (continued)

If the immigration agents have a **valid judicial warrant** signed by a judge:

- Designated Lead **must grant access** to the facility sufficient to detain the person identified in the warrant.
- **Work with agents to minimize disruption** and trauma for all patients and staff. Some examples for Designated Lead to consider:
 - May advise all to remain inside service delivery rooms with the doors closed before providing access to immigration agents.
 - May request all patients in waiting areas to temporarily leave the facility.
 - May arrange for the agents to meet with the person to be detained in a private area or room.
- Ask for agents' names and cards. Contact the Risk Manager in the Compliance Office to let them know, and immediately fax a copy of the warrant to Compliance. [*Risk Manager Terry McGuire: 206-263-8246, or Compliance hotline: 206-205-6191; full contact info on last page*].



What is a valid “judicial warrant”?

A judicial search warrant (if signed by a judge or magistrate within the past fourteen days) grants access to search for the listed items or persons.

Note that immigration agents sometimes have “administrative” arrest warrants (signed by an immigration agent, not a judge) -- but these do NOT grant them permission to enter areas that are not open to the public, even if the person named in the administrative warrant is inside of the building.

- *see samples of warrants on next slide/page*



Sample Warrants

This is a signed Judicial Warrant.

- It is issued by a US District Court.
- It was signed by a Judge or Magistrate
- The “on or before” date (circled in red) should be current

UNITED STATES DISTRICT COURT

for the
Eastern District of California

In the Matter of the Search of)
(Briefly describe the property to be searched)
or identify the person by name and address)) Case No.
540 Oak Avenue)
Davis, California 95616)

SEARCH AND SEIZURE WARRANT

To: Any authorized law enforcement officer **2:11-SW-0161 EFB**

An application by a federal law enforcement officer or an attorney for the government requests the search of the following person or property located in the EASTERN District of CALIFORNIA
(Identify the person or describe the property to be searched and give its location):
SEE ATTACHMENT A, ATTACHED HERETO AND INCORPORATED BY REFERENCE

The person or property to be searched, described above, is believed to conceal (Identify the person or describe the property to be seized):
SEE ATTACHMENT B, ATTACHED HERETO AND INCORPORATED BY REFERENCE

I find that the affidavit(s), or any recorded testimony, establish probable cause to search and seize the person or property.

YOU ARE COMMANDED to execute this warrant on or before **5-9-2011**
(not to exceed 14 days)

in the daytime 6:00 a.m. to 10 p.m. at any time in the day or night as I find reasonable cause has been established.

Unless delayed notice is authorized below, you must give a copy of the warrant and a receipt for the property taken to the person from whom, or from whose premises, the property was taken, or leave the copy and receipt at the place where the property was taken.

The officer executing this warrant, or an officer present during the execution of the warrant, must prepare an inventory as required by law and promptly return this warrant and inventory to United States Magistrate Judge

(name)

I find that immediate notification may have an adverse result listed in 18 U.S.C. § 2705 (except for delay of trial), and authorize the officer executing this warrant to delay notice to the person who, or whose property, will be searched or seized (check the appropriate box) for _____ days (not to exceed 30).

until, the facts justify, the later specific date of _____.

Date and time issued: **4-25-2011**
at 10:00 AM

City and state: **SACRAMENTO, CALIFORNIA**

EDMUND F. BRENNAN, U.S. MAGISTRATE JUDGE
Printed name and title

Sample Warrants

This is an Administrative Warrant.

- It is issued by the US Dept of Justice – NOT by a Court.
- It also is NOT signed by a Judge or Magistrate

U.S. Department of Justice
 Immigration and Naturalization Service

Warrant of Removal/Deportation
 File No: _____
 Date: _____

To any officer of the United States Immigration and Naturalization Service:

_____ (Full name of alien)

who entered the United States at _____ (Place of entry) on _____ (Date of entry)

is subject to removal/deportation from the United States, based upon a final order by:

an Immigration judge in exclusion, deportation, or removal proceedings
 a district director or a district director's designated official
 the Board of Immigration Appeals
 a United States District or Magistrate Court Judge

and pursuant to the following provisions of the Immigration and Nationality Act:
 Section 241(a)(5) of the Immigration and Nationality Act(Act), as amended.

I, the undersigned officer of the United States, by virtue of the power and authority vested in the Attorney General under the laws of the United States and by his or her direction, command you to take into custody and remove from the United States the above-named alien, pursuant to law, at the expense of the appropriation. "Salaries and Expenses Immigration and Naturalization Service 2002," including the expense of an attendant if necessary.

_____ (Signature of INS official)
 _____ (Title of INS official)
 _____ (Date and office location)

Form I-205 (Rev. 4-1-97)N

Additional ways to be prepared

- Post signs that designate private vs. public areas
- Train front-desk staff using the guidance document for staff
- Make sure staff have reference guide posted at front desk
- Make available “know your rights” pamphlets in waiting areas and service delivery rooms.
- Under HIPAA, all personal health information is protected. If agents want to view patient information, they should present a court order or subpoena directly to the PH Compliance Office.
- Two things you cannot do: (1) Interfere or in any way restrict employees from communicating with agents. (2) Hide or conceal any person, or aid in their escape from the premises.



Background

ADDITIONAL INFORMATION

TO UNDERSTAND HOW TO PROTECT YOUR CLIENTS
AND STAFF



King County ¹²

Why we are concerned

Fear of Deportation Makes Communities Less Healthy



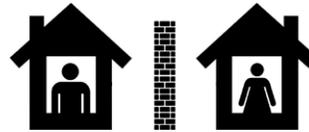
People are afraid to drive,



afraid to use parks and exercise outdoors,



afraid to use public services like clinics



and afraid to get involved in their communities.

This slide courtesy of



Why we are concerned

Fear of Deportation Makes Communities Less Safe

Deportation and the Threat of Deportation:

- **MAKE LAW ENFORCEMENT MORE DIFFICULT** - People who witness/are victims of a crime are less likely to report the crime or cooperate as witnesses if they fear deportation or questions about immigration status for themselves or someone they know.
- **MAKE VICTIMS OF VIOLENCE LESS LIKELY TO GO TO POLICE** - Domestic violence victims often remain with their abuser rather than risk being detained and/or deported when seeking protection from abuse
- **EXACERBATE MENTAL ILLNESS & INSTABILITY** - Documented and undocumented immigrants experience **exacerbated health conditions like stress, anxiety, and hopelessness** due to fears of deportation for themselves or members of their community.

This slide courtesy of



Why we are concerned



11,000,000

undocumented immigrants live in the US currently

4,500,000

US-citizen children live in families in which at least one person is undocumented

150,000+

US-citizen kids a year had a parent deported

This slide courtesy of



Why clinics are designated as “private areas”

- Immigration agents may freely enter into public areas without a warrant or consent to question people they believe to be undocumented. Your patients/clients are more exposed in public locations than in private areas.
- Public Health has adopted a policy establishing Public Health Centers and other Public Health facilities as private areas.
- Immigration agents’ ability to conduct a search is limited by the Fourth Amendment to the U.S. Constitution, which prohibits unreasonable searches and seizures. Whether a search is “reasonable” depends on whether there is a reasonable *expectation of privacy* for people in the area to be searched.
- In order to enter into Public Health’s designated private areas, immigration agents must have a signed judicial warrant.



The role of the Designated Lead

- Designate a specific person or persons as responsible for handling contacts with law enforcement officials. Train all other staff to inform immigration or other law enforcement officials that only a Designated Lead is authorized to review a warrant or to consent to their entry into Public Health facilities, and that they also may decline to answer any questions.
- Designated Lead will not allow immigration agents access to Public Health facilities unless the agents have a judicial search warrant (signed by a judge or magistrate within the past fourteen days) granting them that access to search for the listed items or people. Note that immigration agents sometimes have “administrative” arrest warrants (signed by an immigration agent) but these do NOT grant them permission to enter areas that are not open to the public, even if the person named in the administrative warrant is inside of the building.

See sample warrants and guidance on previous pages



King County

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Understand existing guidance

- Ensure availability of trained interpreters (*Public Health has phone interpreters available 24/7 at 206-535-2498*)
- Post ALL ARE WELCOME HERE signs in buildings and offices (posters available through King County ESJ office)
- Make available “know your rights” pamphlets. King County ESJ office will provide pamphlets (delivered to Public Health Centers via Kim Carmony).
- Train staff/partners to use language/narrative that supports undocumented populations and their families. Work to change a narrative that portrays undocumented people negatively (King County ESJ office can provide this).
- Learn about tools & resources on KC-ESJ webpage

<http://www.kingcounty.gov/elected/executive/equity-social-justice/Immigrant-and-Refugee/Tools-and-Resources.aspx>



Tips for encounters with immigration agents

- Don't give legal advice to clients.
- You may advise any clients who are nearby that they have the right to remain silent and do not have to answer any questions posed by immigration agents. Staff should be careful, however, not to *direct* clients not to speak to the agents as this might be interpreted as interference. If possible, clients should be moved to a private location of the facility until the situation has been resolved.
- Employees are not required to answer questions or provide information to immigration agents.
- Employees should not lie to immigration agents.
- Employees should not take any action to hide or conceal any person, or aid in their escape from the premises.



If you have further questions about King County's approach to immigrants, refugees and immigration enforcement, please contact:

Bookda Gheisar
Office of Equity and Social Justice
King County Executive Office
206-263-5736
bgheisar@kingcounty.gov

Public Health Compliance Office – Contact info

Risk Manager Terry McGuire: 206-263-8246
Terry.McGuire@kingcounty.gov
Compliance hotline: 206-205-6191
Compliance Fax: 206-205-3945





April 2020

Eligibility Overview

Washington Apple Health (Medicaid) Programs



WCA 22-315 (3/18)



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What is Washington Apple Health (Medicaid)?

Medicaid is the federally matched medical aid programs under Title XIX of the Social Security Act (and Title XXI of the Social Security Act for the Children's Health Insurance Plan) that covers the Categorically Needy (CN) and Medically Needy (MN) programs.

Washington Apple Health is an umbrella term or "brand name" for all Washington State medical assistance programs, including Medicaid. The brand name may be shortened to "Apple Health."

The Health Care Authority (HCA) administers most Washington Apple Health programs. (The Department of Social and Health Services administers the Classic Medicaid programs.)

Medicaid expansion: Building on compassion

The Patient Protection and Affordable Care Act (ACA), enacted by Congress in 2010, created an unrivaled opportunity for increasing health coverage. States had the option to expand eligibility for Medicaid and Washington State said yes.

Before Medicaid expansion, coverage was essentially limited to low-income children, people with

disabilities or devastating illnesses, and those whose incomes were far below the federal poverty level.

Today, Apple Health covers adults with incomes up to 138 percent of the federal poverty level. In April 2020 that translated to about \$17,609 for a single person or \$36,156 for a family of four.

For the first time, many low-income adults suffering from chronic conditions, such as diabetes, high blood pressure, asthma, and other diseases have better options than waiting until they are sick enough to go to the emergency room. People living on the edge financially don't have to choose between going to the doctor and paying the electric bill. And people used to doing without are able to get regular doctor visits, including preventive care.

More people served today

The number of people eligible for Apple Health increased significantly with higher income limits. Others who had previously qualified but not enrolled also obtained coverage. By 2020, nearly 600,000 new enrollees were receiving Apple Health for Adults coverage.



How to use this guide

This guide gives an overview of eligibility requirements for Washington Apple Health. It doesn't include every requirement or consider every situation that might arise. The explanation of Scope of Care on page 3 will be helpful in understanding the differences between the programs. Also, refer to the Definitions on page 16 if you are not familiar with some of the terms used in this guide.

Income levels, such as those based on Federal Poverty Level (FPL) and Cost of Living Adjustments (COLA), and specific program standards change yearly, but in different months. Please understand that, while the information in this publication is current at the time of publication, some of these standards will change before the next annual update. For the most current information, go to the Health Care Authority website www.hca.wa.gov/apple-health.





Scope of care

Scope of care describes which medical and health care services a particular Apple Health program covers. There are four categories of scope of care:

- **Categorically Needy (CN):** The broadest, most comprehensive scope of health care services covered.
- **Alternative Benefits Plan (ABP):** The same scope of care as CN, with the addition of habilitative services, applicable to the Apple Health for Adults program.
- **Medically Needy (MN):** This scope of care covers slightly fewer health care services than Categorically Needy. Medically Needy coverage is available to individuals who qualify for disability-based Apple Health, Apple Health for Long-Term Care, or Apple Health for Kids or Pregnant Women, except that their income and/or resources are above the applicable Apple Health program limits.
- **Medical Care Services (MCS):** This scope of care covers fewer health care services than Medically Needy. MCS is a state-funded medical program available to adults who are not eligible for Apple Health programs with CN, ABP, or MN scope of care and meet the eligibility criteria for either the Aged, Blind or Disabled–cash or the Housing Essential Needs (HEN) program.



Modified Adjusted Gross Income (MAGI) Programs

Adults

Adult Medical (N05):

Effective April 1, 2020	
Household Size	Monthly Income Limit
1	\$1,415
2	\$1,911
3	\$2,408
4	\$2,904
5	\$3,401
6	\$3,897

This program provides ABP coverage to adults with countable income at or below 133 percent of the FPL who are ages 19 up to 65, who are not incarcerated, and who are not entitled to Medicare.

Family Medical (N01):

Effective April 1, 2020	
Household Size	Monthly Income Limit
1	\$511
2	\$658
3	\$820
4	\$972
5	\$1,127
6	\$1,284

This program provides CN coverage to adults with countable income at or below the applicable Medicaid standard and who have dependent children living in their home who are under the age of 18.

Health Care Extension (N02):

This program provides CN coverage to individuals who lost eligibility for Family Medical because of an increase in their earned income after they received Family Medical coverage for at least 3 of the last 6 months. These individuals are eligible for up to 12 months extended CN medical benefits.

Pregnancy and Family Planning

Pregnancy Medical (N03, N23):

Effective April 1, 2020	
Household Size	Monthly Income Limit
1	N/A
2	\$2,773
3	\$3,494
4	\$4,214
5	\$4,935
6	\$5,655

This program provides CN coverage to pregnant women with countable income at or below 193 percent of the FPL without regard to citizenship or immigration status. Once enrolled in Apple Health for Pregnant Women, the individual is covered regardless of any change in income through the end of the month after the 60th day after the pregnancy end date (e.g., pregnancy ends June 10, health care coverage continues through August 31). Women receive this post-partum coverage regardless of how the pregnancy ends.

Women who apply for Pregnancy Medical after the baby's birth may not receive postpartum coverage, but they may qualify for help paying costs related to the baby's birth if they submit the application within three months after the month in which the child was born.

To determine the pregnant woman's family size, include the number of unborn children with the number of household members (e.g., a woman living alone and pregnant with twins is considered a three-person household).

Medically Needy Pregnant Women (P99):

This program provides MN coverage to pregnant women with income above 193 percent of the FPL. Individuals who qualify are eligible for MN coverage after incurring medical costs equal to the amount of the household income that is above the 193 percent FPL standard.

Family Planning Extension (P05):

This program provides family planning services only for 10 months after Pregnancy Medical ends. Women receive the Family Planning Extension automatically, regardless of how the pregnancy ends.

Family Planning Only (P06):

This program provides both men and women coverage for pre-pregnancy family planning services to help participants take charge of their lives and prevent unintended pregnancies.

Family Planning Only:

- Annual examination.
- Family planning education and risk reduction counseling.
- FDA-approved contraceptive methods including: birth control pills, IUDs, and emergency contraception.
- Over the counter contraceptive products, such as condoms, and contraceptive creams and foams.
- Sterilization procedures.

Clients access Family Planning Only services through local family planning clinics that participate in the program.

Find additional information at www.hca.wa.gov/family-planning.

Apple Health for Kids

Apple Health for Kids coverage is free to children in households with income at or below 210 percent of the FPL and available for a monthly premium to children in households with income at or below 312 percent of the FPL.

Effective April 1, 2020

Household Size	Monthly Income Limit 210% FPL (No Cost)	Monthly Income Limit 260% FPL (\$20 Premium/Child, \$40 Family Maximum)	Monthly Income Limit 312% FPL (\$30 Premium/Child, \$60 Family Maximum)
1	\$2,233	\$2,765	\$3,318
2	\$3,017	\$3,736	\$4,483
3	\$3,801	\$4,706	\$5,648
4	\$4,585	\$5,677	\$6,812
5	\$5,369	\$6,648	\$7,977
6	\$6,153	\$7,618	\$9,142

Apple Health for Newborns (N10):

This program provides 12 months of CN coverage if the mother was enrolled in an Apple Health program when the child was born. There is no resource or income limit for this program.

Apple Health for Kids (N11, N31):

This program provides CN coverage to children under age 19 whose families have income at or below 210 percent of the FPL. Children who would have been eligible for Apple Health for Kids had they met immigration status requirements receive CN coverage under state-funded Apple Health for Kids.

Apple Health for Kids with Premiums (N13, N33):

This program provides CN coverage to children under age 19 whose families have income above 210 percent and at or below 312 percent of the FPL. Participants pay a low-cost monthly premium.

Children who would have been eligible for Apple Health for Kids with Premiums had they met immigration status requirements receive CN coverage under state-funded Apple Health for Kids with Premiums.

Apple Health for Medically Needy Kids (F99):

This program provides MN coverage to children under age 19 whose families have income above 312 percent of the FPL. Children who qualify and are enrolled in Apple Health for Medically Needy Kids become eligible for MN coverage after incurring medical costs equal to the amount of the household income that is above the 312 percent FPL standard.





Classic Medicaid Programs

Breast and Cervical Cancer Treatment Program (BCCTP) for Women (S30):

This federally-funded program provides health care coverage for women diagnosed with breast or cervical cancer or a related pre-cancerous condition. Eligibility is determined by the Breast, Cervical, and Colon Health Program (BCCHP) in the Washington State Department of Health (DOH). DOH is responsible for screening and eligibility, while HCA administers enrollment and provider payment. Coverage continues through the full course of treatment as certified by the BCCHP.

A woman is eligible if she meets all of the following criteria:

- Screened for breast or cervical cancer under the BCCHP.
- Requires treatment for either breast or cervical cancer or for a related pre-cancerous condition.
- Is under age 65.
- Is not covered for another CN (Categorically Needy) Apple Health program.
- Has no insurance or has insurance that is not creditable coverage.
- Meets residency requirements.
- Meets social security number requirements.
- Meets citizenship or immigration status requirements.
- Meets income limits set by the BCCHP.

For further information, go to the DOH website:

www.doh.wa.gov/YouandYourFamily/IllnessandDisease/Cancer/BreastCervicalandColonHealth.aspx

Foster Care/Adoption Support/Former Foster Care (D01, D02, D26):

This program provides CN coverage to children receiving foster care or adoption support services. This program also provides CN coverage to individuals from the age of 18 up to 26 who age out of foster care in Washington State.

Medical Care Services (A01, A05):

This state-funded program provides limited health care coverage to adults who are not eligible for Apple Health programs with CN, ABP, or MN scope of care and meet the eligibility criteria for either the Aged, Blind or Disabled–cash or the Housing Essential Needs (HEN) program.

Refugee (R02, R03):

The Refugee Medical Assistance program (RMA) provides CN coverage to refugees who are not eligible for Apple Health programs with CN or ABP scope of care and who meet the income and resource standards for this program. RMA is a 100 percent federally funded program for persons granted asylum in the U.S. as refugees or asylees. Individuals enrolled in RMA are covered from the date they entered the U.S.

Eligibility for refugees/asylees that have been in the United States for more than eight months is determined the same as for U.S. citizens.

Immigrants from Iraq and Afghanistan who were granted Special Immigrant status under Section 101(a)(27) of the Immigration and Nationality Act (INA) are eligible for Medicaid and Refugee Medical Assistance (RMA) the same as refugees.





Non-Citizen Programs

Alien Emergency Medical (AEM) (K03, N21, N25, S07):

This program covers health care services to treat qualifying emergency medical conditions. To be eligible for AEM, an individual must:

- Be categorically relatable to a Medicaid program but not eligible for the Medicaid program solely due to immigration status requirements (which program an individual is related to determines whether they follow the MAGI or Classic Medicaid eligibility rules and application processing); and
- Have a qualifying emergency medical condition as described in WAC 182-507-0115, or 182-507-0120, that is approved by HCA's medical consultant team.
- Income and resource limits are the same as for the program to which the AEM applications are categorically relatable.

Below is a summary of the 3 WACs that cover the Alien Emergency Medical Programs:

- **182-507-0110:** Alien Medical Programs: This explains the eligibility requirements for the program.
- **182-507-0115:** Alien Emergency Medical (AEM): The qualifying services must be provided in a hospital setting (inpatient, outpatient surgery, emergency room) that includes evaluation and management visits by a physician and be needed to treat the emergency medical condition. Certification is limited to the dates on which the qualifying services were provided.
- **182-507-0120:** Alien Medical for Dialysis and Cancer Treatment: The qualifying services must be needed to treat the qualifying condition of cancer, acute renal failure, or end stage renal disease, or be anti-rejection medication. These services do not need to be provided in a hospital setting.

State-funded long-term care services (L04, L24)

- This program provides in-home, residential, or nursing facility care for a limited number of individuals who are not eligible for medicaid due to immigration status who need long-term care services.
- **182-507-0125:** State-funded long-term care services – The applicant must meet all other eligibility factors for placement including receiving an assessment that the person meets nursing facility level of care, and receive prior authorization by the Aging & Long-Term Support Administration (AL TSA). This program is subject to caseload limits.





Supplemental Security Income (SSI) Related Programs

SSI Program (S01):

This program provides CN coverage to individuals receiving SSI (Supplemental Security Income) cash benefits.

SSI-Related Program (S02):

Effective January 1, 2020		
Household Size	Monthly Income Limit	Resource Limit
1	\$783	\$2,000
2	\$1,175	\$3,000

This program provides CN coverage to individuals who meet the SSI income and resource limits and at least one of the following requirements:

- 65 years old or older (aged).
- Blind (as defined by the Social Security Administration and determined by DSHS).
- Disabled (as defined by the Social Security Administration and determined by DSHS).

SSI-Related MN Program (S95, S99):

Effective January 1, 2020	
Household Size	Monthly Income Limit
1	\$783
2	\$783
3	\$783
4	\$783
5	\$858
6	\$975

This program provides MN coverage to individuals with income above the SSI income and resource limits. Individuals who qualify and enroll in the Apple Health SSI-Related MN Program become eligible for MN coverage after incurring medical costs equal to the amount of the household income that is above the SSI income standard.

Apple Health for Workers with Disabilities (HWD) (S08):

This program provides CN coverage to adults with disabilities (aged 16 through 64) with earned income who purchase health care coverage based on a sliding income scale.

HWD has no asset test and no upper income limit.

To be eligible, an individual must meet federal disability requirements, be employed (including self-employment) full or part time, and pay the monthly premium. To receive HWD benefits, enrollees pay a monthly premium determined as a percentage of their income. The premium will never exceed 7.5 percent of total income and may be less. American Indians and Alaska Natives are exempt from paying premiums for HWD. Also, while enrolled in HWD, a person may put earnings into a separate and designated account that will not be counted when determining eligibility for another program.





Medically Needy (MN) and Spenddown

Medically Needy (F99, G95, G99, K95, K99, L95, L99, P99, S95, S99):

The Medically Needy (MN) program is a federal and state-funded Medicaid program for individuals who are aged, blind, disabled, pregnant, or a child with income above the applicable CN limits. MN provides slightly less health care coverage than CN and requires greater financial participation by the individual.

Spenddown

An individual with income above the limits for the applicable CN program may enroll in the MN program. An enrollee is given a base period, typically three or six months, to spend down excess income—in other words, to incur financial obligations for medical expenses equal to his or her spenddown amount. (Spenddown is the amount of the individual's income minus the income limit for his/her particular program.) The enrollee is responsible for paying these medical expenses.

The enrollee receives MN health care coverage for the selected base period once the spenddown is met.



Example: Martha is 67 years of age and applies for Apple Health for MN coverage in April. Her monthly Social Security benefit is \$1,187. She is over the SSI monthly income limit of \$783 by \$404 (\$20 is disregarded from her Social Security benefits).

Martha is found eligible for the MN spenddown program for the aged. She selects a six-month spenddown base period. Her spenddown amount is \$2,424 (\$404 x 6 months) for April through September. This means that Martha is responsible for the first \$2,424 in medical costs she incurs.

On May 12, Martha has surgery. After Medicare pays the eligible 80 percent of the bill, there remains a balance of \$5,200 that Martha is responsible to pay. Based on her participation in the MN spenddown program, she is liable for \$2,424. Once her spenddown has been met, Apple Health will pay the remaining amount of the bill. Her certification period is May 12 to September 30.

If Martha's monthly income were below \$783, she would have qualified for the no-cost Apple Health for the Aged program for 12 months coverage.



Medicare Savings Program (MSP)

The Medicare Savings Program (MSP) can provide assistance with premium costs, copayments, deductibles, and co-insurance for individuals who are entitled to Medicare and meet program requirements.

Qualified Medicare Beneficiary (QMB) (S03)

- Pays Part A and Part B premiums.
- Pays deductibles.
- Pays copayments except for prescriptions.

Specified Low-Income Medicare Beneficiary (SLMB) (S05)

- Pays Part B premiums.

Qualified Individual (QI-1) (S06)

- Pays Part B premiums.

Qualified Disabled Working Individual (QDWI) (S04)

- Pays Part A premiums.

Income Limits—Effective April 1, 2020 (Below limits include a \$20 disregard allowed to all households)

Medicare Savings Program	Federal Poverty Level (FPL)	Monthly Income Limit – One Person	Monthly Income Limit – Two Persons
QMB	100%	\$1,064	\$1,437
SLMB	120%	\$1,276	\$1,724
QI-1	135%	\$1,436	\$1,940
QDWI	200%	\$2,127	\$2,874

Resource Limits—Effective April 1, 2020

Medicare Savings Program	Resource Limit – One Person	Resource Limit – Two Persons
QMB	\$7,860	\$11,800
SLMB	\$7,860	\$11,800
QI-1	\$7,860	\$11,800
QDWI	\$4,000	\$6,000





Long-Term Services and Supports (LTSS) and Hospice

Hospice services

Apple Health benefits include hospice services for people who are eligible under categorically needy (CN), medically needy (MN) or alternative benefit plan (ABP) programs. If a person is not eligible for CN, MN or ABP, a determination can be made using special eligibility rules under a separate Hospice program. The hospice provider notifies the agency when hospice services are elected. The Hospice program pays for hospice care at home, hospice care center, or nursing facility.

Long-Term Services and Supports (LTSS)

Long-term Services and Supports (LTSS) are services which are tailored to fit client individual needs and situations. Services may be authorized by Home and Community Services (HCS) or the Developmental Disabilities Administration (DDA) in the Department of Social and Health Services (DSHS). These services enable people to continue living in their homes with help meeting their physical, medical, and social needs. When these needs can't be met at home, care in a residential or nursing facility is available.

In HCS there are also programs available that provide help to caregivers and people without a caregiver—Tailored Supports for Older Adults and Medicaid Alternative Care. The person receiving care must be age 55 or older and meet financial eligibility criteria.

Different income standards are used to determine eligibility for CN or MN coverage for LTSS. To be eligible for most LTSS programs, a person must file an application and meet the financial eligibility rules and

functional eligibility criteria (based on a comprehensive assessment).

For more information about nursing home care, or home & community based services offered by HCS, contact a local HCS office. To locate the closest HCS office: www.altsa.dshs.wa.gov/Resources/clickmap.htm.

For information about financial eligibility for the Hospice program or DDA services, contact the LTC Specialty Unit at 1-855-873-0642.

For information about functional eligibility criteria for home and community-based services through DDA, go to <https://www.dshs.wa.gov/dda>.

LTSS services include the following programs:

Through HCS:

- Community Options Program Entry System (COPES), New Freedom, and Residential Support Waiver (RSW) (L21, L22)
- Community First Choice (CFC) (L51, L52)
- Roads to Community Living (RCL) (L41, L42)
- Program of All-Inclusive Care for the Elderly (PACE) (L31, L32)
- Nursing Facility LTC (L01, L02, L95, L99)
- Tailored Supports for Older Adults (T02)

Through DDA:

- Developmental Disabilities Administration (DDA) Waivers (L21, L22)
- DDA Residential Habitation Centers and Intermediate Care Facilities (L01, L02, L95, L99)
- Hospice program (L31, L32)



Covered services—scope of service

Apple Health provides access to a wide range of medical services. Not all eligibility groups receive all services. Coverage is broadest under the Categorically Needy (CN) and Alternative Benefits Plan (ABP) programs.

The scope of services covered for any individual depends on the Apple Health program in which the individual is enrolled. The table on pages 12-13 lists specific health care services and shows which scope of service category covers which services. An individual's age is also a factor. Some services may require prior authorization from HCA, the individual's Apple Health Managed Care plan, or DSHS as applicable.

This table is provided for general information only and does not in any way guarantee that any service will actually be covered at the time of inquiry, because benefits, coverage, and interpretation of benefits and coverage may change at any time. Coverage limitations can be found in federal statutes and regulations, state statutes and regulations, state budget provisions, and Medicaid provider guides. Individuals with questions regarding coverage should call the 800 number on the back of their Services Card.

Benefit packages by program

Service	ABP 20-	ABP 21+	CN ¹ 20-	CN 21+	MN 20-	MN 21+	MCS
Ambulance (Ground/Air)	Y		Y	Y	Y	Y	Y
Applied Behavior Analysis (ABA)	Y	N	Y	N	Y	N	N
Behavioral health services	Y	Y	Y	Y	Y	Y	Y
Blood/blood products/related services	Y	Y	Y	Y	Y	Y	Y
Dental services	Y	Y	Y	Y	Y	Y	Y
Diagnostic services (lab and X-ray)	Y	Y	Y	Y	Y	Y	Y
Early and periodic screening, diagnosis, and treatment (EPSDT) services	Y	N	Y	N	Y	N	N
Enteral nutrition program	Y	Y	Y	Y	Y	Y	Y
Habilitative services	Y	Y	N	N	N	N	N
Health care professional services	Y	Y	Y	Y	Y	Y	Y
Health homes	Y	Y	Y	Y	N	N	N
Hearing evaluations	Y	Y	Y	Y	Y	Y	Y
Hearing aids	Y	Y	Y	Y	Y	Y	Y
Home health services	Y	Y	Y	Y	Y	Y	Y
Home infusion therapy/parenteral nutrition program	Y	Y	Y	Y	Y	Y	Y
Hospice services	Y	Y	Y	Y	Y	Y	N
Hospital services Inpatient/outpatient	Y	Y	Y	Y	Y	Y	Y
Intermediate care facility/services for persons with intellectual disabilities	Y	Y	Y	Y	Y	Y	Y
Maternity care & delivery services	Y	Y	Y	Y	Y	Y	Y
Medical equipment, durable (DME)	Y	Y	Y	Y	Y	Y	Y
Medical nutrition therapy	Y	N	Y	N	Y	N	Y
Nursing facility services	Y	Y	Y	Y	Y	Y	Y
Organ transplants	Y	Y	Y	Y	Y	Y	Y
Orthodontic services	Y	N	Y	N	Y	N	N
Out-of-state services	Y	Y	Y	Y	Y	Y	N
Outpatient rehabilitation services (OT, PT, ST)	Y	Y	Y	Y	Y	N	Y
Personal care services	Y	Y	Y	Y	N	N	N
Prescription drugs	Y	Y	Y	Y	Y	Y	Y
Private duty nursing	Y	Y	Y	Y	Y	Y	N
Prosthetic/orthotic devices	Y	Y	Y	Y	Y	Y	Y

Benefit packages by program

Service	ABP 20-	ABP 21+	CN ¹ 20-	CN 21+	MN 20-	MN 21+	MCS
Reproductive health services	Y	Y	Y	Y	Y	Y	Y
Respiratory care (oxygen)	Y	Y	Y	Y	Y	Y	Y
School-based medical services	Y	N	Y	N	Y	N	N
Vision care Exams, refractions, and fittings	Y	Y	Y	Y	Y	Y	Y
Vision hardware Frames and lenses	Y	N	Y	N	Y	N	N

LEGEND

Y = A service category is included for that program. Services within each service category are subject to limitations and restrictions listed in the specific medical assistance program rules and agency issuances.

N = A service category is not included for that program.

¹ Clients enrolled in the Apple Health for Kids programs (with and without premium) receive CN-scope of health care services. The Apple Health for Kids programs includes the children's health insurance program (CHIP).

ABBREVIATIONS

ABP - Alternative Benefit Plan

CN - Categorically Needy Program

MCS - Medical Care Services

MN - Medically Needy Program



Other services

Non-Emergency Medical Transportation (Brokered Transport)

HCA covers non-emergency medical transportation for eligible clients to or from covered services through contracted brokers. The brokers arrange and pay for trips for qualifying clients. Currently, eligible clients are those in Apple Health (Medicaid & CHIP) and other state-funded medical assistance programs that include a transportation benefit. Transportation may be authorized for individuals who have no other means to access medical care.

The most common types of transportation available include: public transit bus, gas vouchers, client and volunteer mileage reimbursement, taxi, wheelchair van or accessible vehicle, commercial bus and air, and ferry tickets. More information is available

online at: www.hca.wa.gov/transportation-help. Comments and questions may be directed to HCA Transportation Services at hcanemttrans@hca.wa.gov.

Interpreter Services – Sign Language

HCA covers the cost of sign language interpreters for eligible clients. This service must be requested by Medicaid providers, HCA staff or HCA-authorized DSHS staff, and must be provided by the HCA-approved contractor.

Interpreter Services – Spoken language

HCA covers interpreter service for eligible clients through the HCA approved contractor. Requests for this service must be submitted by Medicaid providers, HCA staff, or HCA-authorized DSHS staff.



Where to apply for health care coverage

Modified Adjusted Gross Income (MAGI) programs

- **Online:** www.wahealthplanfinder.org.
- **Phone:** 1-855-923-4633
- **Paper:** HCA Form 18-001P (Application for Health Care Coverage) available at www.hca.wa.gov/assets/free-or-low-cost/18-001P.pdf.

To submit a completed application by mail:
Washington Healthplanfinder
P.O. Box 946, Olympia, WA 98507

Or send it by fax to: 1-855-867-4467

If you want help applying, you can work with an in-person assister or call Healthplanfinder Customer Support at 1-855-923-4633.

Aged, Blind, Disabled Coverage

Disability-based Washington Apple Health, refugee coverage, coverage for seniors 65+, and programs that help pay for Medicare premiums and expenses:

- **Online:** www.washingtonconnection.org
- **Paper:** HCA Form 18-005 (Application for ABD/LTC) available at www.hca.wa.gov/assets/free-or-low-cost/18-005.pdf.

To submit a completed application by mail:
DSHS – Community Services Division
P.O. Box 11699, Tacoma, WA 98411-6699

Or send it by fax to: 1-888-338-7410

- **In-person:** Visit a local Community Service Office. For locations, go to www.dshs.wa.gov/esa/community-services-find-an-office.

Questions? Call 1-877-501-2233

Long-Term Care

Nursing home care, in-home personal care, assisted-living facilities, and adult family home programs:

- **Online:** www.washingtonconnection.org.
- **Paper:** HCA Form 18-005 (Application for ABD/LTC) available at www.hca.wa.gov/assets/free-or-low-cost/18-005.pdf.

To submit a completed application by mail:
DSHS – Home & Community Services
P.O. Box 45826, Olympia, WA 98504-5826
Or send it by fax to: 1-855-635-8305

- **In-person:** Visit a local HCS office. For locations, go to www.dshs.wa.gov/AL TSA/resources.

Questions? Call a local HCS office. For locations, go to www.dshs.wa.gov/AL TSA/resources.



Resources

Telephone	
Apple Health Medical Assistance Customer Service Center (MACSC) Open 7 a.m. – 5 p.m. (weekdays)	Clients 1-800-562-3022 (option 3) or https://fortress.wa.gov/hca/p1contactus/ Providers 1-800-562-3022 (option 4) or https://fortress.wa.gov/hca/p1contactus/ Orders for large print or Braille 1-800-562-3022 (option 1, option 3, option 1) TRS: 711
Apple Health Medical Eligibility Determination Services (MEDS) Open 8 a.m. – 5 p.m. (weekdays)	1-800-562-3022 or https://fortress.wa.gov/hca/p1contactus/ TRS: 711
Online	
Apple Health (Medicaid)	www.hca.wa.gov/apple-health
Apple Health (Medicaid) Manual	www.hca.wa.gov/free-or-low-cost-health-care/program-administration/apple-health-eligibility-manual
Access to rules	
Washington Administrative Code (WAC) sections pertaining to “scope of care”	Healthcare general coverage: http://apps.leg.wa.gov/WAC/default.aspx?cite=182-501-0050 Healthcare coverage Scope of covered categories of service: http://apps.leg.wa.gov/WAC/default.aspx?cite=182-501-0060 Healthcare coverage Description of covered categories of service: http://apps.leg.wa.gov/WAC/default.aspx?cite=182-501-0065

HCA complies with all applicable federal and Washington state civil rights laws and is committed to providing equal access to our services.

If you need an accommodation, or require documents in another format or language, please call 1-800-562-3022 (TRS: 711).

[Russian] ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-562-3022 (TRS: 711).

[Spanish] ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-562-3022 (TRS: 711).



Definitions

Apple Health

See *Washington Apple Health*

Managed Care

The majority of individuals enrolled in Apple Health receive their health services through a designated health care plan that contracts with the Health Care Authority. This prepaid comprehensive system of medical and health care services is usually called managed care.

Classic Medicaid

The term used to describe the Medicaid health care programs administered by the Department of Social and Health Services (DSHS). These are Long-Term Care services and Aged, Blind or Disabled coverage. The Modified Adjusted Gross Income (MAGI) health care programs are not Classic Medicaid.

Federal Poverty Level (FPL)

A guideline for determining eligibility for a governmental program based on the Consumer Price Index guide from the year just completed. Many health care coverage programs determine eligibility based on a percentage of the FPL.

Fee-for-Service

This is a health care service delivery system where health care providers are paid for each service (such as an office visit, test, or procedure). Individuals who are not covered by Apple Health Managed Care are covered by Apple Health Fee-for-Service (also referred to as Apple Health coverage without a managed care plan).

Health Care Authority (HCA)

HCA is a Washington State agency that administers a number of programs related to health and wellness, including most Washington Apple Health programs.

Medicaid

The federally matched medical aid programs under Title XIX of the Social Security Act (and Title XXI of the Social Security Act for the Children's Health Insurance Plan) that cover the Categorically Needy (CN) and Medically Needy (MN) programs.

Modified Adjusted Gross Income (MAGI)

The methodology used for calculating income and determining household composition to determine eligibility for Apple Health for Adults, Kids, Families and Caretaker Relatives, and Pregnant Women. This method follows federal income tax filing rules with a few exceptions and has no resource or asset limits.

ProviderOne

The online payment system for health care providers serving individuals enrolled in an Apple Health program.

Scope of Care

Scope of care describes which medical and health care services are covered by a particular Apple Health program. There are four categories of scope of care: Categorically Needy (CN), Alternative Benefits Plan (ABP), Medically Needy (MN), and Medical Care Services (MCS).

Spendedown

This process allows individuals with income above the limits for the applicable CN program to spend down excess income within a specified period of time to become eligible for coverage.

Washington Apple Health

The brand name for all Washington State medical assistance programs, including Medicaid. The brand name may be shortened to "Apple Health."



Washington State
Health Care Authority

HCA administers Washington Apple Health (Medicaid).

HCA 22-315 (3/20)



Toolkit Background

Children of immigrants are the fastest growing population of children in the United States and have contributed to the entire growth in the nation's child population over the past decade. Immigrant families are racially and ethnically diverse, and immigrate for variety of reasons that may include seeking economic opportunity, reuniting with family, fleeing war or violence.

Pediatricians can play a special role in supporting the health and well-being of immigrant children in the United States. By recognizing the unique challenges and strengths that many immigrants experience; pediatricians can identify effective practice strategies and relevant resources that support health within the community.

This toolkit was designed to provide practical information and resources for pediatricians to use to address some common matters related to immigrant child health. To develop the toolkit, the AAP gathered and developed content that addresses issues that AAP members have raised regarding providing optimal care to immigrant children and families. Those issues are addressed as "Frequently Asked Questions." As the AAP continues its work on immigrant child health issues, this content will be expanded.

A state by state directory of legal resources is also provided to help pediatricians determine local services and potential partners to help immigrant families with a variety of issues related to child health and well-being.



Acknowledgements

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The American Academy of Pediatrics thanks the following individuals who created, drafted, and reviewed components in the Immigrant Health Toolkit.

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Key Facts About Immigrant Children

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From the **AAP Policy Statement: *Providing care for immigrant, migrant, and border Children.***
Council on Community Pediatrics. Pediatrics. 2013 Jun;131(6):e2028-34. doi: 10.1542/peds.2013-1099.

Definitions and Demographics

- “Immigrant children” are defined as children who are foreign-born or children born in the United States who live with at least 1 parent who is foreign-born.
- One in every 4 children in the United States, approximately 18.4 million children, live in an immigrant family. Eighty-nine percent of these children are born in the United States and are US citizens.
- Although 64% of all children of immigrants live in 6 states (California, Texas, New York, Florida, Illinois, and New Jersey), immigrant children are dispersed throughout the country. Since 1990, the largest growth in percentage of immigrant children has occurred in North Carolina, Nevada, Georgia, and Arkansas.

Access to Health Care and Health Status

- Children of immigrants are nearly twice as likely to be uninsured as are children in nonimmigrant families.
- Immigrant children are less likely to have a usual source of medical care and to obtain specialty care when needed.
- Immigrant children who are foreign-born may not have received adequate screenings or immunizations in their home country.

Socioeconomic Factors

- Immigrant children are more likely to live below the federal poverty level than nonimmigrant children, despite the fact that immigrant children are more likely to live with two parents and have parents who work.
- Immigrant children can face barriers to accessing programs and benefits that support low income children
- Many immigrant children have less access to quality early education programs and are less likely to be enrolled in preschool programs, such as Head Start.
- Children in immigrant families are less likely to graduate from high school than are their nonimmigrant peers.

Unique Stressors/Family Separation

- Many immigrant children live in a family with a parent who faces the threat of deportation without notice or preparation.
- Children whose parents have been taken into custody/deported may demonstrate a number of health problems including anxiety, depression, poor school performance, sleeping and eating disruptions.
- Forced separations due to immigration enforcement can also result in the loss of family income and have been shown to result in family housing and food instability.
- Children who have crossed the border to enter the United States as well as children who are refugees may have experienced abuse, exploitation, and/ serious trauma.



Clinical Care

What screening resources are recommended for immigrant children?

Are some diseases or conditions more prevalent among immigrant children?

How do I communicate with families that are not English proficient?



WHAT SCREENING RESOURCES ARE AVAILABLE FOR IMMIGRANT/NEWLY ARRIVED CHILDREN?



According to the [2013 AAP Policy, Providing Care for Immigrant, Migrant, and Border Children](#) (May 2013)⁴, pediatricians should use available screening and diagnostic protocols for evaluating foreign-born children for infectious diseases and other medical conditions. Additional screenings commonly required for school entry, including lead testing, vision, and hearing screenings, should be provided for all age appropriate children. The Centers for Disease Control and Prevention (CDC)^{8,27} and the American Academy of Pediatrics (AAP) Red Book¹ offer resources with detailed discussions and/or checklists regarding screening of refugees and international adoptees. However, there has been little detailed guidance about post-arrival medical screening for other new immigrants; this generally has been extrapolated from published experience of screening of refugee and international adoptees. All immigrant children would benefit from comprehensive medical evaluation after arrival in the United States²⁷ and integration into a medical home. Please refer to the AAP [toolkit screening checklist](#) for general screening recommendations for all newly arrived immigrant children that incorporate recommendations from both the CDC and the AAP.

Many new immigrant children may have never had medical screenings or a visit with a health care provider in their country of origin. If children have had prior medical visits, families should be asked to bring all medical records, screening or health histories to the initial visit. Pediatricians should be aware that these records may need to be translated and should be carefully reviewed for accuracy. Immigrant families may be unfamiliar with navigating the health care system as well as standards of practice in the United States. Pediatricians should recognize that US screening and preventive health practices may be an unfamiliar practice in many countries and may need additional explanation. A comprehensive medical evaluation includes asking sensitive questions about issues such as migration experiences, trauma, and family separation. Setting aside adequate time for visits, providing professional interpretation services, and engaging in thoughtful and sensitive inquiry will

facilitate a trusting environment that will lead to optimal care for immigrant children⁸. In screening for trauma, it is essential to incorporate trauma-informed approaches (please see the mental health section of the toolkit for details). If follow-up can be ensured, the comprehensive evaluation does not need to be completed in the first 1-2 visits and some elements can be deferred until a trusting relationship with the family has been established.

Finally, throughout this document, a case study will demonstrate how this process was successfully used in a general pediatric practice setting.

Considerations for the Initial Screening of Immigrant Children

- *Birth country/ethnicity, country/countries of transit and length of time living in these countries, time in the United States*
- *Medical records, if available, including vaccine records*
- *Past medical history, including prenatal serology results of mother/health of mother, birth setting (home/medical facility), gestational age at birth, history of female genital cutting (FGC), other traditional cutting, transfusions, surgeries, tattoos*
- *Sexual history, including whether history of sexual abuse*
- *Nutrition history, including foods available, to determine risk for specific micronutrient deficiencies*
- *Use of complementary and alternative medications*
- *Environmental hazard exposure history, including possible lead exposure risks*
- *Tobacco, alcohol, opium/heroin, betel nut²⁴, khat²⁶, other drug use*
- *Allergies*
- *Dental history*
- *Education: last year of school completed and literacy level of patient/parents as applicable, potential learning difficulty and/or need for special education*
- *Social history—including family structure, support in US, school environment, individuals who live in the same home as the child, primary care taker*

- *Mental health evaluation (see Mental health section for further [details](#)), including use of validated screening instrument (such as the Patient Health Questionnaire [PHQ-9](#)²⁰, the Pediatric Symptom Checklist [PSC](#)²¹, or the Refugee Health Screener [RHS-15](#)²² for those over age 14) and specific screening for trauma*
- *Developmental screening (including use of age-appropriate screening instrument)*

ARE SOME DISEASES OR CONDITIONS MORE PREVALENT AMONG IMMIGRANT CHILDREN?



The specific health risks of immigrant children depend on the child's country/region of origin and experiences prior to arrival in the United States. Each child should be evaluated within the context of unique predisposing factors and experiences.

Infectious Disease

Infectious diseases are among the most common health issues encountered in immigrant children¹. Testing for tuberculosis by tuberculin skin testing or interferon gamma release assay (regardless of history of BCG vaccine) should be universally applied in all immigrant children^{1,8,9}. If there is no documentation of prenatal or parents' lab results, children should also be screened for hepatitis B (regardless of vaccine history), HIV, and syphilis^{8,11,12,13}. Other infectious diseases may be evident with a review of systems (hematuria suggesting schistosomiasis in a child from sub-Saharan Africa), or performance of physical examination (characteristic rash of scabies, or splenomegaly in hyperreactive malaria syndrome) however, some will need specific screening to identify.

Inadequate immunization status (insufficient number, inadequate serologic response due to improper storage of vaccinations, or severe malnutrition) places immigrant children at risk for vaccine-preventable illness^{1,2,4,8,23}. Immunizations should be initiated immediately according to recommended schedules for infants, children, and adolescents.

Specific infectious diseases that should be considered in immigrant children are included in Table 1.

(Please refer to the immigrant checklist for an approach to screening).

Certain parasitic infections, with which clinicians may be less familiar, are particularly prevalent among immigrant populations and warrant more detailed discussion, below. For more detail about specific infections, refer to the AAP Redbook¹ and the CDC Refugee Health Guidelines⁸.

Soil-transmitted helminths

The most common soil-transmitted helminth infections are *Ascaris lumbricoides*, whipworm (*Trichuris trichiura*), and hookworm (*Necator americanus*, *Ancylostoma duodenale*). Transmission of *Ascaris* and whipworm occurs via ingestion of soil contaminated with these helminths in human feces, and infection with hookworm occurs primarily through direct contact between skin (such as bare feet) and contaminated soil. Infections may be asymptomatic or may cause abdominal pain, diarrhea, nausea/vomiting, or anemia due to malabsorption or blood loss. Infections with soil-transmitted helminths may be diagnosed by stool ova and parasite examination, for which, ideally, three samples should be obtained at least 24 hours apart to increase sensitivity. Treatment of choice is albendazole; however clinicians should confirm that patients do not have a history of seizures or other neurologic deficits (which may be indicative of neurocysticercosis*) prior to treatment.

Giardia intestinalis

Giardia, a protozoan, may be asymptomatic, cause bouts of acute symptoms such as watery diarrhea and abdominal pain, or cause prolonged symptoms including foul-smelling stools, abdominal distention, anorexia, malabsorption, or failure to thrive. Neither stool ova and parasite examination nor eosinophilia are sensitive for *Giardia intestinalis*, and clinicians should send giardia specific stool antigen using enzyme immunoassay (EIA) to test for this infection. Treatments of choice are metronidazole, tinidazole, or nitazoxanide.

Strongyloidiasis (Strongyloides stercoralis)

Infections with the nematode roundworm *Strongyloides stercoralis* primarily occur when larvae penetrate skin after contact with infected soil. Thus, infection usually occurs after children are old enough to crawl or walk. Because *Strongyloides* can replicate in human hosts, the infection may persist for decades due to autoinfection and once acquired is considered a life-long infection unless treated. The infection is often asymptomatic, but some patients experience skin manifestations (transient pruritic papules at the site of penetration or erythematous tracks, known as larva currens, transient pneumonitis or gastrointestinal manifestations [abdominal pain, vomiting, diarrhea, malabsorption, or failure to thrive]). In the setting of immunosuppression (most commonly associated with corticosteroid use) *strongyloides* parasites may infiltrate internal organs and unexpectedly manifest as hyperinfection syndrome with associated high rates of morbidity and mortality. Eosinophilia may be present with strongyloides infections, however, its absence does not rule out infection. Ova and parasite testing is very insensitive for detecting strongyloides, given that shedding may occur intermittently and at

low levels¹⁴. Serology for IgG antibodies against strongyloides is the testing of choice for diagnosis. Ivermectin is the treatment of choice but should not be used in patients from **Loa loa-endemic regions unless co-infection has been ruled out**²⁸ (see CDC domestic refugee screening guidelines⁹ for further info).

Schistosomiasis

Schistosoma organisms, the trematode flatworm, are spread via parasites in contaminated fresh water. *Schistosoma* species are **endemic** in many areas of Africa¹⁶; distribution requires snail vectors, infected human reservoirs, and fresh water sources. Infection, also known as bilharzia, is contingent upon environmental exposure with organisms penetrating skin, therefore, children tend to be at risk of infection only once they are crawling or walking. Acute infection may present with fever, abdominal pain, hepatosplenomegaly, rash, or lymphadenopathy. Skin penetration may cause a pruritic, papular dermatitis similar to “swimmer’s itch.” Infection with *Schistosoma haematobium* may lead to bladder inflammation (with associated dysuria, hematuria, secondary urinary tract infections, and pelvic pain), fibrosis, and ultimately, increased risk of bladder cancer or renal failure. Chronic infection with intestinal forms of schistosoma (*S. mansoni*) may ultimately lead to portal hypertension. Eosinophilia may be present with schistosoma infections, however, its absence does not rule out infection. Ova and parasite testing is also insensitive for diagnosis. Blood schistosoma IgG antibody testing is the diagnostic method of choice. Treatment of choice is praziquantel. If seizures or neurologic deficits of unknown etiology are present, neurocysticercosis* must be ruled out with neuroimaging prior to treatment with praziquantel.

Malaria

Malaria classically presents with high fevers, chills, rigors, sweats, and headache. Although five species of malaria infect humans, *Plasmodium falciparum* causes the most significant morbidity and mortality and is hyper- and holo-endemic in some areas of sub-Saharan Africa. For newly arrived immigrants from areas in sub-Saharan Africa where *P. falciparum* is **endemic**¹⁵, CDC currently recommends presumptive treatment, particularly for specific refugee populations from areas that have greater than 40% endemicity (dark red on the **endemicity map**) for malaria infection¹⁵. For immigrants from regions outside of sub-Saharan Africa as well as immigrants from sub-Saharan Africa who are not presumptively treated, evaluation for malaria should be based on symptoms. Screening with thin and thick blood smears in asymptomatic patients has low sensitivity. Performing daily smears over three days increases sensitivity. PCR testing is available through CDC, particularly in cases of symptomatic infants or pregnant teens and women. A Rapid Diagnostic Test (RDT) is now available in the U.S and offers an alternate way of quickly establishing the diagnosis of malaria infection by detecting specific malaria antigens in blood. Although the use of the RDT does not eliminate the need for malaria microscopy, it can reduce diagnostic delay that may occur in some clinical settings due to challenges in accessing timely microscopic evaluation¹⁸. Presumptive treatment for *P. falciparum* is with atovoquone-proguanil or artemether-lumefantrine.

Table 1: Infectious diseases to consider in immigrant children
(Please refer to Medical Screening and Treatment Checklist for tiered approach to appropriate work-up)

<i>M tuberculosis</i>	Typhoid fever (<i>Salmonella Typhi</i>) among recently arrived febrile patients
<i>M Bovis</i>	Geographically specific infections:
HIV 1, 2	<ul style="list-style-type: none"> • Schistosoma spp. (trematode) • <i>Opisthorchis</i> species • Chagas Disease— (Trypanosoma cruzi) • Coccidioidomycosis • Histoplasmosis • Lymphatic filariasis • <i>Loa loa</i> • Leishmaniasis • Chikungunya virus
Viral hepatitis	Sexually Transmitted Infections
<ul style="list-style-type: none"> • Hepatitis A • Hepatitis B • Hepatitis C (overseas surgery, transfusion, female genital mutilation, traditional cutting, tattoos, sexual abuse)¹² • Hepatitis D (chronic carriers of Hepatitis B) 	<ul style="list-style-type: none"> • <i>Gonococcus</i> • <i>Chlamydia</i> • Syphilis
Parasitic infections	Skin infections
<ul style="list-style-type: none"> • Soil-transmitted helminths <ul style="list-style-type: none"> – Roundworm (<i>Ascaris lumbricoides</i>) – Whipworm (<i>Trichuris trichura</i>) – Hookworm (<i>Necator americanus, Ancylostoma duodenale</i>) • <i>Strongyloides stercoralis</i> (nematode) • <i>Entamoeba histolytica</i> • <i>Giardia intestinalis</i> • Cryptosporidium • <i>Taenia solium</i> (cysticercosis, pork tapeworm) • <i>Toxocara canis and visceral larva migrans</i> 	<ul style="list-style-type: none"> • Scabies • Lice • Impetigo • cutaneous larva migrans
Malaria	<i>Helicobacter pylori</i>

Nutritional Issues

Immigrant children may present with under-nutrition and malnutrition, including wasting and stunting⁸. Overweight and obesity are increasingly prevalent concerns among immigrant children⁸. A detailed dietary history, complete physical examination, and thoughtful laboratory evaluation can help clinicians to detect particular nutritional issues.

Throughout the world, iron deficiency is the most common nutritional issue. Among immigrant children with anemia, it is important to also consider undiagnosed hemoglobinopathies, particularly for children of African, Southeast Asian, East Asian, Hispanic or Mediterranean ethnicities^{1,2,4}. Vitamin D deficiency is also common among immigrant children, particularly in those with growth delay, poor vitamin D intake or limited sun exposure due to geography, veiling, or institutionalization^{2,8}. Other micronutrients that may be deficient among immigrant children in resource-limited settings include vitamin A, zinc, vitamin B12, iodine, vitamin B3 (niacin), tryptophan, vitamin B1 (thiamine) or vitamin C⁸. Refer to AAP Pediatric Nutrition handbook³ or CDC domestic refugee screening guidelines⁸ with further details regarding signs, symptoms and regional risks for specific micronutrient deficiencies.

Toxic and Environmental Exposures

As a result of living conditions in home countries and/or impoverished living conditions in the United States, toxin exposure is common among immigrant children. Lead exposure is the most widespread toxin exposure among immigrant children. Exposures prior to arrival in the U.S. may include leaded gasoline, contaminated home remedies or traditional cosmetics, leaded ceramic glazes, the use of car batteries as a domestic power source, leaded cookware, or air pollution^{4,8,27}. After arrival in the U.S., exposures may include many of the same items, in addition to lead paint in older homes in the US^{8,27}. A number of culture-specific exposures have been associated with elevated blood lead levels in children; see [Table 1](#) in the CDC refugee guidelines⁸ for further detail regarding lead exposure. The [CDC offers comprehensive guidelines](#)⁶ and a [Toolkit](#)¹⁰ regarding prevention of lead poisoning among refugee children.

A comprehensive medical history may reveal other potential hazardous environmental exposures. Prenatal exposure to alcohol may be associated with fetal alcohol syndrome that was not previously diagnosed^{1,2}. It is important to inquire about the use of non-prescribed medications as well as traditional treatments or herbal remedies obtained overseas or locally. Migrant children are also at particular risk for health problems related to workplace injuries⁴.

Other General Health Issues

Many immigrant children may have lacked access to pediatric medical care and their mothers may have had home births without prenatal medical screenings, including testing for hepatitis B, HIV, and syphilis. Dental problems, including dental caries or more serious dental diseases, are pervasive in immigrant children, given scant, if any access to dental preventive care and treatment in their countries of origin^{2,4,8}. Undiagnosed vision and hearing problems may be present^{1,2}. Other medical issues, such as thyroid disease, congenital defects, or genetic conditions, may be present and require subspecialty care^{1,8}. Overweight/obese immigrant children may be increasingly at risk for chronic conditions such as hypertension, diabetes, and cardiovascular disease⁸.

It is important to inquire about history of female genital cutting (also known as female genital mutilation, female circumcision) and parents' beliefs regarding this practice¹⁹, particularly if a child is from Africa (where female genital cutting is practiced in over 27 countries) or parts of the Middle East^{19,25}. Using a culturally sensitive and non-judgmental approach, pediatricians should discuss the illegality of female genital cutting in the US with families, including the illegality of sending children back to country of origin for the procedure (sometimes referred to as "vacation cutting") educate families about significant morbidity and mortality associated with this practice^{8,19}.

Developmental delays may be undetected or detected at a later age among immigrant children¹⁷. Pediatricians who care for immigrant children should conduct careful developmental surveillance and screening at regular intervals as recommended by the AAP. Developmental screening requires consideration of important issues by families, medical providers, interpreters, and school/child care personnel. Questionnaires and screening tools should be administered using validated translations or with the help of trained interpreter staff when possible. Appropriate referral for early intervention services and/or psychoeducational evaluation should be initiated as soon as a concern is identified.

Mental Health

Mental health merits particular attention in immigrant populations. Stressful experiences may take place prior to departing from one's country of origin, during transit or upon arrival to the United States. Sensitive and trauma-informed approaches to care are essential. In addition, immigrant children and families may experience discrimination and fear within the United States⁸, and acculturation may place stress upon children, adolescents, and families. Immigrant children may also have mental health conditions that are prevalent among the general U.S. population, such as depression, anxiety, posttraumatic stress disorder, somatization, sleep disturbance, and substance abuse^{2,8}. Mental health services should be sought for the entire family when appropriate. [See Immigrant Health Toolkit Mental Health Section for further details.](#)

*Cysticercosis is a parasitic tissue infection caused by larval cysts of *Taenia solium*, also known as the pork tapeworm. These cysts can infect the brain (neurocysticercosis), which may present as seizures or neurologic deficits in children. It may also manifest as cysts in the muscles and other tissues. Presumptive treatment with praziquantel or albendazole in the setting of neurocysticercosis is contraindicated without concomitant anti-epileptic and steroid pre-treatment because these drugs may provoke significant brain inflammation and seizures. If child has history of seizures or neurologic deficits of unknown cause, do not treat with praziquantel or albendazole until the presence of neurocysticercosis has been eliminated through neuroimaging.

HOW DO I COMMUNICATE WITH FAMILIES THAT ARE NOT ENGLISH PROFICIENT?

Language access is critical for ensuring that immigrant children and families are able to access and use health care services. 82 percent of immigrant children are fluent English speakers, however 40% of immigrant children live with at least one parent that does not speak English fluently. Approximately 24 percent of immigrant children live in a linguistically isolated household where no one over age 13 speaks English fluently in the home.²⁹

Families that are not fluent in English and cannot access language supports may be deterred from even making appointments for health care services. In health care settings, language barriers can lead to inadequate communication that may cause confusion, dissatisfaction, and/medical errors.³⁰ Language barriers have been linked to less routine and timely care for children whose parent's primary language at home is not English.³¹

Language barriers can occur in clinical settings from the outpatient clinic to the intensive care unit, or in non-clinical settings, like administrative, billing, and legal departments.

Trained medical interpreters can help pediatricians communicate with families that do not speak English or have limited English proficiency.

Trained medical interpreters are valuable assets to the health care team and essential bridges to navigating language barriers. Trained medical interpreters may include trained bi-lingual staff, on-staff interpreters, contract interpreters, or telephone interpreters.

Trained bi-lingual staff are employed by the practice for a different primary role and also have interpreter duties as a secondary role

On-staff interpreters are employed by the practice solely for interpreter services.

Contract interpreters are not employed by the practice, and provide services on an on-call basis

Telephone interpreters provide interpreter services through telephone language lines, often providing interpretation for less commonly requested languages.

Although less common than telephone services, interpretation services can also be provided through Video Medical Interpretation.

Best practices for working with medical interpreters:

- *Treat interpreters as an important member of the health care team.*
- *Provide the interpreter with a brief summary of the patient and briefly share what is anticipated and will be covered during the visit.*
- *Establish and maintain eye contact with the parent or patient.*
- *Speak slowly, clearly, and concisely, with appropriate for interpretation. Try to avoid jargon.*
- *Avoid interrupting the interpreter once the session has started.*
- *Pay attention to the parent and patient's body language and other non-verbal cues.*
- *De-brief with the interpreter after the patient visit.*

Best practices for working with families with limited English proficiency

Determine a family's preferred language. To determine the patient's or family's language of preference, provide a brief to read a brief **language identification document** with a simple sentence in many different languages.

Unless you are fluent in the patient's preferred language, do not attempt to speak that language with a patient.

Avoid using family members, particularly children, as interpreters. Untrained interpreters may not accurately interpret information which may lead to misunderstandings, misdiagnoses, and medical errors. The most common interpretation errors involve omissions and editing of information.³² Children should not be used for interpretation for a variety of reasons including the potential for errors, omissions, and the potential for burdening the child or creating role reversal within the family.

Take caution when asking patients to read English-language information or to complete forms in English, when English is not their primary language.

Resources

AAP Culturally Effective Care Toolkit: Interpretive Services
<http://www.aap.org/en-us/professional-resources/practice-support/Patient-Management/pages/Culturally-Effective-Care-Toolkit-Interpretive-Services.aspx?nfstatus=402&nftoken=00000000-0000-0000-0000-000000000000&nfnstatusdescription=ERROR%3a+Local+oken+is+not+valid>

Language Access Assessment and Planning Tool for Federally Conducted and Federally Assisted Programs
http://www.spanadvocacy.org/sites/startingpointstemplate.drupalgardens.com/files/files/2011_Language_Access_Assessment_and_Planning_Tool_0.pdf

Health education materials for family members about common conditions affecting pediatric patient populations in multiple languages
<https://ethnomed.org/patient-education/pediatric-health-topics>

National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care
<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>

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Medical Screening and Treatment Recommendations for Newly Arrived Immigrant Children

The following section provides general medical screening recommendations for diverse immigrant children including unaccompanied minors, undocumented immigrants, asylees, refugees, and others.



A comprehensive medical evaluation should be available to all immigrant children, either within the medical home or coupled with referral to a medical home. Many aspects of this evaluation are routinely recommended per *Bright Futures*¹³ guidelines for evaluation of all children but have nuances specific to immigrant children. The Centers for Disease Control and Prevention (CDC)⁷ and the American Academy of Pediatrics (AAP) Red Book¹ offer resources with detailed discussions and/or checklists regarding screening of refugees and international adoptees. However, there has been little detailed guidance about post-arrival medical screening for other new immigrants; this generally has been extrapolated from published experience of screening of refugee and international adoptees.

The following checklist provides general medical screening recommendations for unaccompanied minor, undocumented immigrant, asylee, refugee, and other immigrant children from low resourced countries, especially if from low socioeconomic circumstances. These recommendations are consistent with current **CDC domestic refugee screening guidelines**⁷, and this document will be updated periodically in effort to maintain consistency with existing guidelines. Although the AAP defines “immigrant children” as children who are foreign-born or children born in the United States who live with at least 1 parent who is foreign-born², these recommendations are specific to foreign-born immigrant children. For all patients without legal access to health insurance (such as unaccompanied minors and other undocumented children), providers must balance the medical needs of individual patients with the reality of patient/institutional costs for laboratory evaluations and prescribed **medications**.

Comprehensive history and physical examination	
History (Initial/Interval)	<ul style="list-style-type: none"> • Immigration information (e.g. country of origin, country of transit, refugee camp history, time residing in the United States) • Birth history (e.g. home birth, prenatal lab records) • History of overseas blood transfusions, surgeries, female genital cutting, other traditional cutting, tattoos* • Nutritional history: Foods available overseas/while in-transit, risks for micronutrient deficiencies • Environmental exposure risks (e.g. lead, second-hand smoke) • Treatment prior to arrival (e.g. pre-departure therapy for parasitic infections for refugees, overseas medications/home remedies, treatment while in ORR** custody for unaccompanied minors) • Prior medical records including labs and immunizations <ul style="list-style-type: none"> • Menarche/LMP for females; pubertal onset for males and females • Family medical history (e.g. maternal/paternal HIV, Hep B, C, TB) • Social history (e.g. family structure, status of parents if not in the home, legal guardian/primary care taker, other individuals living in the household, social support) • Educational assessment (e.g. last year of school completed, literacy level of patient/parents as applicable, potential learning difficulty and/or need for special education) • Substance use— prior and current*** • Sexual history— consensual/non-consensual • History of trauma or abuse
Developmental Assessment	<ul style="list-style-type: none"> • Developmental screening tools+ with multiple available languages, such as the ASQ³, M-CHAT R¹⁶, PEDS¹⁹, and/or SWYC²⁵
Psychosocial Assessment	<ul style="list-style-type: none"> • Signs/symptoms of PTSD, depression, anxiety • Psychosocial screening tools+ such as the PHQ-9²⁰, PSC²¹, or RHS-15²³ (>14 years)

CONTINUES >

Comprehensive history and physical examination (continued)

Complete Physical Examination/Measurements	<ul style="list-style-type: none"> • Growth evaluation[#] • Screening for female genital cutting (FGC) in at-risk populations: routine external genital examination for all females^{##} • Complete skin evaluation (e.g. scarification, tattoos) • Pubertal development for males/females 	<ul style="list-style-type: none"> • Dental evaluation • Blood pressure evaluation (> 3 years or risk factors) • Vision screen (> 3 years) • Hearing screen (Newborn, > 4 years)
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* Possible risk factors for Hepatitis C¹¹

** ORR—Office of Refugee Resettlement (<http://www.acf.hhs.gov/programs/orr/programs/ucs>)¹⁷

*** Tobacco, marijuana, alcohol, opium/heroin, betel nut²⁴, khat²⁸, other

+ Validation of these tools for use in languages other than the English language varies by tool. Be sure that translated materials have been translated using internationally accepted translation methodology.

Use WHO growth charts for infants 0-2 years.

Children and adolescents who have not had a genital exam may find this experience less upsetting if deferred until a future encounter if follow-up is ensured.

Tiered^a laboratory screening/parasite treatment options for most immigrant children originating from resource-limited settings or from low socioeconomic circumstances

1. **Tuberculosis testing: IGRA (TST if <5 years old)^{b,1,9}**
2. **Cbc/Diff**
3. **Lead^{d,6}:**— Children 6mo–16 years
4. **Hep B sAg^{e,10,11}**
5. **Intestinal Parasite Evaluation** (NB: for refugees, may omit if received pre-departure treatment per CDC guidelines)
 - **Stool O & P** >24 hours apart x 3^f **OR** presumptive treatment with **Albendazole**
 - AND**
 - **Strongyloides IgG OR** presumptive treatment with **Ivermectin^g**
6. **HIV^h**
7. **Syphilis EIA, reflex RPR if positive^{i,5}**

- a. Consider laboratory tiering in this order when patients or health care facilities have no access to discounted financial coverage programs
- b. Interferon gamma release assay (IGRA), tuberculin skin test (TST). Screen regardless of history of BCG vaccine^{1,9}. If IGRA unavailable, may use TST at any age. Repeat TB screening in 6 months. NB: Repeat if chronic disease, malnutrition once medical issues managed, given that anergy may give a false negative result.
- c. Screen for anemia, eosinophilia (NB: absolute eosinophilia >400 warrants further work-up).
- d. Repeat in 3-6 months in children 6 mo-6 years⁶.
- e. If never screened for infection, screen even if documentation of complete hepatitis B vaccine series. Vertical and horizontal transmission possible^{10,11}.
- f. Greater number increases sensitivity of test—most experts recommend 2 or 3 samples.
- g. Consider presumptive treatment with ivermectin without serology if >15 kg, unless from **Loa loa endemic countries³⁰**.
- h. If > 1 year old and no history of seizures or other signs/symptoms of neurocysticercosis*.
- i. If prenatal lab results or recent maternal results available with negative screens and no risk for horizontal transmission, may omit.

Optional laboratory screening/presumptive treatment for children of specific ages, with specific exposures or risk factors

- Urine B HCG^j
- Urine GC/Chlamydia^k
- Hep C Ab^l
- Newborn screen, per state guidelines^m
- TSHⁿ
- Giardia stool antigen
- Hemoglobin electrophoresis^p
- G6PD activity^q
- Vitamin deficiency screening based on clinical presentation^r
- Schistosoma IgG^s OR Presumptive treatment for schistosomiasis
- Praziquantel
- Malaria thin and thick blood smears x 3^t OR Malaria Rapid Diagnostic Test¹⁸ OR Presumptive treatment for *P falciparum*^t
- Atovoquone-proguanil^t OR
- Artemether-lumafantrine^t

j. All pubertal girls (prior to vaccines or medication administration)

k. All pubertal boys and girls or pre-pubertal boys and girls with history of sexual abuse

l. If history of HCV-positive mother, overseas surgery, transfusion, major dental work, IVDU, tattoos, sexual activity/abuse, FGC, other traditional cutting¹¹

m. If no state specific guidelines, infants <6 month old

n. All children 6mo-3 years (screening for congenital hypothyroidism)

o. If clinical suspicion based upon failure to thrive or gastrointestinal symptoms given low sensitivity of stool O&P and eosinophilia

p. To evaluate for **SS, SC, S trait**²², and **thalassemias**²⁹ in high-risk populations

q. For males from **high-risk areas**^{4,14}

r. See **CDC review of micronutrient deficiencies**⁸

s. For immigrants from **endemic regions of Africa**¹⁵ with no pre-departure treatment; May consider empiric treatment with praziquantel if > 4years and if no history of known neurocysticercosis*)

t. New immigrants from areas of sub-Saharan Africa (SSA) **where *P falciparum* is endemic**¹² or with signs or symptoms of infection. For immigrants from SSA **where *P falciparum* is endemic**¹², if not pre-treated per CDC guidelines prior to departure and history of living **in area with high malaria risk**¹² consider treatment with atovoquone-proguanil or artemether-lumafantrine (if > 5kg), given that sub-clinical malaria infection is common and blood testing lacks sensitivity, particularly for specific refugee populations from areas that have greater than 40% endemicity (dark red on the **endemicity map**¹²) for malaria infection. For infants and pregnant teens with symptoms consistent with malaria, CDC recommends blood PCR testing.

*Cysticercosis is a parasitic tissue infection caused by larval cysts of *Taenia solium*, also known as the pork tapeworm. These cysts can infect the brain (neurocysticercosis), which may present as seizures or neurologic deficits in children. It may also manifest as cysts in the muscles and other tissues. Presumptive treatment with praziquantel or albendazole in the setting of neurocysticercosis is contraindicated without concomitant anti-epileptic and steroid pre-treatment because these drugs may provoke significant brain inflammation and seizures. If child has history of seizures or neurologic deficits of unknown cause, do not treat with praziquantel or albendazole until the presence of neurocysticercosis has been eliminated through neuroimaging.

Treatments and referrals

- Multi-vitamin with iron^u
- Fluoride varnish^v
- Vaccines, with catch-up plan as needed
- Contraception for all sexually active males and females
- Confirmation of medical home/assignment of specific PCP
- Dental Referral
- WIC Referral (infants & children < 5 years, pregnant adolescents)
- Mental health referral as needed
- Care coordination, including orientation to US health care system
- Set up follow-up appointment

u. All children 6 months-59 months and children 5 years and older with clinical evidence of poor nutrition

v. All children up to 5 years of age

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Access to Health Care and Public Benefits

What health insurance options are available to immigrant children and families?

What rights do immigrant children have in schools? Can they obtain English language assistance or any other special services?

How can I help immigrant children access the benefits that they are eligible to receive?



WHAT HEALTH INSURANCE OPTIONS ARE AVAILABLE TO IMMIGRANT CHILDREN AND FAMILIES?



Children of immigrants are nearly twice as likely to be uninsured as are children in nonimmigrant **families**.¹ Access to health care insurance is dependent upon the child's immigration status as well as federal and state level policies. Eligibility requirements and waiting periods can present barriers for immigrant families to access health insurance. However, many uninsured immigrant children are eligible for Medicaid or CHIP but are not enrolled. The following provides a quick guide to health insurance options for immigrant children and their families:

Overview of health care benefits options for immigrant children and families

Immigrant Status	Medicaid ¹	CHIP ²	ACA Subsidies
Pregnant Women	In some states, may be eligible for prenatal care regardless of immigration status ⁴	In some states, may be eligible for prenatal care regardless of immigration status ⁵	Not applicable
U.S. Citizen Children with undocumented parent(s)	Eligible	Eligible	Eligible
Lawful Permanent Resident (under age 18)	Eligible after 5 years of legal residency in the U.S.; states have the option to waive the 5 year ban	Eligible after 5 years of legal residency in the U.S.; states have the option to waive the 5 year ban	Eligible
Lawful Permanent Resident (age 18 and over)	Eligible after 5 years of legal residency in the U.S.; states have the option to waive the 5 year ban	Eligible after 5 years of legal residency in the U.S.; states have the option to waive the 5 year ban	Eligible
Refugees, Asylees, Victims of Trafficking and other humanitarian grounds	Eligible	Eligible	Eligible
Members of the military and veterans (and their spouses and children)	Eligible	Eligible	Eligible
Unauthorized Immigrants (including children and pregnant women)	Eligible for Emergency Medicaid Only. Some states may cover children	Not Eligible	Not Eligible (barred from purchasing coverage on their own in the Health Insurance Exchange)
Temporary Protected Status (TPS)	Not Eligible	Not Eligible	Eligible

- Depending on their state of residence, applicants who are lawfully present immigrant children may be subject to a five-year waiting period before they are legally able to access Medicaid or CHIP.⁶
- Children born in the United States are U.S. citizens regardless of their parents' immigration status, and are therefore eligible for Medicaid or CHIP at birth with no waiting period.
- Refugees, asylees, victims of trafficking, members of the military and veterans (and their spouses and children) are eligible for Medicaid, CHIP, and health insurance subsidies without being subjected to the five-year waiting period.
- Undocumented immigrant children are not eligible for Medicaid, CHIP or health insurance subsidies provided through the ACA. However, the Emergency Medical Treatment and Active Labor Act (EMTALA)⁷ requires hospitals to provide care to anyone needing **emergency healthcare** treatment regardless of citizenship, legal status or ability to pay. While EMTALA requires that hospitals offer emergency treatment to stabilize the individual, it does not mandate preventative or out-patient care. If an undocumented parent and child presents with a medical emergency, pediatricians should not hesitate to encourage treatment at a hospital's emergency room.

Resources

Coverage of Lawfully--Residing Immigrant Children and Pregnant Women without a 5 Year Waiting Period (January 2013) Georgetown University Health Policy Institute Center for Children and Families
<http://ccf.georgetown.edu/wp-content/uploads/2012/04/Coverage-of-Lawfully-Residing-Immigrant-Children-and-Pregnant-Women-without-a-5-Year-Waiting-Period-ICHA-Option.pdf>

Key Facts on Health Coverage for Low-Income Immigrants Today and Under the Affordable Care Act (March 2013)
<http://www.kff.org/uninsured/upload/8279.pdf>

ARE IMMIGRANT CHILDREN AND FAMILIES ELIGIBLE TO RECEIVE PUBLIC BENEFITS SUCH AS SNAP, TANF, PUBLIC/SUBSIDIZED HOUSING?



30 percent of children in immigrant families live below the federal poverty level;⁸ however these families may face barriers to accessing public assistance programs that help with basic needs such as food and housing. Eligibility requirements, lack of knowledge about programs, or fear can prevent families from securing benefits for their children. The eligibility standards for immigrant children and families to access key public benefit programs are outlined below:

Overview of public benefits options for immigrant children and families⁹

Immigrant Status	SNAP ¹⁰	TANF	Non-cash benefits under TANF such as subsidized child care or transit subsidies ¹¹	Public Housing ¹²
Lawful Permanent Resident (under age 18)	Eligible with no waiting period	Eligible after 5 years of legal residency in the U.S.; states have the option to waive the 5 year ban	Eligible after 5 years of legal residency in the U.S.; states have the option to waive the 5 year ban	Eligible
Lawful Permanent Resident (age 18 and over)	Eligible after 5 years of legal residency in the U.S.; states have the option to waive the 5 year ban	Eligible after 5 years of legal residency in the U.S.; states have the option to waive the 5 year ban	Eligible after 5 years of legal residency in the U.S.; states have the option to waive the 5 year ban	Eligible
Refugees, Asylees, Victims of Trafficking, other humanitarian grounds	Eligible with no waiting period	Eligible with no waiting period	Eligible with no waiting period	Eligible
Members of the military and veterans (and their spouses and children)	Eligible with no waiting period	Eligible with no waiting period	Eligible with no waiting period	Eligible with no waiting period
Unauthorized Immigrants (including children and pregnant women)	Not Eligible	Not Eligible	Not Eligible	May live in residence with eligible family member
Temporary Protected Status (TPS)	Not Eligible	Not Eligible	Not Eligible	Not Eligible

- **Supplement Nutrition Assistance Program (SNAP) (formally “Food Stamps”):** SNAP is available to almost all low income households. The program is meant to help low income individuals purchase food and improve their nutrition. Nearly 72 percent of SNAP participants are in families with children. The average SNAP benefit is about \$133.41 a month (or about \$4.45 a day).¹³ Undocumented parent(s) may apply for SNAP benefits on behalf for their U.S. citizen children. The SNAP benefit amount will be calculated based on the parents’ income, but the parent (and any undocumented children) will be excluded from the household size.
- **Temporary Assistance for Needy Families (TANF):** TANF is a federal block grant that provides states, territories, and Tribes federal funds each year. The funds are used to provide beneficiaries with cash and/or benefits and services, such as subsidized child care or transit subsidies. In general, undocumented immigrants are not eligible for TANF. However, ineligible parents can receive TANF benefits for their U.S. citizen children.
- **Public Housing/Subsidized Housing:** Public and subsidized housing programs were created to provide safe and affordable rental housing for low-income individuals, people with disabilities and the elderly.¹⁴ U.S. citizens and qualified immigrants¹⁵ are eligible for assistance regardless of the immigration status of other family members. For mixed-status families living in the same household, benefits are prorated: the benefit is reduced by the proportion of nonqualified immigrants in the household.

WHAT RIGHTS DO IMMIGRANT CHILDREN HAVE IN SCHOOLS? Can they obtain English language assistance or any other special services?



Immigrant children, regardless of immigration status, have the right to free public K-12 education.¹⁶ Public schools may not:

- Require proof of citizenship or legal residence to enroll or provide services to immigrant students.

- Make inquiries of students or parents that may expose their immigration status.
- Require students or parents to provide social security numbers.
- Treat a student differently to determine residency.
- Engage in any practices to “chill” or “hinder” the right of access to education.

Like other children, undocumented students are obligated under state law to attend school until they reach a mandated age. Even if an undocumented student is not living with a parent or legal guardian, school districts must enroll the student if the child resides in the district and the district cannot establish parents/guardians residence in a different district.

Immigrant children with unstable housing are also protected by the McKinney-Vento Homeless Education Assistance Act.¹⁷ The McKinney-Vento Act requires that school districts allow homeless children¹⁸ to enroll in public schools, even if they are unable to prove residency or guardianship.

The Right to Secondary Services in School

All secondary services, such as transportation, school based nursing services, free or reduced-meals, special education,¹⁹ and counseling are available and should be accessible to immigrant children regardless of their legal status because they are central to the student’s educational experience.

Immigrant parents and students who have limited English proficiency (LEP) are also entitled to language-assistance programs.²⁰ Under Title VI of the Civil Rights Act of 1964, private entities and state agencies that receive federal funding for programs are required to provide equal access to aid for eligible persons, regardless of their race, color, or national origin.²¹ Title VI prohibits conduct that has a disproportionate effect on LEP individuals because such conduct constitutes national-origin discrimination.²² Because refusing to provide services in other languages might be discriminatory in some localities,²³ special efforts should be made to ensure that there is access to translated materials and interpreters.²⁴

HOW CAN I HELP IMMIGRANT CHILDREN ACCESS THE BENEFITS THAT THEY ARE ELIGIBLE TO RECEIVE?



1. *Screen for basic needs*

Screening for basic needs as a standard part of practice is essential for detecting and addressing issues such as hunger and housing insecurity. Practices can use a brief written screener or verbally ask family members questions if the family is having difficulty with issues such as food, housing, and heat. Screening for basic needs can help uncover new and “hidden” economic difficulties that impact child health. Practices should take a universal approach to screening, and never target specific families.

2. *Work with community partners to provide public benefits information*

When unmet basic needs are identified, immigrant families will need up to date, understandable information about public benefits programs. In order to provide families with the most accurate information and referral resources, practices should build relationships with trusted local and state organizations that have expertise with public benefits. Key partners will likely include local and state departments of public health, **legal services organizations**, and community development organizations that have ties to immigrant communities. These partners can help provide pediatricians with accurate benefits information to provide for families in the practice.

3. *Work with the care team and community partners to help encourage families to access public benefits*

Immigrant families may be reluctant to sign up for public benefits for a variety of reasons. Pediatricians can work with organizations and individuals that are trusted in the community to conduct education and outreach activities about public benefits. Within the practice, social workers, case managers, legal advocates, or peer educators can be effective messengers about public benefits. Working with local community institutions, faith based institutions, and community development organizations can also help pediatricians promote public benefits to immigrant families.

4. *Reassure families that the information they provide in the health care setting is confidential and that the practice is not involved in immigration enforcement.*

Inform them that undocumented parents of US citizen children can apply for benefits on behalf of their eligible citizen children.

Resources

Helping Immigrant Patients (page 10) in “Clinical Partners in Advocacy: How Can I-HELP?” Medical Legal-Partnership Boston October 2009
http://api.ning.com/files/sHxuGddmuirJjxyAENqoX48kxDVf0JoMj07pcfYiKQ2pQ*HLGqti5n8RS9eljY0Od1xXhzKXwUaSZ1AVy9mJlFwwMuEx9Khl/IHELPGuide.pdf

Reaching, Supporting, and Empowering Immigrant Families: Experiences of the Statewide Parent Advocacy Network (SPAN)
<http://www.cpe.rutgers.edu/njdcf/docs/Reaching-and-Serving-Immigrant-Families.pdf>

Strategies for Engaging Refugee and Immigrant Families
http://www.promoteprevent.org/sites/www.promoteprevent.org/files/resources/strategies_for_engaging_immigrant_and_refugee_families_2.pdf

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- 4 Unborn Child Option is state specific. It only covers services related to pregnancy or conditions that could complicate pregnancy can be covered under this option. Check individual state regulations.
- 5 *Id.*
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- 9 Fortuny & Chaudry, *supra* note 10.
- 10 Benefits not subject to “public charge” consideration
- 11 *Id.*
- 12 *Id.*

- ¹³ CENTER ON BUDGET AND POLICY PRIORITIES, POLICY BASICS: INTRODUCTION TO SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) (2012).
- ¹⁴ U.S. Dep't of Housing and Urban Dev., HUD's Public Housing Program, http://portal.hud.gov/hudportal/HUD?src=/topics/rental_assistance/phprog
- ¹⁵ Qualified aliens are defined as: legal permanent residents; refugees; asylees; an alien who is paroled into the U.S. (under INA §212(d)(5)) for a period of at least one year; an alien whose deportation is being withheld on the basis of prospective persecution; an alien granted conditional entry pursuant to INA §203(a)(7) as in effect prior to April 1, 1980; and Cuban/Haitian entrants. For further explanation and legal citations, see CONGRESSIONAL RESEARCH SERVICES, IMMIGRATION: NONCITIZEN ELIGIBILITY FOR NEEDS-BASED HOUSING PROGRAMS 1-2 (Jan. 23, 2012), <http://www.fas.org/sgp/crs/homesec/RL31753.pdf>.
- ¹⁶ *Plyer v. Doe*, 457 U.S. 202 (1982). The Supreme Court of the United States found that states must educate children of undocumented immigrants, interpreting the equal protection clause of the 14th Amendment to apply to anyone who lives in the U.S., regardless of citizenship.
- ¹⁷ 42 U.S.C. §1143a(2)(B)(i).
- ¹⁸ *Id.* The McKinney-Vento Act defines homeless children as "individuals who lack a fixed, regular, and adequate nighttime residence." The act provides examples of children who would fall under this definition: children and youth sharing housing due to loss of housing, economic hardship or a similar reason; children and youth living in motels, hotels, trailer parks, or camp grounds due to lack of alternative accommodations; children and youth living in emergency or transitional shelters; children and youth abandoned in hospitals; children and youth awaiting foster care placement; children and youth whose primary nighttime residence is not ordinarily used as a regular sleeping accommodation (e.g. park benches, etc); children and youth living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations; migratory children and youth living in any of the above situations.
- ¹⁹ Undocumented children with disabilities have a statutory right to services under the Individuals with Disabilities Education Act (IDEA) or Section 504 of the Rehabilitation Act of 1973 (Section 504). For a state to be eligible for federal assistance under IDEA Part B, it must provide assurance that a free appropriate public education is available to all children with disabilities residing in the state.
- ²⁰ *Lau v. Nichols*, 414 U.S. 563 (1974). The Supreme Court of The United States found that school districts not providing their limited English proficient students with language-assistance programs were violating Title VI of the Civil Rights Act.
- ²¹ 42 U.S.C. § 2000d (2004).
- ²² *Lau*, 414 U.S. at 568.
- ²³ The U.S. Department of Justice considers four factors to determine the obligations of state welfare agencies receiving federal funding in providing services to LEP individuals. The factors are: (1) the number or proportion of persons with LEP who would not have access without removing the language barriers; (2) the frequency with which persons with LEP contact the agency; (3) the nature and importance of the benefits to its beneficiaries; and (4) the resources available within the agencies and programs. This balancing of these four factors is meant to provide critical services to those in need, but not impose undue burdens on small business, small local governments, or small non-profits. Bilingual services are required when the number and frequency of contact by LEP persons are high, where the total costs for LEP services are reasonable, and when the lack of access to services may have dire consequences for the recipients. 67 Fed. Reg. 41459 (Jun. 18, 2002).
- ²⁴ 65 Fed. Reg. 50121 (Aug. 16, 2000).



Immigration Status and Related Concerns

What is the impact of parental separation or deportation on child health?

How do I assist families that face the deportation or removal of a child's parent or primary care giver?

What should I do if a family asks me to write a letter of support to prevent deportation or removal of a child's primary care giver?

Can immigration enforcement request information about my patient families?

What do I do if this happens?



The following content is for informational purposes only and not for the purpose of providing legal advice.

WHAT IS THE IMPACT OF PARENTAL SEPARATION OR DEPORTATION ON CHILD HEALTH?



Immigrant children may live in a “mixed status” family with an undocumented parent/primary care giver who lacks the proper documentation to live legally in the United States. Immigration enforcement actions can lead to the sudden removal of an undocumented parent without giving the family notice or time to prepare for the parent’s removal.

Children whose parents are taken into custody and/or deported have been shown to experience mental and emotional health problems including sleeping and eating disturbances, anxiety, depression, poor school performance, and other types of distress. Forced separations due to immigration enforcement can also result in a child’s household losing a working parent, which has been shown to threaten in family housing and food **stability**.¹

The mere possibility of deportation can negatively impact the well-being of some immigrant children, whether or not they themselves or family members are undocumented. Mexican immigrant children specifically have shown emotional distress, fear, confusion and anxiety.²

As part of the social history, pediatricians may consider asking families if a parent/other key family member has left or is potentially going to leave the family for any reason. This information may help provide insight into the child’s health. Reassure families that the information they provide in the health care setting is confidential and that the practice is not involved in immigration enforcement.

It is extremely important for parents or primary caregivers who may face separation from their children to develop a plan for their children’s health and safety, in the event of separation.

HOW DO I ASSIST FAMILIES THAT FACE THE DEPORTATION OR REMOVAL OF A CHILD’S PARENT OR PRIMARY CARE GIVER?



Pediatricians should advise parents or primary caregivers who may be at risk for separation from children to take the following basic steps:³

- *Appoint power of attorney to a trusted adult to care for children in the event of removal or deportation. Because the requirements for legally executed Powers of Attorney vary considerably by state, seeking the assistance of attorney is recommended.*
- *Maintain copies of medical records, including immunization history, medications and other health information. Give a copy to a trusted adult.*
- *Maintain copies of your child’s birth certificate, social security card and passport(s). Give a copy to a trusted adult.*
- *Maintain documentation about any public benefits your child may be receiving from local, state, or federal programs. Eligibility for these programs may be affected by parental deportation. Give a copy to a trusted adult who can help maintain the child’s benefits if possible.*
- *Maintain documentation of children’s school records. Give a copy to the adult that you have designated as Power of Attorney.*

Pediatricians should refer families to legal partners for assistance with legal and immigration related issues, such as **local legal aid organizations and non-profit advocacy groups**. When addressing deportation issues with families, pediatricians should reassure families that the information they provide in the health care setting is confidential and that the practice is not involved in immigration enforcement.

Resources

Suarez-Orozco et. al. Growing Up in the Shadows: The Developmental Implications of Unauthorized Status, Harvard Educational Review Vol. 81 No. 3 Fall 2011 <http://hepg.org/document/163/>

Detailed checklists are available for families to prepare for deportation/separation: Phil Storey, *Immigrant Family Preparedness Checklist* (2011), http://cj-network.org/cj/wp-content/uploads/2011/12/CJ_DeportationChecklist2011_Eng.pdf

WHAT SHOULD I DO IF A FAMILY ASKS ME TO WRITE A LETTER OF SUPPORT TO PREVENT DEPORTATION OR REMOVAL OF A CHILD'S PRIMARY CARE GIVER?

If I write the letter, what is most helpful to include or address?



Pediatricians may be asked to write a letter of support for immigrant families who face parental deportation or separation from a child. Support letters may also be requested for visa applications and other immigration administrative hearings. The pediatrician may be asked to attest that the parent(s) appear to be providing good care for a child and/or that the child seems to emotionally and physically well. Alternatively, the pediatrician might be requested to attest that the child has medical and/or psychological conditions for which he/she is currently being treated, and it is the pediatrician's professional opinion that it is not in the child's best interest to disrupt this care or send him/her to a location where adequate care may not be available.

If a pediatrician chooses or is required to attest to the state of the child's physical health, psychological health, and/or the need for treatment, he/she should: (1) reference medical notes when appropriate, (2) clearly identify as opinion any opinions offered, (3) release or disclose HIPAA-protected information only after obtaining proper consent or authorization, and (4) restrict his/her comments to fact with which he or she is personally familiar; care should be taken not to include false statements or to mislead officials. The pediatrician may incur significant liability risks if the statements are knowingly false or markedly exaggerated.

Support letters must be individualized and tailored to address any legitimate hardship that a child would face if the child's parent is detained or deported. If the child's parent(s) is working with an immigration attorney, the pediatrician should contact the attorney to address what to include in the letter. However, generally, a pediatrician should consider the following when writing a letter of support or affidavit:

- Write the letter specifically for your patient. Honestly address your patient's issues and situation without exaggeration or falsehood.⁴
- Provide an overview of the physician's education, training, expertise, and the number of years in practice. This may persuade the immigration judge to accept the physician as an expert witness.⁵
- Provide an objective and individualized description of the child's medical diagnosis, treatment, and prognosis. The letter must be factual, unbiased and authoritative.⁶
- Discuss the instrumental role the parent plays in seeking, supporting and maintaining treatment, e.g. taking child to treatment, administering medication or otherwise providing care.
- Discuss how the child will be harmed physically, emotionally, and psychologically if the parent is detained or deported.⁷ Provide examples of the health consequences the child would face without their parent participating in their health care. If possible, discuss how the child would not get the care they need in their parent's country. Overall, your written testimony should support the parent's assertion that the child will suffer extreme hardship if the parent is detained or deported.⁸
- Always provide facts and rationale for your medical opinion.⁹
- Provide supporting medical documents or reports.

CAN IMMIGRATION ENFORCEMENT REQUEST INFORMATION ABOUT MY PATIENT FAMILIES?

What do I do if this happens?



It is imperative that anytime immigration enforcement contacts a pediatrician for patient information that the pediatrician forwards the request to their health care facility's legal department, or in the case of a sole practitioner, their legal counsel. There are many complex and multi-faceted legal issues associated with producing medical records to Immigration and Customs Enforcement. The request for documents may be impacted by the following laws:

- *U.S. Constitution, Fourth Amendment*;¹⁰
- *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*;¹¹
- *Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act of 2001 (USA PATRIOT Act)*;¹²
- *Individual State Privacy Laws*;¹³ and
- *Legal Process such as court-ordered or administrative warrants, subpoenas, or summons.*

It is helpful to develop written policies and procedures on handling document requests and to train health care providers on how to interact with immigration authorities.¹⁴ Because there may be legal obligations on the health care provider if the request is a valid court order, a physician should never simply ignore a request. Pediatricians should document any experiences of intimidation or involvement with immigration enforcement officials. This information should be shared with the health care facility's legal department.

Practices may choose to designate a specific individual or individuals to assume primary responsibility for handling contacts with law enforcement officials. If this occurs, inform all other staff about the role of the designated individuals and any other established procedures for the practice in the event of an immigration enforcement action.

References

- ¹ Facing Our Future: Children in the Aftermath of Immigration Enforcement Chaudry, Ajay; Capps, Randy; Pedroza, Juan Manuel; Casteneda, Rosa Maria; Santos, Robert; Scott, Molly M. The Urban Institute 2010 http://www.urban.org/uploadedpdf/412020_FacingOurFuture_final.pdf Accessed March 7 2013
- ² The Burden of Deportation on Children in Mexican Joanna Dreby Immigrant Families Journal of Marriage and Family 74 (August 2012): 829–845)
- ³ Phil Storey, *Immigrant Family Preparedness Checklist*, http://cj-network.org/cj/wp-content/uploads/2011/12/CJ_DeportationChecklist2011_Eng.pdf
- ⁴ Expert affidavits that are general in nature and not specifically prepared for the patient are given less weight by immigration judges. See Wang v. BIA, 437 F.3d 270, 274 (2d Cir. 2006).

⁵ Katherine J. Eder, *The Importance of Medical Testimony in Removal Hearings for Torture Victims*, 7 DEPAUL J. HEALTH CARE L. 281, 306 (Spring 2004) ("Expert evidence, which includes both documentary and testimonial evidence, can be very significant and potentially determinative in whether a party meets his or her burden of proof."); see also Garry Malphrus, *Expert Witnesses in Immigration Proceedings*, 4 IMMIGRATION LAW ADVISOR 1, 13 (May 2012), available at <http://www.justice.gov/eoir/vll/ILA-Newsletter/ILA%202010/vol4no5.pdf>.

⁶ Id.

⁷ Id.

⁸ Eder, supra note 8 at 305.

⁹ Expert testimony and affidavits that are highly conclusory in its opinion without facts and rationale for the opinion are not persuasive. See Malphrus, supra note 8 at 13.

¹⁰ Generally bars the government from engaging in unreasonable searches and seizures. U.S. CONST., amend. IV.

¹¹ 45 C.F.R. § 164.512(f)(2002); For a general summary of HIPAA Privacy Rules, see <http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html>

¹² 50 U.S.C. § 1861.

¹³ State laws may offer stronger consumer protection than HIPAA.

¹⁴ CA. PRIMARY CARE ASS'N, INFORMATION FOR CLINICS IN THE EVENT OF AN IMMIGRATION (ICE) RAID: THE RIGHTS OF CLINIC, CLINIC STAFF AND THEIR PATIENTS (Oct. 2012), <http://www.cpcpa.org/cpca/assets/File/Policy-and-Advocacy/Active-Policy-Issues/MSFW/2012-10-17-ICE-Raid-Summary-Updated.pdf>; see also, NAT'L IMMIGRATION LAW CTR., IMMIGRATION ENFORCEMENT: KNOW YOUR PATIENTS' AND YOUR RIGHTS (Jan. 2011), [http://www.cpcpa.org/cpca/assets/File/Policy-and-Advocacy/Active-Policy-Issues/MSFW/2011-01-11-NILC-Know-Your-Rights-Clinics\(1\).pdf](http://www.cpcpa.org/cpca/assets/File/Policy-and-Advocacy/Active-Policy-Issues/MSFW/2011-01-11-NILC-Know-Your-Rights-Clinics(1).pdf).



Mental, Emotional and Behavioral Care

- What considerations should be included in a mental health assessment of immigrant children?
- What risk and protective factors should be included in the mental health assessment?
- What mental health screening instruments are available for use with children of immigrants?
- How can I help children link to mental health treatment?
- What are some proven intervention and treatment strategies for children with PTSD and other mental, emotional and behavioral health problems?
- What are some high-risk circumstances that may require special attention?



WHAT CONSIDERATIONS SHOULD BE INCLUDED IN A MENTAL HEALTH ASSESSMENT OF IMMIGRANT CHILDREN? ???

Overall, immigrant children are well adjusted and should be treated as all children in the pediatric medical home. However, the experiences of immigrant children may interfere with critical stages of intellectual, social, emotional and physical development.

This section of the toolkit addresses mental health considerations for immigrant children and pediatric assessments for children who may need mental health services. Disruption to families, education, and witnessed traumatic events compound developmental concerns. Assessment of mental health among children in immigrant and refugee families involves several key elements:

- Screening for trauma
- The influence of acculturation
- Consideration of changing social support structure
- Resilience

Screening for trauma:

Immigrants and refugees to the United States may come from regions characterized by violence and extreme poverty, such as Central America, the Caribbean and some Asian and African countries, placing them at high risk for emotional and behavioral health problems. Immigrant children may experience trauma in their country of origin, en route to the United States, upon arrival, or while living the community. Unaccompanied minors and refugees are at particular risk for traumatic exposure.

The influence of acculturation:

The influence of acculturation should be evaluated over three generations:

- *First generation immigrants (parents and children born in the country of origin) may experience more recent trauma but may be reluctant to seek mental health of services because of cultural expectations or, in the case of mixed status or undocumented families, because of the perceived risk of deportation.*

- *Second generation children (Americans born of immigrant parents), especially those in families with mixed legal status, often have more emotional and behavioral problems associated with persistent poverty, perceived lack of opportunity, intergenerational conflicts and explicit societal prejudice. These immigrants have been shown to use mental health services at a higher rate than those who immigrate as children.*
- *Third generation immigrants (both parents and children born in the US) experience the cumulative risk and chronic stressors common to life in poor, violent neighborhoods and, by many researchers, are considered native. Evidence strongly associates cumulative childhood adverse experiences with adult chronic illness and a shorter lifespan.*

Consideration of changing social support structure:

At the time of departure from the country of origin, children often lose the direct support of extended family networks, familiar cultural expectations and important intimate relationships such as with extended family members. During the migration, they may experience separation from caregivers.

Resilience:

As with all children, family functioning mediates the effects of poverty on emotional and behavioral health. If families are healthy, characterized by resilient parents and good interpersonal connectedness, children are better adjusted and have fewer difficulties with anxiety, depression and aggression. Biculturalism (and bilingualism) appears to be the most adaptive response retaining important elements for the culture of origin but adopting many values from the new culture.

Learn more:

Abe-Kim, J., Takeuchi, D., Hong, S., et al. Use of Mental Health-Related Services among Immigrant and US-Born Asian Americans: Results from the National Latino and Asian American Study. *Am J Public Health*. 2007;97:91-98.

Beiser et al. Poverty, Family Process, and the Mental Health of Immigrant Children in Canada. *Am J Public Health*. 2002;92:220-227

Fazel, M. and Stein, A. The mental health of refugee children. *Arch Dis Child* 2002;87:366-370

Lustig et al. Review of Child and Adolescent Refugee Mental Health. *J. Am. Acad. Child Adolesc. Psychiatry*, 2004;43(1):24-36.

Perreira, K. and Ornelas, I. 2011. The Physical and Psychological Well-being of Immigrant Children. *The Future of Children*. 2011: 21(1) pp.195-218 http://www.princeton.edu/futureofchildren/publications/docs/21_01_09.pdf Pumariega A, Rothe, E and Pumariega J. Mental Health of Immigrants and Refugees. *Community Mental Health Journal*. 2005;41(5): 581-597

Refugee Resettlement: Chapter 3.3 Investing the Future: Refugee Children and Young People. www.unhcr.org.

Child Trends Data Bank <http://www.childtrends.org/?indicators=immigrant-children#sthash.2MRsiehi.dpuf>

WHAT RISK AND PROTECTIVE FACTORS SHOULD BE INCLUDED IN A MENTAL HEALTH ASSESSMENT?



A variety of risk factors place immigrant children at risk for emotion, behavioral or relational problems:

- *Children of isolated, linguistically-challenged and depressed families are at high risk for emotional and behavioral problems.*
- *Pre-existing cognitive, emotional or physical disorder increases the likelihood of maladaptation.*
- *High intelligence and education level does not protect children from post-traumatic disorders.*
- *Unaccompanied children and young immigrant adolescents are at high risk for emotional distress and enduring relational difficulties.*
- *Disrupted family composition by death or other loss increases risk as do single parent families and parental mental illness.*
- *Persistent poverty, particularly associated with housing and food insecurity, are significant cumulative risk factors and many migrant families settle in poor neighborhoods with limited support services.*
- *Living in ethnic enclaves isolated from mainstream society may be detrimental for the second and third generation immigrants by slowing acculturation and by provoking intergenerational conflict.*

- *Perceived cultural prejudice and either overt or implicit prejudice are all associated with increased risk of poor acculturation and individual symptoms of stress.*

Protective factors should be encouraged and discussed by pediatricians with immigrant families:

- *High family cohesion, two-parent families, interpersonal support and communication, in addition to strong work ethics and aspirations are all strongly protective.*
- *Being part of an engaging community of fellow immigrants from the same country of origin on arrival also leads to better mental health outcomes.*
- *For foster children, a same ethnic origin foster parent may be protective.*
- *Perceived acceptance in receiving communities, safety in schools and strong neighborhood connections are protective, buffering many of these children from the negative influences of mainstream society.*

Resources for practices:

National Child Traumatic Stress Network: Addressing the Mental Health Problems of Border and Immigrant Youth: http://www.nctsn.org/sites/default/files/assets/pdfs/BorderlandersSpecialReport_Final_0.pdf

American Psychological Association: <http://www.apa.org/topics/immigration/index.aspx>

Chadwick Center: Adaptation Guidelines for Serving Latino Children and Families Affected by Trauma: <http://www.chadwickcenter.org/Documents/WALS/Adaptation%20Guidelines%20for%20Serving%20Latino%20Children%20and%20Families%20Affected%20by%20Trauma.pdf>

Learn more:

Fazel et al. Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors. *Lancet* 2012; 379: 266–82

Griffin, M., Son, M. and Shapleigh, E. Children's Lives on the Border. *Pediatrics* 2014;133:e1118

Shields, Margie K. Shields, Richard E. Behrman (2002) "Children of Immigrant Families: Analysis and Recommendations", *The Future of Children*, Vol. 14, No. 2, Children of Immigrant Families (Summer, 2004), pp. 4-15.

ARE SOCIO-EMOTIONAL SCREENING INSTRUMENTS AVAILABLE FOR USE WITH IMMIGRANT CHILDREN?



Many mental health and developmental screening instruments that are normed to the general culture are useful for children in immigrant families with some caveats. Although some instruments have been translated into Spanish, others are only available in English. It is important that the historian has the literacy level to answer the questions (if the instrument is written) and that a skilled medical interpreter is provided when needed. For a list of instruments, please refer to Table 1.

Table 1: Mental Health and Developmental Screening Instruments and Resources

Anxiety/ PTSD	Trauma Symptom Checklist for Children and Trauma Symptom Checklist for Young Children (TSCC and TSCYC) http://www4.parinc.com Child PTSD Symptom Scale (CPSS) foa@mail.med.upenn.edu Univ. of California at Los Angeles Posttraumatic Stress Disorder Reaction Index (UCLA-PTSDRI) http://www.istss.org/UCLAPosttraumaticStressDisorderReactionIndex.htm
Depression	Patient health questionnaire (PHQ-9) http://www.phqscreeners.com/overview.aspx?Screener=02_PHQ-9
ADHD	Vanderbilt ADHD forms http://www.brownfamilymedicine.org/pdf/vanderbilt%20-%20parent%20-%20spanish.pdf
Relational, emotional and behavioral development in pre-school children	Strengths and Difficulties Questionnaire (SDQ) in many languages http://www.sdqinfo.org/a0.html Ages & Stages Questionnaires®: Social Emotional (ASQ:SE) in Spanish http://products.brookespublishing.com/Ages-Stages-Questionnaires-Social-Emotional-ASQSE-in-Spanish-P580.aspx
Relational, emotional and behavioral development in school-aged children	Pediatric Symptom Checklist in many languages http://www.massgeneral.org/psychiatry/services/psc_forms.aspx http://www.brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklist.pdf
Autistic Spectrum Disorders	M-Chat available in many languages http://www.firstsigns.org/screening/tools/rec.htm
Maternal Depression	The Patient Health Questionnaire-2 (PHQ-2) http://www.cqaimh.org/pdf/tool_phq2.pdf Maternal depression screening implementation guide http://www.commonwealthfund.org/publications/resources/2007/jan/section-four--guide-for-organizations-to-assist-practices-implementing--depression-screening
Intimate partner/ family violence	https://www.acog.org/About_ACOG/ACOG_Departments/Violence_Against_Women/Es_Usted_Victima_de_Maltratos HITS screen in English, Spanish and Creole http://www.orchd.com/violence/
Social determinants of health	WE CARE Project http://healthbegins.ning.com/page/social-screening-tools
Refugee health	Refugee Health Screener http://www.refugeehealthta.org/files/2012/09/RHS15_Packet_PathwaysToWellness.pdf

HOW CAN I HELP LINK IMMIGRANT CHILDREN TO TREATMENT?



Linking immigrant children to treatment and facilitating retention in quality mental health care are fraught with obstacles.

- *Families with mixed legal status are fearful of referrals because of the risk of detection or deportation.*
- *The referral to a mental health therapist often carries a stigma and may conflict with cultural values that disparage or deny the possibility that children may have emotional or mental problems.*
- *In many regions of the US, there may be a shortage of therapists with language and cultural concordance or cross-cultural experience.*
- *Few interpreters are trained in mental health care that include subtleties in communication and ethics.*
- *Funding for mental health care in most communities is limited and uninsured families find the payments prohibitive.*

Developing a multi-disciplinary medical home that provides community-based care coordination can help immigrant families engage in treatment. Nurses or social workers may perform the full spectrum of activities related to care coordination including maintenance of a centralized medical record. Often lay members of the immigrant community who are trained as community health workers (e.g. promotores de salud) are able to identify children in need, link them to services and improve engagement in treatment. Enhanced medical homes that include co-located mental health providers can be extremely helpful in reducing barriers to access such as transportation, limited hours of operation and stigma. If co-location or an integrated model is not practical, primary care pediatricians may develop agreements for facilitated referrals to therapists and psychiatrists in the community who they know will be receptive to immigrant families.

Resources for practices:

American Academy of Child and Adolescent Psychiatry. Facts for Families: Finding Mental Healthcare for Children of Immigrants. http://www.aacap.org/aacap/Families_and_Youth/Facts_for_Families/Facts_for_Families_Pages/Finding_Mental_Healthcare_for_Children_of_Immigrants_112.aspx

Introduction to Community Health Workers/Promotores de Salud <http://minorityhealth.hhs.gov/templates/content.aspx?lvl=2&lvlid=207&ID=8930>

Outreach-direct, one-to-one assistance from persons with similar experiences <http://kff.org/disparities-policy/issue-brief/connecting-eligible-immigrant-families-to-health-coverage/>

Rural Assistance Center Community Health Worker toolkit <http://www.raconline.org/communityhealth/chw/files/community-health-workers-toolkit.pdf>

WHAT ARE SOME PROVEN INTERVENTION AND TREATMENT STRATEGIES FOR CHILDREN WITH PTSD AND OTHER MENTAL, EMOTIONAL AND BEHAVIORAL HEALTH PROBLEMS?



Community pediatricians may be called upon to evaluate and recommend treatment strategies that have proven outcomes. Many evidence-based treatments are effective for children from various cultural backgrounds without significant adaption except for language. These include:

- *Cognitive-behavioral therapy (CBT) for anxiety and child focused play therapy are examples of therapies that are effective without modification.*
- *Functional Family Therapy (FFT) and Multi-Systemic Therapy (MST) for families with adolescents with substance abuse or conduct disturbance have been effect across cultures.*
- *Incredible Years and Parent-Child Interaction Therapy have similar outcomes in culturally modified and unmodified forms.*

Some treatment strategies have been developed or modified specifically for particular immigrant populations. These adaptations are often school based in order to increase identification and retention of children who otherwise would be difficult to reach because of lack of health coverage, parental perceptions and unrecognized need for care.

- *Cognitive Behavioral Intervention for Trauma in Schools (CBITS) utilizes bilingual therapy sessions, trauma narratives that use music settings familiar to the children and group treatment that may include faith tradition activities such as forgiveness rituals to improve social problem solving.*
- *Group TF-CBT (trauma focused cognitive behavioral therapy) and Functional Family Therapy have both been modified with reliably successful outcomes with Hispanic children.*

Learn more:

Kataoka et al. A School-Based Mental Health Program for Traumatized Latino Immigrant Children. *J. Am. Acad. Child Adolesc. Psychiatry*. 2003, 42(3):311–31

Malgady, R. Treating Hispanic Children and Adolescents Using Narrative Therapy. In: *Evidence-Based Psychotherapies for Children and Adolescents*. 2012 The Guilford Press. New York

McCabe, Kristen and Yeh, May(2009) 'Parent-Child Interaction Therapy for Mexican Americans: A Randomized Clinical Trial', *Journal of Clinical Child & Adolescent Psychology*. 38: 5, 753 — 759

McLaughlin et al. Trauma Exposure and Posttraumatic Stress Disorder in a National Sample of Adolescents. *J. Am. Acad. Child Adolesc. Psychiatry*. 2013;52(8):815–830.

National Child Trauma Stress Network: www.nctsn.org

Ngo et al. Providing Evidence-Based Practice to Ethnically Diverse Youths: Examples From the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) Program. *J. Am. Acad. Child Adolesc. Psychiatry*. 2008,47(8):858–862

Practice Parameter for the Assessment and Treatment of Children and Adolescents with Posttraumatic Stress Disorder. *J. Am. Acad. Child Adolesc. Psychiatry*. 2010;49(4):414–430.

Robbins, M., Horigan, V., Szapocznik, J. and Ucha, J. Treating Hispanic Youths Using Brief Strategic Family Therapy. In: *Evidence-Based Psychotherapies for Children and Adolescents*. 2012 The Guilford Press. New York

WHAT ARE SOME HIGH-RISK CIRCUMSTANCES THAT MAY REQUIRE SPECIAL ATTENTION?



Children living in mixed legal status (at least one undocumented parent), in families affected by deportation and in foster care require special attention during the assessment.

Children living in mixed status families

An analysis by The Pew Research Center based on 2009 data estimates that there are 4.5 million children who are US citizens and who are living with one or more parents or guardians who are undocumented. Another million children who live in mixed status families are themselves undocumented. These families often live in constant anxiety of detection and fear of deportation so consequently use medical and mental health services at a low rate. In one survey, 40% of children in mixed status families had not seen a doctor in the previous year. Living with constant anxiety about their parents' future as well as their own is associated with poor school performance and a rate of school drop-out higher than children in a more secure family status.

Learn more:

Enchautegui, Maria. Broken Immigration Policy: Broken Families. The Urban Institute 2013 available from: <http://www.urban.org/UploadedPDF/412806-Broken-Immigration-Policy-Broken-Families.pdf>

Henderson S and Bailly C. Parental Deportation, Families, and Mental Health. *J. Am. Acad. Child Adolesc. Psychiatry*. 2013;52(5):451–453

Human Impact Partners. June 2013. Family Unity, Family Health: How Family-Focused Immigration Reform Will Mean Better Health for Children and Families. Oakland, CA. www.familyunityfamilyhealth.org

Pew Research Hispanic Trends Project: <http://www.pewhispanic.org/>

Immigrant children in foster care

One particularly toxic effect of deportation is an increase in US citizen children in long-term foster care. It is estimated that 5,100 children are living in foster care (2011) due to deportation of a parent. The current immigration enforcement systems are significant barriers to reunification. The children left by deported parents are often denied placement with extended family members because of issues related to documentation. The effects of abrupt and total separation from parents and family may have profound effects on the child's emotional development which may be expressed by withdrawal, anxiety, depression or oppositional defiance.

Resource for practices:

Helping Foster and Adoptive Families Cope with Trauma <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/Guide.pdf>

Learn more:

Applied Research Center. (2011) Shattered Families: The Perilous Intersection of Immigration Enforcement and the Child Welfare System. Available from: <https://www.raceforward.org/research/reports/shattered-families>

Unaccompanied Minors and Asylum Seekers

In 2014, a humanitarian crisis involving children occurred at the southern border of the United States. The Customs and Border Protection (CBP) apprehended over 50,000 children and youth from three Central American countries (Guatemala, Honduras and El Salvador) who arrived without a guardian. A study by the United Nations High Commissioner on Refugees (UNHCR) found that over half of the unaccompanied minors “were forcibly displaced because they suffered or faced harms that indicated a potential or actual need for international protection.” The displaced children were often exposed to or threatened by gang violence, abuse in the home or drug cartel related activities. An additional 15,000 children and youth were Mexican nationals, one-third of whom, according to the UNHCR, had been recruited into human trafficking. Many children suffered assault, theft and rape as they made their way to the US border. In addition to the tremendous need for trauma informed mental health care, some children and youth may qualify for asylum status. Being able to remain in the US, as a refugee would make available appropriate treatment. The website for Physicians for Human Rights (PHR) contains much important information helpful for pediatricians to understand the legal process of applying for asylum.

Resources for practices:

Physicians for Human Rights training resources
<http://physiciansforhumanrights.org/training/asylum/>

American Bar Association Immigrant Children Assistance Project
http://www.americanbar.org/groups/public_services/immigration/projects_initiatives/south_texas_pro_bono_asylum_representation_project_probar/immigrant_childreassistanceprojecticap.html

Learn more:

Byrne, O. and Miller, E. 2012. *The Flow of Unaccompanied Children through the Immigration System: A Resource for Practitioners, Policy Makers and Researchers*. New York: Vera Institute of Justice.
<http://www.vera.org/sites/default/files/resources/downloads/the-flow-of-unaccompanied-children-through-the-immigration-system.pdf>

Southwest Border Unaccompanied Alien Children. U.S. Customs and Border Protection. Department of Homeland Security. <http://www.cbp.gov/newsroom/stats/southwest-border-unaccompanied-children>

Children on the Run: Unaccompanied Children Leaving Central America and Mexico and the Need for International Protection. A Study Conducted by the United Nations High Commissioner for Refugees Regional Office for the United States and the Caribbean. Washington, D.C. (2014) http://www.unhcrwashington.org/sites/default/files/1_UAC_Children%20on%20the%20Run_Full%20Report.pdf

Immigrant youth who identify as Lesbian, Gay, Bisexual or Transgender

Immigrant youth may face additional cultural challenges and discrimination because of sexual orientation or gender identity. The need for socio-emotional support or mental health treatment may be especially acute if the young person left their country of origin after persecution because of sexual orientation and, upon arrival, experiences isolation, alienation and exploitation at the margins of society in the United States.

Resources for practices:

American Academy of Pediatrics. Committee on Adolescence Policy Statement. *Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth*. Pediatrics. 2013 Jul;132(1):198-203.
<http://pediatrics.aappublications.org/content/132/1/e297.full.pdf+html>

Immigrant Legal Resource Center
<http://www.ilrc.org/info-on-immigration-law/lgbt-immigrant-rights>

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