The TANF Time Limit:

Profile of Families at Imminent Risk

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Family Investment Administration Steering Committee
Maryland Department of Human Resources

February 2001

This report was prepared by the Welfare and Child Support Research and Training Group, School of Social Work, University of Maryland, 525 West Redwood Street, Baltimore, Maryland 21201 with support from its long time research partner, the Maryland Department of Human Resources.

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Executive Summary

The historic Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) made many significant changes to the nation's cash assistance program for poor children and their families. Among the most controversial and unprecedented changes was the imposition of a five year lifetime limit on the receipt of federally-financed assistance payments. The five year clock began to tick in our state in January 1997 and, in January 2002 the first Maryland families will begin to reach the limiting threshold.

PRWORA recognizes that, despite customers' and agencies' best efforts, there are some families for whom federally-financed aid should be continued beyond the 60 month mark. Specifically, the Act permits states to extend benefits to up to 20% of the caseload for reasons of hardship or because the case contains a person victimized by domestic violence. PRWORA does not define "hardship," leaving this determination to each individual state.

Maryland has a long, productive history of using empirical research to inform and shape public welfare policy. Consistent with this tradition, the Family Investment Administration Steering Committee, local case managers and the University of Maryland School of Social Work have collaborated on a study to help inform deliberations about time limit extension/exemption policy choices. This paper, using administrative data and case manager-provided survey data, profiles the characteristics of cases at most immediate risk of reaching the time limit. The barriers and service referral needs which case managers perceive are present in each case are also documented. Specifically, the study looks at the universe of Temporary Cash Assistance (TCA) cases in Maryland which, by the end of September 2000, had received benefits in at least 36 of the 45 months since the start of the state's time clock in January 1997.

In brief, the study shows that there are fewer than 5,000 imminent risk cases statewide (n=4446), but that the vast majority are located in Baltimore City (n=3620). In terms of demographics, the predominance of City cases in the at-risk group means that the "statewide" profile of these cases is, in reality, a profile of the at-risk cases in Baltimore City. With this caveat in mind, the statewide profile of Maryland families at most immediate risk of crossing the 60 month mark is that of a Baltimore City (80%) assistance unit headed by an African American (87.5%), never-married (85.5%), female (97.9%) in her early thirties (mean age: 32.7 years). In about three of five cases (61.6%) the mother gave birth to her first child before age 21; in about one case in three, the first birth occurred before the mother's 18th birthday (31.2%). The average age of the youngest child in these families is 5.49 years and the proportions of assistance units containing only one (29.4%) or two (29.4%) children are identical. About one in three families had been on welfare without interruption (45 of 45 months) since the time clock began to tick. A bit more than half of all families were on welfare for at least 95% of the time covered by the study.

Survey data on barriers most often perceived by case managers are consistent with what empirical research and practice wisdom have long opined: education, especially the lack of a high school or equivalency diploma; disability; and child care are among the most common obstacles in the lives of families with long histories of reliance on welfare. Administrative data point to another important obstacle as well: lack of a recent work history. Half of all payees in these at-risk cases (52.6%) did not work in a Maryland job covered by the Unemployment Insurance program in the two year period immediately prior to the start of the time limit clock (January 1995 - December 1996).

Survey data on service needs are similar. Job skill training, GED preparatory classes, referrals for potential receipt of disability-linked benefits (e.g., SSI and SSDI) and purchase of child care are the most commonly identified referral needs.

This study does provide information that can be useful in deciding what our state's initial time limit extension policy choices should be. Unlike certain other of our recent welfare research studies, however, results from this time limit study do not suggest one clear, "right" path to follow. Short of a decision to provide extended benefits to everyone (a choice which might be feasible at present, but probably not wise), there is no way to escape the fact that, under any time limit policy adopted, cash assistance will be involuntarily ended in some cases. The difficult decision confronting policy-makers is to determine the bases on which extensions will or will not be granted.

Introduction

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 is referred to as "welfare reform." In actuality, however, PRWORA repealed Aid to Families with Dependent Children (AFDC), which had existed with few structural changes since the mid-1930s, and replaced it with Temporary Assistance for Needy Families (TANF). As the U.S. General Accounting Office (1997) has noted, PRWORA instituted "the most fundamental reform of welfare since the program's inception" (pg. 2).

In addition to replacing the open-ended AFDC program with an effectively fixed-funded block grant, the Act also imposed a lifetime limit on receipt of federally subsidized cash aid.[1] For most families aid is limited to 60 months in a lifetime.[2] The Act also lets states set shorter maximums if they wish[3]. Maryland, like most states, chose a five year limit; the first Maryland families will reach that threshold in January 2002.

While federal time limits were unprecedented and initially very controversial, their adoption was consistent with the clear theme of TANF as providing financial assistance for "state-designed programs of time-limited and work-conditioned aid to families with children" (U.S. House of Representatives, 1998, pg. 494). Time limits were a clear, practical signal of federal intent to "turn welfare from a permanent support to a transitional subsidy" (Wagner, et. al. 1998, pg.1). However, the Act does recognize that, despite everyone's best efforts, there would be some families for whom reaching the five year limit is unavoidable. Thus, PRWORA

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[1] The Act also made many other substantive, changes to cash assistance and other means-tested programs; our focus here on the time limit provision is not meant to minimize the scope, impact or importance of these other significant provisions.

[2] Child-only cases are exempt from the federal time limit.

[3] States may continue to provide cash assistance to families which include an adult who has received aid for five years, but would have to absorb the total cost of such assistance from their own funds. State funds used for this purpose would count toward required Maintenance of Effort (MOE) expenditures.

allows states to exempt up to 20 percent of their caseloads from the five year limit on the grounds of hardship, or in cases which include victims of domestic violence.

The five year clock began ticking for Maryland TANF recipients on January 1, 1997. Thus, in less than one year the first Maryland families will cross the five year threshold. As this deadline nears, the issue of time limits has become a question of great concern to welfare administrators, legislators, advocates and families. Among the key questions of interest are ones such as: How many families are at risk of hitting the time limit right away? What are the characteristics of these at-risk families? Will the 20% hardship exemption be sufficient to protect all families who crash into the five year wall? And, perhaps of greatest practical and immediate importance, how should "hardship" be operationally defined in our state?

In the view of the Family Investment Administration (FIA) Steering Committee, a group of state and local TANF program administrators who meet regularly to discuss welfare reform issues, information about the characteristics and circumstances of those at greatest immediate risk of reaching the 60 month mark should be considered in these deliberations. This paper reports on a research project initiated by the Committee and carried out by front-line TANF case managers and the School of Social Work, University of Maryland-Baltimore, designed to gather this important information.

Background

Among the most hotly-debated issues in the mid-1990s era of welfare reform were the wisdom, practicality and consequences of imposing time limits on cash assistance receipt. Supporters of time-limits argued that the open-ended nature of cash assistance programs encouraged long-term welfare use or dependency. The adoption of time limits, it was asserted, would spur recipient adults to increase their work efforts and move off the rolls quickly, thereby avoiding the trap of long-term reliance on welfare. In short, the argument was that most recipients generally are able to work and that, by setting a firm deadline, recipients would be motivated to find a job and exit cash assistance (Greenberg, et. al., 1996). That is, time-limit proposals assumed that the presence of a firm deadline would induce many recipients to leave welfare earlier, a reasonable assumption to those who believe that long-term welfare receipt is largely attributable to recipients' behavior, as opposed to the nature of the opportunities available to them (Bloom and Butler, 1995).

Opponents countered that time limits would eliminate the safety net for families, push more than one million children into poverty (Zedlewski, Clark, Meieer and Watson, 1996) and increase homelessness (Bassuk, Browne and Buckner, 1996). It was believed that time limits would have these consequences because they were based on a faulty premise: that the adults most likely to be affected by time limits were those who would be able to successfully compete in the labor market (Meyer and Cancian, 1996). Among other things, it was noted that it remained unclear what proportion of welfare recipients had physical or mental problems that made it impossible for them to work steadily (Bloom and Butler, 1995).

Proponents and opponents of time limit adoption both drew on the accumulated body of welfare use patterns research to support their respective points of view. In actuality though,

despite the passionate rhetoric on both sides of the time limits issue, there was virtually no empirical evidence available on either the salutary or sinister effects of a time-limited welfare system. By the mid-1990s, nearly half the states had approved or pending welfare waiver programs which incorporated some form of a time limit. However, no state program had operated long enough for sizable numbers of families to have reached the time limit and none had completed formal evaluations of the effects of time-limited welfare on caseloads or families (Greenberg, Savner and Schwartz, 1996). Despite the fact that nothing like a truly time-limited welfare system had ever been tried in our country (Ellwood, 1992), the 60 month limit was incorporated into the 1996 PRWORA statute. In each state the time limit clock was to begin ticking when the changeover from AFDC to TANF took place, but no later than July 1, 1997.

Time limits were a “front-and-center” issue before the adoption of PRWORA, but has received considerably less attention from academics and administrators during the first years of the TANF program. This occurred in part because states were struggling with myriad other implementation issues, but also because, for the majority of states which had adopted the 60 month criterion, time limits were not a looming threat. More recently, in states with limits less than the 60 month federal maximum, the limiting threshold has been reached. As of June 2000, families had begun to reach time limits in 18 states and three additional states (Arkansas, Georgia, Ohio) reached the threshold in January 2001 (Center on Law and Social Policy, 2000).

With few exceptions, published literature about these milestones and what happens to affected families is scarce. However, the limited information available seems to suggest that, so far, massive numbers of families have not been dropped from the TANF rolls because of

time limits. According to a Washington Post survey conducted in states which were the first to reach their limits: “the limits are largely being sidestepped because states with plunging caseloads believe they can afford to give those on the rolls a break” (Havemann and Vobejda, 1998).

A number of states appear to have adopted policies that, one way or another, permit families (or children) to continue receiving some type of assistance after eligibility for federal TANF benefits has been exhausted. One approach, of course, is to use a segregated or separate state program to provide cash assistance beyond the 60 month point.[4] As noted previously, such expenditures can be counted toward states’ required Maintenance of Effort (MOE) expenditures and thus, in contrast to simply eliminating all assistance to needy children and their families, may be an appealing option in some states. Feeley and Stein (1999) note that “several other states, including Connecticut and Maine, have enacted [other] policies that make it possible for families to continue receiving benefits beyond their initial time limit....so long as families have a history of cooperation with the social service agency and are making a good faith effort to obtain or maintain employment” (pg. 2).

One might be tempted to opine that, generally speaking, “so far, so good” is a reasonable assessment of the time limit provision of PRWORA. Perhaps. But certain realities seem inescapable both nationally and at the state and local level. First, with the continued passage of time, more and more families will inevitably reach the time limit. Second, eventually, states will not deem it feasible, for financial or other reasons, to provide extensions or exemptions to every family which exhausts their eligibility for federally-subsidized cash

[4] The time limit clock is not ticking in Maryland for certain groups of families who are receiving aid via a separate state program. Most generally, these are cases involving domestic violence, disability, or caretaker relatives.

assistance. Third, it seems unlikely that states will be willing or able to continue cash aid to all families using 100% state funds. It also seems inevitable that, sooner or later, some recipients will reach their time limits during recessionary or slow growth periods.

Under any scenario, each state, must make explicit policy choices about what it will do when families exhaust their lifetime eligibility for federally-funded TANF benefits.[5] PRWORA itself provides a partial answer to this question; the statute provides that up to 20 percent of the state's caseload can continue to receive federally-subsidized benefits beyond the 60 month mark when there is "hardship" or the case includes an individual who has been a domestic violence victim. The federal statute does not define what constitutes a hardship, however.

The absence of a federal definition of "hardship," the nature of MOE and segregated state program rules, and greatly decreased caseloads afford states great flexibility in establishing and defining their own state-appropriate policies for dealing with families who have exhausted eligibility for federal aid. As a general rule, however, most states adopted "general language similar to the federal TANF language...without any further guidance or interpretation" (Schott 1998, pg. 7) and only as their within-state time limit approaches begin to more specifically define "hardship" and extension/exemption policies. The State of Maryland is now within one year of having its first families reach the 60 month limit and, therefore, is engaging in serious dialogue about what the specifics of our extension/exemption policies should be, at least initially. Many things need to be taken into account when making

[5] Schott (1998) makes a useful distinction between these policy choices and those relating to exemptions. Exemption policies usually recognize that time limits should not apply for certain groups of families based on circumstances that exist during the period of welfare receipt, while extension policies generally identify circumstances - usually related to hardship - under which benefits to families to whom time limits do apply should continue even though the time limit clock has run out.

these decisions. Findings reported in the remainder of this paper about the population of Maryland families who are at most immediate risk of reaching the limit is one such factor. It is also useful to consider the policy choices that have been made in other states. Thus, we conclude this background chapter by borrowing extensively from Schott's (1998) paper, "State Choices on Time Limit Policies in TANF-Funded Programs". This paper, issued by the Center on Budget and Policy Priorities, offers a succinct summary of the types of policies adopted in other states and, considered in concert with other research, program, expenditure and caseload projection data, should help Maryland decision-makers as they wrestle with these issues.

As previously noted, extension policies and criteria - including the state-defined, operational definition of "hardship" - address how and for whom a state will continue to provide assistance **after** the time limit has been reached. In the case of Maryland, this means after a family has accumulated 60 months of countable federally-financed TANF assistance.[6] Schott notes that, generally, states' extension policies are based on individual or family circumstances which exist when the time limit is reached; usually, the qualifying types of personal or familial "hardship" are explicitly stated. Some states' policies also include other acceptable individual or personal reasons for extension such as completing an in-progress training program or substance abuse treatment. Finally, some states' extension policies also take into account broader situations of "hardship" which apply to all families in a given geographic area, such as high rates of unemployment.

[6] Certain months of federally-financed TANF aid may not be countable because the family was "off the clock" either because they were exempt or they were receiving assistance through a separate, state-funded program where the federal time limit does not apply.

In addition to delineating personal hardship criteria, Maryland decision-makers may also wish to consider making provision for some type of community-wide "hardship" trigger in crafting the state's TANF time limit extension policy. The most likely candidate for consideration would probably be the local unemployment rate; another might be some quantifiable indicator of an insufficient number of jobs in the locality. Precedent does exist in Maryland for using a community-wide "hardship" measure to exempt individuals from federal program requirements. Currently, able-bodied adults without dependents (ABAWDS) in certain Maryland subdivisions are exempt from Food Stamp work requirement time limits because they live in a designated labor surplus area or because the employment-population ratio in their area is worsening (Jackson, 1997). If there is interest in exploring the desirability and feasibility of incorporating some type of locality-based economic hardship criterion into the TANF extension policy, program guidance materials issued by the Food and Nutrition Service might provide a good place of beginning.[7]

In making the important decisions about TANF time limit extension/exemption criteria one important piece of information, as noted, is that which describes the population at most immediate risk of being affected by the decisions reached. Consistent with Maryland's well-established and nationally-renowned tradition of using empirical research to inform public welfare policy, the remainder of this paper describes the method and findings of a recent study concerned with TANF time limits. Specifically, the paper describes a study of Maryland families who are at risk of reaching the 60 month time limit in the initial months of calendar year 2002.

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[7] The current situation may not warrant this type of community-wide hardship trigger. In more recessionary times, if caseloads increase, welfare spell durations lengthen and wall-hitting becomes les s rare, however, such mechanisms might be appropriate. The time to think about which such indicator might work best and how such an approach might be operationalized, of course, is now.

Methodology

The purpose of this study is to provide information that can inform deliberations about the criteria to be used in deciding if benefits will be extended once a family reaches the 60 month time limit. Specifically, the study provides current, valid data about Maryland families who are at most immediate risk of reaching this threshold, beginning in January 2002. The analysis seeks to answer several specific questions about this population:

1. *What are the characteristics of the at risk population?*
2. *What barriers to independence do these families face?*
3. *What services do their caseworkers think these families need?*

The remainder of this chapter describes how the research was conducted, beginning with a description of the study sample.

Sample

The cohort of Temporary Cash Assistance (TCA) families of interest in this study are those who, at the end of September 2000, had received benefits for 36 or more months during the 45 month period beginning with January 1997, the start of Maryland's time limit clock. [8] Cases meeting this criterion were identified via a query of the Client Automated Resource and Eligibility System (CARES). CARES is the state's automated system containing demographic data as well as case- and client-level data about the utilization of public assistance programs under the purview of the Department of Human Resources (DHR) and local Departments of Social Services (LDSS).[9] This query identified 4446 cases statewide

[8] A month of TCA receipt is not counted towards the time limit if the benefits are paid with state rather than federal funds or if the family is exempt.

[9] Maryland's welfare program is state-supervised by the cabinet-level Department of Human Resources and locally administered by the Departments of Social Services of which there are 24, one in each of the state's 23 counties and in the separate, incorporated City of Baltimore.

which met the TCA utilization criterion. An instrument, *Potential Time Limit Evaluation Form*, was developed for this study by the FIA Steering Committee and sent to LDSS case managers responsible for each case identified in the query. Completed surveys were returned to DHR and forwarded to the School of Social Work for data entry, data analysis and report preparation. A total of 3983 usable surveys were received for the 4446 cases, a response rate of 89.6%.[10]

Data Sources

The Time Limit Evaluation Form was one key data source. This form was meant to gather data from front-line staff about barriers faced by the family and service referrals needed by the family. A sample form is attached as Appendix A.

To compliment this information, data from two information management systems were also utilized. The first is CARES which provided demographic and service utilization data for clients of programs under the purview of DHR. The second is MABS, Maryland Automated Benefits System, which contains official data on employment and earnings in Maryland jobs covered by the State's Unemployment Insurance (UI) program.[11]

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[10] Of the 463 forms not returned, virtually all of them (n=459/463 or 99.1%) were from Baltimore City (n=441/463 or 95.2%) or Prince George's County (n=18/463 or 3.9%). Duplicate forms and forms completed on out-of-range cases were also received; these were eliminated during the data cleaning process.

[11] About 93% of in-state jobs are covered. Important within-state omissions include military and civilian federal employees, among others. We also have no data on out-of-state jobs, a severe constraint because more than one in three employed residents in some Maryland counties are known to work in other states or the District of Columbia.

Findings

In this chapter we present descriptive findings on the characteristics of TCA recipient families in Maryland who, compared to all other families, are at greatest imminent risk of reaching the federally-mandated 60 month limit on receipt of cash assistance benefits.[12] Caseworkers' perceptions of the problems or barriers faced and service referrals needed by these families are also reported. We begin with a description of the geographic distribution of the at-risk population.

Where Are These Cases Located?[13]

Table 1, on the following page, shows how at-risk sample cases (n=3983) are distributed across the state's 24 local jurisdictions. As shown, the families in most immediate danger of reaching the 60 month time limit are not evenly distributed across the state. Rather, the vast majority of these families are located in Baltimore City. Indeed, just about eight of every 10 at-risk families (n=3179/3983 or 79.8%) were City residents. Another 10% of families (n=431/3983 or 10.8%) were in Prince George's County, while about four percent (n=155/3983 or 3.9%) resided in Baltimore County. These three subdivisions together account for 94.5% of all Maryland families at most immediate risk of reaching the 60 month limit. In contrast, there are three subdivisions (Allegany, Kent and Talbot counties) where no families are projected to reach the limit in January 2002; in seven other counties, fewer than five families are at immediate risk (Calvert, Caroline, Cecil, Howard, Queen Anne's, Washington, Worcester).

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[12] Clients can accumulate 60 months of on-the-clock benefit receipt either in one long continuous spell or through a series of shorter, separate spells perhaps spread over many years. PRWORA, however, makes no distinction between the two situations; for purposes of the time limit trigger, 60 months is an absolute.

[13] As noted in the Methodology chapter, 463 surveys were not returned, virtually all of them (n=459/463, 99.1%) from Baltimore City (n=441/463 or 95.2%) or Prince George's County (n=18/463 or 3.9%). Our analysis is restricted to the 3983 cases (4446-463) for which forms were received.

Table 1. Distribution of At-Risk Cases by Jurisdiction

Jurisdiction	Number of At-Risk Cases	Percent of Statewide Total
Allegany	0	0.0%
Anne Arundel	45	1.1%
Baltimore County	155	3.9%
Calvert	2	*
Caroline	3	*
Carroll	12	*
Cecil	1	*
Charles	29	*
Dorchester	16	*
Frederick	5	*
Garrett	5	*
Harford	16	*
Howard	3	*
Kent	0	0.0%
Montgomery	32	*
Prince George's	431	10.8%
Queen Anne's	1	*
Saint Mary's	11	*
Somerset	8	*
Talbot	0	0.0%
Washington	4	*
Wicomico	24	*
Worcester	1	*
Total - *All Counties*	804	20.1%
Baltimore City	3179	79.9%
Total - *Statewide*	3983	100.0%

Note: * = less than one percent

In the most general sense, the distribution of at-risk cases is in line with overall caseload proportions. That is, subdivisions with proportionately high numbers of at-risk clients are also those with proportionately high cash assistance caseloads. However, the at-risk group is much more highly concentrated in Baltimore City (79.9%) than were September 2000 TCA active cases (17560/28797 or 60.9%) in general.[14] Notably also, Baltimore City (79.9%) and Prince George's County (10.8%) together account for nine of every 10 cases facing the most immediate threat of benefit exhaustion (90.7% of the statewide total).

At least in the short-run, it seems clear from these universe data that "wall hitting" is predominantly an urban phenomenon. As will be discussed later in the report, however, it would be a mistake to assume that, over time, wall hitting will not be a problem in rural parts of the state.

What Are These Families' Patterns of Welfare Use?

By definition, all families with whom this paper is concerned were ones who, by the end of September 2000, had accumulated a minimum of 36 months of welfare receipt during the first 45 months of time-limited welfare in Maryland (1/1/97 - 9/30/00). Put another way, to be included in this study, families had to have been on welfare for at least 80% of the time (36/45 months). Table 2, following, presents more specific information on the number of months of receipt (36 to 45) by sample families during the January 1997 (time clock start) to September 2000 (study end date) period.

[14] Authors' calculations from *TCA Core Caseload Report*, Family Investment Administration, November 2, 2000

Table 2. Months of TCA Use: January 1997 - September 2000[15]

Total Months on TCA	Number of Cases	Percent of Cases	Cumulative Percent
36 months	221	5.5%	5.5%
37 months	273	6.8%	12.3%
38 months	243	6.1%	18.4%
39 months	238	6.0%	24.4%
40 months	241	6.1%	30.5%
41 months	303	7.6%	38.1%
42 months	293	7.4%	45.5%
43 months	354	8.9%	54.4%
44 months	558	14.0%	68.4%
45 months	1,259	31.6%	100.0%
Total	*3,983*	*100.0%*	*100.0%*

It is immediately apparent from Table 2 that the most common pattern among these at-risk families is to have received cash assistance in all 45 months. Not quite one of every three families (n=1259/3983 or 31.6%) were on welfare continuously - that is, they received cash assistance for 100% of the time. It is this particular group of families who, all else equal, and assuming their situations do not change - will crash into the 60 month barrier in January 2002.

Table 2 also shows that, with only a few exceptions, the general pattern among this cohort is one of "more" rather than "less" use of welfare during the study period. That is, 45 of 45 months of welfare receipt is the most common situation, followed by 44 of 45 months on welfare and then 43 of 45 months on aid. When we examine these data in terms of "percent

[15] For purposes of this report, we did not examine whether clients on TCA for less than 100% of the time had accumulated their total months on TCA in one spell or multiple spells. We also made no attempt to ascertain the benefit start date, the length of time between spells, or reasons for case closure/reopening when there were multiple spells.

time on welfare," we see that a bit more than half of all families (n=2171/3983 or 54.5%) in our at-risk cohort were on welfare for at least 95% of the time covered by the study (n=43 months/45 months).

We also examined participation patterns separately for each of the 21 subdivisions where there was at least one family who had received TCA in at least 36 of the most recent 45 months.[16] Participation patterns were quite similar. In 14 of the 21 counties, the most common situation was receipt of welfare in all 45 months. In the seven counties where this was not the case (Calvert, Caroline, Cecil, Garrett, Howard, St. Mary's, Worcester), there was no consistent pattern.[17]

Thus far the analysis suggests that the first families who will reach the 60 month time limit in Maryland share two characteristics: they overwhelmingly reside in Baltimore City (79.9%) and they have been on welfare at least 95% of the time since January 1997 when the clock began ticking. For program planning and/or extension/exemption policy decision-making, however, an important caveat must be stated. That is, one should not conclude that, over time, it is only or even primarily urban and continuous recipient families who will be at greatest risk of reaching time limit thresholds. This caution is warranted because the very first customers to reach the 60 month mark in Maryland will do so in a 60 month period (January 1997 - January 2002). By definition, therefore, the first wave of wall-hitters are all also long-term welfare recipients.[18]

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[16] The CARES query identified no such families in Allegany, Kent and Talbot counties.

[17] Because the number of at-risk cases in most subdivisions is less than 20, we are not presenting subdivision-specific data in tabular form or presenting detailed findings in the text as an added safeguard to insure the anonymity of at-risk families.

[18] There are differences of opinion among scholars as to what constitutes long-term or chronic welfare use/dependency. Nonetheless, we believe virtually all would agree that all customers

We would not dispute that chronic, uninterrupted welfare use is, itself, a type of "hardship," but PRWORA clearly indicates that merely exhausting one's eligibility for aid is not the type of "hardship" for which time limit extensions were meant to be granted. Thus, the authors believe state and local elected and appointed officials should proceed with great caution in developing exemption/extension policies and criteria. In particular, we would not recommend basing these important decisions solely or even mainly on data describing the first wave of potential wall-hitters. These families' situations may not be and, we think, are not likely to be representative of the hardships experienced by families who reach the 60 month limit later on. At minimum, we believe exemption/extension policies should not be written into statute in order to facilitate the process of change as more - and potentially very different - families reach the 60 month limit.[19]

What Is the Profile of an At-Risk Case?

Table 3, following this discussion, presents summary data on the 3983 families who had received TCA benefits in Maryland for at least 36 of the 45 months since the clock began ticking on January 1, 1997 and for whom a survey was completed.[20] Because these families are long-term, generally continuous users of welfare, they are at the most immediate risk of reaching the 60 month wall. In reviewing the table, readers are asked to bear in mind first

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examined in this study can and should be characterized as "long-term" users.

[19] In terms of absolute numbers, it is likely that more wall-hitters will always be from Baltimore City than anywhere else simply because the City now accounts for at least 60% of the entire state caseload. This reality notwithstanding, clients in other parts of the state (e.g., rural residents whose employment opportunities are often seasonal) are also at risk of reaching the time limit.

[20] Using CARES data, we were also able to profile the demographic characteristics of the 463 cases for whom no caseworker survey was returned. This profile can be found in Appendix B. As expected, this profile is similar to that shown in Table 3 since non-surveyed cases (n=441/463 or 95.2%), like surveyed cases (n=3179/3983 or 79.9%), were overwhelmingly in Baltimore City.

that these data really are a profile of at-risk cases in Baltimore City since City cases account for eight of every 10 cases in the statewide sample (n=3179/3983 or 79.9%). Second, there is also considerable overlap between this profile and the profile of a long-term or chronic welfare case since, by definition, all cases in this first at-risk cohort are all also long-term welfare users. For these and other reasons, the profile of families at risk to hit the 60 month threshold can be expected to change over time. The general caveat is this: long-term reliance on cash assistance and "hardship" are not necessarily synonymous, especially in terms of this very first cohort of families.

A composite sketch of the Maryland TCA family at most immediate risk of accumulating 60 months of welfare receipt in 2002 is that of a Baltimore City (80%) assistance unit headed by an African American (87.5%), never-married (85.5%), female (97.9%) in her early thirties (mean age: 32.7 years). In about three of five cases (61.6%), the mother gave birth to her first child before age 21; in about one case in three (31.2%) , the first birth occurred before the mother's 18th birthday.[21] The average age of the youngest child in these families is 5.49 years and the proportions of at-risk assistance units containing only one (29.4%) or two (29.4%) children are identical. About one case in three (31.8%) contains a child under the age of three years.

[21] Age at first birth estimates for female payees are conservative. They are calculated using the payee's date of birth and the date of birth of her oldest child in the assistance unit. Our figures understate the true rate of early childbearing among the sample if payees have other, older children who are not included in the assistance unit.

Table 3. Profile of Cases at Risk of Benefit Exhaustion

Payee Demographics	
Female Heads of Assistance Units	97.9%
Racial/Ethnic Group	
African-American	87.5%
Caucasian	9.5%
Unknown	2.5%
Hispanic	0.2%
Native American	0.2%
Asian	0.1%
Marital Status	
Never Married	85.5%
Separated	8.5%
Divorced	2.4%
Married	2.4%
Widowed	0.3%
Unknown	0.2%
Age of Payee	
Mean	32.7
Median	32.0
St. Dev.	7.47
Range	20 to 66
Payee's Estimated Age at Birth of First Child	20.76
Mean	19.00
Median	5.30
Std. Dev.	14 to 47
Range	
	31.2%
Payees who gave birth before 18	61.6%
Payees who gave birth before 21	

Assistance Unit Composition	
Assistance Unit Size	
Mean	3.38
Median	3.00
Std. Dev.	1.43
Range	1 to 14
Cases with one adult	99.9%
Cases with only one child	29.4%
Cases with two children	29.4%
Cases with three children	21.2%
Cases with four children	10.4%
Age of youngest child in assistance unit	
Mean	5.49
Median	4.00
Std. Dev.	4.53
Range	0 to 19
Assistance Units with a Child Under 3	31.8%

What Barriers Do These Families Face?

By definition, all families in this study had been on welfare more than they had been off the rolls during the 45 month period from January 1997 to September 2000. Indeed, as previously discussed, the majority of them had received cash assistance for at least 95% of the time. Given the early intervention and "work first" orientation of the new welfare program, a reasonable assumption would be that study families might well be facing barriers that have prevented them from making the transition from welfare to work.

In planning for the next few years of welfare reform in general and, particularly, in planning the state's time limit extension and exemption policies, of course, empirical data, rather than assumptions, are much more reliable. Thus, a primary intent of the survey and this analysis is to begin to document the nature and number of barriers which caseworkers believe are present in these at-risk cases. To capture this information, the survey form listed seven discrete categories of barriers which the literature and experience have shown to be common in this population: health; education; substance abuse; mental health; housing; transportation; and child care. The form also provided space where "other" barriers could be listed in open-ended form and workers were instructed to check as many barriers as appropriate for each family.

In examining study results on identified barriers, readers are asked to bear in mind that, for a variety of reasons, clients may be reluctant or unwilling to confide in their caseworkers, especially about highly sensitive matters. Thus, our data may paint an incomplete picture of the true complexity of these clients' situations and/or the barriers to independence which they actually face. Readers are also reminded that the barrier patterns evident in this first at-risk cohort may not be representative of patterns which will characterize families who reach the 60

month mark in subsequent months or years. With these important caveats in mind, what does the survey reveal?

As shown in Table 4, following, for the statewide sample, the most commonly-identified barrier was education, specifically the customer's lack of a GED or [high school] diploma. This was identified as an issue in nearly one of every two cases (46.8%). Health was a distant second, being seen as problematic in 15.6% of study cases. The remaining five listed barriers and the proportion of cases in which each was seen by the worker as being a barrier were: child care (12.4%); substance abuse (8.6%); transportation (7.8%); housing (4.1%); and mental health (3.5%). On more than half of the forms (56.3%), some notation was also made under "other". On virtually all of these forms, however, the notations consisted of explanatory information about the client's situation (e.g., mild mental retardation as an explanation of the customer's health barrier), rather than the identification of "other" barriers. In the relatively few instances (n< 50) where "other" barriers actually were identified, they were such things as the need for budget management, pregnancy, criminal background, language difficulties, and lack of a work history.

Although not part of the survey, we also examined the possibility that these customers faced another barrier to independence: lack of work history. Specifically, we looked at the extent to which caseheads in these at-risk families had worked in Maryland jobs covered by the Unemployment Insurance system in the periods immediately prior to the imposition of time limits. Findings suggest that, for a sizeable proportion of cases, lack of recent work experience may, in fact, be a relevant and important barrier. Indeed, this barrier appears to be more prevalent than any of the others covered by the survey. Just over half (52.6%, n=1879/3750) of all payees for whom survey and employment data were available did not

work at all in the two year period between January 1995 and December 1996. Nearly two of three (65.4%, n=2333/3750) did not work at all in the calendar year (1996) immediately before the time limit clock began to tick.

Table 4. Proportion of Families Facing Various Barriers[22]

Category of Barrier	Number of Cases	Proportion of Cases
Education[23]	1864	46.8%
Health	621	15.6%
Child care	494	12.4%
Substance abuse	344	8.6%
Transportation	310	7.8%
Housing	162	4.1%
Mental health	138	3.5%

Because Baltimore City cases are so predominant in the study sample (79.9% of all cases statewide), it was important to look at workers' perceptions of families' barriers separately for each subdivision. This analysis revealed tremendous diversity across the state. For each of the 21 subdivisions containing one or more at-risk families (Allegany, Kent and Talbot had none), the following table indicates the "top three" barriers identified for that locality's at-risk families.[24]

[22] On 391 of 3983 forms (9.8%) no barriers were checked or listed. We have not examined these cases in detail, but the vast majority of them (n=345/391 or 88.2%) were cases from Baltimore City (n=291/391 or 74.4%) or Prince George's County (n=54/391 or 13.8%).

[23] The survey was constructed such that the education barrier question was a forced-choice item where workers were to indicate if the client possessed "no diploma or GED" or "possess diploma/GED or post-secondary". Figures appearing in the table (n=1864 or 46.8%) represent the number of forms on which workers indicated "no diploma or GED".

[24] No numbers are provided as an extra anonymity protection because the numbers of cases in some subdivisions are extremely small.

Table 5. Top Three Barriers by Subdivision

Subdivision	Barrier #1	Barrier # 2	Barrier #3
Anne Arundel	Health	Mental health	Education, Child Care, Transportation, Substance Abuse
Baltimore County	Education	Health	Child care
Calvert	Education, Health Mental Health	Education, Health Mental Health	Education, Health Mental Health
Caroline	Health	Child care	-------
Carroll	Education and Health	Education and Health	Substance Abuse, Mental Health, Housing, Transportation
Cecil	Education, Health Mental Health	Education, Health Mental Health	Education, Health Mental Health
Charles	Transportation	Education	Child care
Dorchester	Transportation Child Care	Transportation Child Care	Education
Frederick	Education Child Care	Education Child Care	Transportation, Health, Substance Abuse
Garrett	Health	Mental health	Education, Transportation, Housing
Harford	Health	Transportation	Education
Howard	Health, Mental Health, Substance Abuse, Transportation	Health, Mental Health, Substance Abuse, Transportation	Health, Mental Health, Substance Abuse, Transportation
Montgomery	Health	Mental health	Housing
Prince George's	Child care	Transportation	Education
Queen Anne's	Mental health	--------	-------
Saint Mary's	Education	Health	Transportation
Somerset	Mental health	Health	Education, Transportation, Substance Abuse
Washington	Health	Child care	------
Wicomico	Education	Health, Transportation	Health, Transportation
Worcester	None listed	None listed	None listed
Baltimore City	Education	Health	Substance abuse

Note: Multiple entries in the same cell indicate a tie between/among the barriers listed.

The sub-division specific data indicate that the tremendous diversity which characterizes our small state also characterizes the barriers or problems faced by families who are at most immediate risk of reaching the 60 month time limit. These data also point out that "statewide" figures often do mask important intra-state variations. That is, Table 5 appears to suggest that, just as the state rejected a "one size fits all" approach to welfare reform, it may need to consider how some degree of local flexibility (within state parameters) can likewise be incorporated into time limit extension/exemption policy parameters. Indeed, it seems imperative that this be done so that local Departments of Social Services actually are able to protect families who, in the context of their own local communities, are experiencing real "hardship".

Transportation difficulties, to illustrate, would probably not make it onto a list of acceptable reasons for time limit extension/exemption, if one looked only at the statewide figures. Table 5, however, shows that in 10 of 20 counties, transportation is seen as one of the top three barriers for at-risk families. Mental health problems, similarly, appear on the top three list in nine of 20 local jurisdictions, although not ranking high on the "statewide" list. Regardless of the specifics, it certainly seems that these extension/exemption decisions should be made on a case-by-case basis, that the barriers be specifically identified, the extension be granted for a specified period of time, that a case plan be developed and, certainly that all of this is carefully documented in the case file/CARES.

The explicit purpose of this study is to identify characteristics and circumstances of families at most imminent risk of crossing the 60 month threshold. An implicit purpose, we trust, is to provide beginning food for thought as to how amenable to intervention and resolution some of these families' problems may or may not be and what might be needed in

the way of resources to address those problems. The documented data on barriers alone seems to make it crystal-clear that, just as the initial phases of welfare reform and “welfare to work” required cross-agency and community-wide efforts, so too will our efforts over the coming years to work with high risk families such as these. It is obvious from Table 5 that many of the most common barriers faced by these families are ones that the local welfare agency, in isolation, is probably powerless to ameliorate. The next section of the report speaks more directly to the question of identified service needs.

What Services/Referrals Are Needed by These Families?[25]

The section of the form soliciting information about service needs instructed staff to indicate the referral needs indicated in the case record or assessed by the case manager completing the data collection instrument. The same seven topic areas (health, education, substance abuse, mental health, housing, transportation, and child care) were listed and space where “other” answers could be recorded was also provided. For each topic except mental health, several sub-categories of response could also be checked and, once again, case managers were asked to check all items which, in their opinion, applied to the family. Table 6, following, presents statewide findings at the most general level (the seven topic areas). In examining the table, readers are cautioned that these data likely understate families' involvement with service programs. That is, for most questions the survey response choices required workers to select from a list of "referrals to" (e.g. a referral to SSI/SSDI, referral to Vocational Rehabilitation). It is thus conceivable, and in our view likely, that many

[25] To the extent that workers were unaware of barriers facing families, these data may understate service referral needs among families at risk of reaching the 60 month time limit.

families in need of the various services, but already referred to or engaged with the service provider will not be captured in this data.

Table 6. Identified Service/Referral Needs: At-Risk Families Statewide

Area of Service Need	Number of Cases	Proportion of Cases
Education	1,380	34.6%
Child care	658	16.5%
Health	483	12.1%
Transportation	403	10.1%
Substance abuse	353	8.9%
Housing	191	4.8%
Mental health	114	2.9%

The table shows that, consistent with the barriers identified, the most commonly-needed services are those related to education (34.6% of cases), child care (16.5%) and health (12.1%).[26] Again, however, these are statewide figures and, because Baltimore City accounts for eight of every 10 study cases, do not necessarily reflect service/referral needs identified in the individual counties. The next table presents the top three service needs by jurisdiction for the 21 subdivisions where there was at least one sample family.

[26] On 615 forms (15.4%), some "other" referral need was checked. In most instances, however, the written response provided explanatory information about the family's situation rather than identification of some "other" referral need.

Table 7. Top Three Identified Service Needs by Jurisdiction

Jurisdiction	#1 Service Need	#2 Service Need	#3 Service Need
Anne Arundel	Health	Education	Housing
Baltimore County	Education	Health	Child care
Calvert	Education	-----	-----
Caroline	Health	Education	-----
Carroll	Health	Education, Substance Abuse	Education, Substance Abuse
Cecil	Health	Education	-----
Charles	Education	Health, Transportation	Health, Transportation
Dorchester	Child care	Education Transportation	Education Transportation
Frederick	Health	-----	-----
Garrett	Health	Mental health	Housing, Transportation
Harford	Child care	Health, Education	Health, Education
Howard	Health	-----	-----
Montgomery	Health	Education, Mental Health	Education Mental Health
Prince George's	Education	Child care	Transportation
Queen Anne's	Health	-----	-----
Saint Mary's	Education	Transportation	Health, Child Care
Somerset	Health	Mental Health, Transportation	Mental Health Transportation
Washington	None listed	None listed	None listed
Wicomico	Transportation	Health	Education
Worcester	Health	-----	-----
Baltimore City	Education	Substance Abuse	Health

Note: multiple entries in the same cell indicate a tie between/among the referral needs listed.

The subdivision-specific data once again illustrate the wide diversity across counties and within this at-risk population. In our view they also illustrate that effectively serving at-risk families requires that resources outside the control of the state and local welfare system be available and brought to bear. More specific insight into the nature of the services or referrals needed by these families is provided by examination of the sub-category information which workers could complete for six of the seven topic areas.[27] We examine each area in turn at both the statewide and subdivision level. In interpreting these data, readers are cautioned that, due to item construction, the reported figures may understate the true incidence of each service "need" within this at-risk population.[28]

Health Service Needs

Under the category of health, workers could more specifically indicate that a referral was needed to one of three services or programs: Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI); some other type of disability insurance program; or to Vocational Rehabilitation. Statewide there were 483 forms (12.1%) on which the case record documented or the case manager assessed that the family had a health referral need. The data show that, when a health referral was indicated, overwhelmingly, the perceived need was for referral to Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). Three of every four identified health needs were of this type (n=365/483 or 75.5%). Only about one in five customers (n=66/483 or 13.6%) were thought appropriate for referral to

[27] No sub-categories were listed on the form under mental health.

[28] As noted, the main survey question asks workers to "identify the services needed by the family" in each of the seven topic areas. Almost all of the sub-topic response choices, however, are of the form "referral to x". The two phenomena (needing a service and needing a referral) are not exactly the same; since one might not need a referral, but still be in need of the service (e.g., which has already begun), the reported figures may be an accurate barometer of "referral needs" for problems of which case managers are aware, but almost certainly underestimate "service needs".

Vocational Rehabilitation, while about one in 10 (n=52/483), it was thought, should be referred to another, though unspecified, disability program.

Examination of data at the LDSS level reveals that in nine of 19 jurisdictions where at least one health service/referral need was indicated, the most common specific need was for referral to SSI/SSDI. Perhaps notably, however, in eight jurisdictions - primarily smaller, rural counties - referral to vocational rehabilitation was the most commonly noted health need or was tied with SSI/SSDI as the most common need.

Education Service/Referral Needs

Case managers could check one of four specific types of referrals related to educational needs in sample families. These were referrals to: high school or GED preparatory courses; job skills training classes; learning disability assessment; and community college or other post-secondary education. Statewide, managers specified an educational need in 1380 cases, or about one in every three cases (34.6%). Consistent with the "work first" philosophy, but perhaps also indicative of these at-risk customers' attractiveness to potential employers, the statewide data reveal that, in about one of every two cases with an identified education referral need (n=709/1380 or 51.3%), the specific referral need was for job skills training. Notably, about one in three clients (n=476/1380 or 34.4%) were deemed to need referral to high school or GED preparatory courses. Only one in 10 (n=161/1380, 11.6%) were assessed as needing referral to post-secondary education, while assessment for the presence of a learning disability was indicated in 2.4% (n=34/1380) of cases.

At the sub-division level, we find that in seven jurisdictions, including Baltimore City and the counties of Montgomery, Prince George's and Wicomico, the most commonly-noted education referral need was for job skills training. In the remaining seven jurisdictions in

which at least one education referral was noted, the number one referral need was for high school or GED preparatory courses.

Housing

Statewide there were 191 cases (from 11 jurisdictions) on which a specific housing-related referral was shown as being indicated in the case. Not quite three of five such cases (n=107/191 or 56%) were from Baltimore City. "Other" was the most commonly-noted housing referral need (n=95/191 or 49.7%), followed by referral to RAP, the Rental Assistance Program (n=69/191 or 36.1%).[29] A bit more than one in 10 customers (n=27/191 or 14.1%) were assessed by their case managers as needing referral to housing shelter.

Among the 11 jurisdictions where at least one customer was identified as having a housing related referral need, "other" was the most commonly-cited need in seven localities, including Baltimore City. In three jurisdictions, RAP referrals were the most common housing referral noted and in one small jurisdiction, the housing referral most often noted was to a shelter.

Transportation

Case managers were able to select from three possible transportation referrals (vehicle purchase program, voucher program, van service) or to indicate that referral to some "other" transportation program seemed indicated for the family. For the state as a whole, there were 403 surveys, or about one in 10 (n=403/3983 or 10.1%) cases where referral to a transportation program was indicated. Among these 403, by far the most commonly-needed referral, in the opinion of case managers, was to the voucher program; about three of every

[29] Typically, the "other" text offered additional information about the case (e.g., lives in Section 8 housing) rather than identification of a unique housing referral need.

five transportation referral needs (n=249/403 or 61.8%) were of this type. Referral to van service (n=91/402 or 22.5%) was next most common, cited in a bit more than one in five cases. Referral to some "other" type of transportation service/program was third (n=36/403 or 9.0%) and least frequently cited among the choices available was referral to the vehicle purchase program (n=27/403 or 6.7%).

At the sub-state level, there were 12 of 21 jurisdictions where at least one family was perceived by the caseworkers as being in need of a transportation referral. Perhaps notably, in the largest jurisdictions, the most common type of transportation need noted was referral to the voucher program. In smaller, generally more rural subdivisions, van service and "other" types of referrals predominated, no doubt reflecting the general lack of public transportation services in these areas.

Child Care

Statewide, among cases in which a child care referral need was indicated (n=658), the specific type of care most often specified was purchase of care from a licensed center (n=302/658 or 45.9%). Referral for purchased care from a licensed child care home was next most common (n=253/658), accounting for 38.4% of identified referral needs. Some type of "other" child care referral was indicated on 103 of the 658 forms noting a child care service referral need (15.5% of these cases).

There were 10 jurisdictions (of 21 with at least one at-risk family) where a child care service referral need was identified in one or more cases. In five of the 10, center-based care was the referral type indicated; in two jurisdictions, home-based care was singled out, in two places "other" was most common and, in one subdivision, all three types of referrals were noted with equal frequency.

Substance Abuse

Unlike all service-related survey questions, response choices pertaining to the substance abuse topic were not of the “referral to x” variety. Rather, in cases where substance abuse was noted, the caseworker was asked to indicate the customer’s status vis-a-vis treatment, electing one of four listed response choices. For the statewide sample, there were 353 cases (8.8%, 353/3983) where service status information was noted on the form. By far, the large majority of customers were listed as being enrolled in a treatment program (n=271/353 or 76.8%). The next most common situation, according to caseworkers, was that the client was awaiting treatment. This response was noted on 46 forms or 13.0% of all forms where a substance abuse service need was identified. It may be noteworthy that virtually all (n=44 of 46) “waiting treatment” cases were in Baltimore City. Patterns at the sub-division level were similar; in virtually all jurisdictions, the majority of clients perceived as having a substance abuse issue were reported as being enrolled in a treatment program.

Conclusion

This paper has examined administrative and caseworker-provided survey data on the cohort of Maryland families who are at most immediate risk of reaching the first ever 60 month limit on federally-funded cash assistance. The analysis has revealed that there are relatively few such cases statewide but that the vast majority are located in Baltimore City. By definition, these families are also ones who have been on assistance most, if not all, months since the time clock began to tick in Maryland on January 1, 1997. In terms of the barriers faced and service referrals needed by these families, at least insofar as these are known to agency caseworkers, the data reveal no surprises. Instead, findings are very consistent with what empirical research and front-line wisdom have long opined: education, health, and child care are very common problems in families known to cash assistance and they represent areas where intervention is often needed. Lack of a recent work history is also common among payees in these case.

Study findings also illustrate, once again, that statewide figures often mask potentially important intra-state variations. This is particularly true with regard to the cohort of families who are closest to benefit exhaustion because of the extreme predominance of Baltimore City (n=3179 of 3983) cases in the at-risk group.

Given these general findings, what guidance does this study offer to policy-makers who must soon make decisions about the bases on which benefit extensions beyond 60 months will be granted or denied to Maryland families? In our opinion, the study provides some information that can be useful in deliberations about these important policy choices but, unlike some other of our studies, no clear-cut policy direction is evident in the data. For example, should the state wish to do so, given the relatively small number of at-risk cases, it would

probably be possible to provide extensions to **all** cases which reach the 60 month limit. However, while this might be the easiest choice to make, it may not be programmatically or politically wise; at least for some portion of this first group of wall-hitters, the practical effect would be to reward (with continued benefits) persons who had managed to remain on welfare for a full five years. Then, too, there is the reality that the 20% hardship exemption can, over time, protect only a finite number of Maryland families. Thus, to the extent that these slots are utilized to protect those who reach the limit early, they will not be available for those who reach the limit later.

When all is said and done, the important decisions about whether or not benefits should and will be extended simply must be made at the local level, on a case-by-case basis, within broad state policy parameters. Just as our state's welfare reform program includes an individualized assessment at the outset of cash assistance, a similar assessment is needed at the 60 month threshold. On a case-by-case basis, answers are needed to questions such as: What, really, is the situation in this particular family which has caused them to reach the 60 month limit? What is being done by the family, the local Department of Social Services, and other community-based providers to address the situation and what more needs to be done, by whom, and with what desired outcome?

Individualized assessment and decision-making in all cases which reach the 60 month limit are thought essential to an effective policy, but to insure equity both within and across jurisdictions, some type of state-determined parameters or guidelines governing caseworker choice are also thought imperative. In crafting state-level guidelines or criteria, however, our data make it clear that some 'safety valve' language needs to be included so that local agencies - particularly in rural parts of the state - are able, under the guidelines, to exempt

families who face “hardship” perhaps peculiar to those types of communities.[30] Neither program administrators nor our state’s low-income families have any prior experience with lifetime time limits. Thus, careful thought should also be given to insuring adequate, thorough documentation (in CARES and the case file) of each case decision, including the rationale and, in the case of an extension/exemption, the case plan.

Policy-makers should also be prepared to revisit the initial policy choices over the next few years. With the passage of time, it is inevitable that more and more families will reach the 60 month threshold. As they do, the characteristics of families reaching the limit may also change and the barriers they face may or may not resemble those documented as existing in the first or earliest group of at-risk families. In these uncharted, but important waters, the ability to quickly make any needed mid-course corrections would seem vitally important. Therefore, as noted in the report, it would also seem wise not to adopt our extension/exemption policies via statute. Another area that may require future consideration is that of adopting some type of community-wide exemption/extension trigger, perhaps related to unemployment rates or job availability.

[30]Transportation difficulties, are perhaps the most obvious example.

Appendix A. Potential Time Limit Evaluation Form

POTENTIAL TIME LIMIT EVALUATION FORM

LOCAL DEPARTMENT _____ DISTRICT OFFICE _____

EVALUATOR/CASE MANAGER _____

EVALUATOR/CASE MANAGER PHONE # _____

HEAD OF HOUSEHOLD NAME _____

ASSISTANCE UNIT # _____

1. Identify all barriers that are being faced by the family.

- ❛ (A) Health
- ❛ (B) Education
  - (B-1) No diploma or GED
  - (B-2) Possess diploma/GED or post-secondary
- ❛ (C) Substance Abuse (Positive Screening 1177 in record)
- ❛ (D) Mental Health
- ❛ (E) Housing
- ❛ (F) Transportation
- ❛ (G) Child Care
- ❛ (H) Other (specify) _____

2. Identify the services that are needed by the family as indicated in the case record or assessed by the case manager completing this evaluation form.

    1. Health
        - (A) Referral to SSI or SSDI
        - (B) Referral to another type of disability insurance program
        - (C) Referral to Vocational Rehabilitation

    2. Education
        - (A) Referral to High School or GED preparatory courses
        - (B) Referral to job skills training classes
        - (C) Referral for learning disability assessment
        - (D) Referral to community college or other post-secondary education

    3. Substance Abuse – (Compliance Status per 1178 in record)
        - (A) Awaiting available treatment facility
        - (B) Enrolled in treatment program
        - (C) Not maintaining active attendance/participation
        - (D) Successfully completed program

    4. Mental Health
        - Specify

    5. Housing
        - (A) Referral to housing shelter
        - (B) Referral to the Rental Assistance Program
        - (C) Other, specify

    6. Transportation
        - (A) Referral to vehicle purchase program
        - (B) Referral to transportation voucher program
        - (C) Referral to van service program
        - (D) Other, specify

    7. Child Care
        - (A) Referral to purchase of child care (licensed center)
        - (B) Referral to purchase of child care (licensed day care home)
        - (C) Other, specify

    8. Other
        - Specify

Appendix B. Demographic Characteristics of At-Risk Families: Surveys Not Returned

Payee Demographics	
Female Heads of Assistance Units	98.9%
Racial/Ethnic Group	
African American	89.6%
Caucasian	7.1%
Hispanic	0.4%
Native American	0.2%
unknown	2.6%
Marital Status	
Never Married	86.6%
Separated	8.2%
Divorced	1.7%
Married	1.3%
Unknown	0.4%
Widowed	0.4%
Age of Payee	
Mean	31.76
Median	31.00
St. Dev.	7.35
Range	20 to 57
Payee's Estimated Age at Birth of First Child	20.14
Mean	19.00
Median	5.58
Std. Dev.	11 to 41
Range	
	38.0%
Payees who gave birth before 18	66.3%
Payees who gave birth before 21	

Assistance Unit Composition	
Assistance Unit Size	
Mean	3.51
Median	3.00
Std. Dev.	1.43
Range	1 to 10
Cases with one adult	100.0%
Cases with only one child	22.0%
Cases with two children	35.4%
Cases with three children	20.5%
Cases with four children	11.2%
Age of youngest child in assistance unit	
Mean	4.92
Median	4.00
Std. Dev.	4.15
Range	0 to 18
Assistance Units with a Child Under 3	36.7%

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