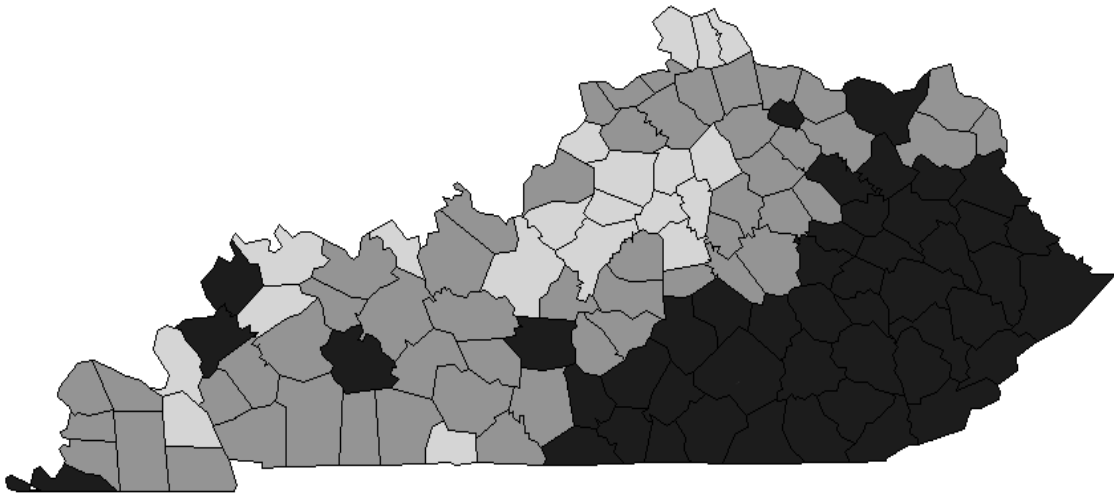


Report of the Poverty Task Force



Research Memorandum No. 504

Legislative Research Commission
Frankfort, Kentucky

December 2009

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MEMORANDUM

TO: Senate President David L. Williams
 House Speaker Gregory D. Stumbo
 Co-Chairs, Legislative Research Commission

FROM: Senator Brandon Smith and Representative Gregory D. Stumbo
 Co-Chairs, Poverty Task Force

SUBJECT: Report of the Poverty Task Force

DATE: December 31, 2009

The Legislative Research Commission established the Poverty Task Force to examine current and emerging antipoverty efforts on a national and regional basis and to recommend efforts deemed potentially effective for Kentucky. The task force was also to report on recommendations for legislative actions. The task force met four times in the 2009 Interim to gather information and formulate recommendations. The task force report is attached.

Report of the Poverty Task Force

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Foreword

The Poverty Task Force was established by the Legislative Research Commission on September 9, 2009. The task force was charged with examining current and emerging antipoverty efforts on a national and regional basis and to recommend efforts deemed potentially effective for Kentucky. To achieve the goals of the task force, the members chose to consider a small number of policy options to address poverty in Kentucky: children in poverty, financial literacy, affordable credit, transportation, and homelessness. The task force was to report to the Legislative Research Commission any recommendations for legislative action. The task force co-chairs wish to thank all individuals who attended task force meetings and provided testimony.

Robert Sherman
Director

Legislative Research Commission
Frankfort, Kentucky
December 31, 2009

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Summary

Established by the Legislative Research Commission, the Poverty Task Force was created to examine current and emerging antipoverty efforts on a national and regional basis and to recommend efforts deemed potentially effective for Kentucky.

Research documents and testimony were provided to the task force by staff of the Legislative Research Commission; the Cabinet for Health and Family Services; the Education Cabinet; the Federal Deposit Insurance Corporation; the Hazard/Perry County Community Ministries; the Kentucky Department of Financial Institutions; the Kentucky Department of Veterans Affairs; the Leslie, Knott, Letcher, Perry Community Action Council, Inc.; the Transit Authority of River City; and the University of Kentucky Center for Poverty Research.

Organization of Chapters

This report focuses on the specific policy options selected by the task force. Chapter 1 reviews basic poverty statistics from Kentucky and the United States and summarizes possible long-term policy options for combating persistent poverty in Kentucky. Chapter 2 reviews some poverty statistics for children under 18 years of age and provides an overview of government programs for children in poverty. Chapter 3 describes two financial components that significantly affect those who are in poverty: financial literacy and access to bank financing. The chapter also provides an overview of the Federal Deposit Insurance Corporation (FDIC) Money Start program, the Kentucky financial education program Jump\$start, and the FDIC small-dollar loan pilot program. Chapter 4 summarizes the relationship between transportation and poverty and provides an overview of the efforts of two agencies to serve the transportation needs of the low-income population: the Transit Authority of River City and the Leslie, Knott, Letcher, Perry Community Action Council, Inc. Chapter 5 highlights the latest figures on homelessness in Kentucky and provides an overview of service needs for the homeless population including mental health issues and services targeted to homeless veterans.

Recommendations

Recommendations are presented at the end of each chapter. The recommendations address educational needs, tax changes, high-speed telecommunications (broadband), the Earned Income Tax Credit, Kentucky Homeplace, oral health care, the Health Access Nurturing Development Services program, preschool programs, child care centers, small-dollar lending, financial literacy, public transportation, mental health services for the homeless, and homeless veterans. Reauthorization of the Poverty Task Force was also recommended.

Chapter 1

Poverty in Kentucky

Introduction

This chapter reviews some of the basic poverty statistics from Kentucky and the United States, summarizes possible long-term policy options presented to the task force for combating persistent poverty in Kentucky, and lists related task force recommendations.

Definition of Poverty

This report uses the standard United States Census Bureau definition of poverty: a family is classified as living below the poverty line if the family's income falls below a certain income threshold defined by the Census Bureau. These poverty thresholds are revised every year and adjusted for the cost of living. Poverty thresholds differ depending on the size of the family, number of children, and age of the head of household. For example, a family of three with one adult and two children under the age of 18 is classified as living below the poverty level if the annual family income is less than \$17,346 per year.

The 2008 poverty thresholds for different types of families are displayed in detail in Table 1.1. It should be noted that poverty is determined from income sources only. Wealth is not considered in determining whether a family is living below poverty. Because of this, some individuals with sizable assets but little income can be classified as living below the poverty line.

Table 1.1
Census Poverty Thresholds, 2008

Size of Family Unit	Weighted average thresholds	Related Children Younger Than 18								
		None	One	Two	Three	Four	Five	Six	Seven	Eight or more
One person (unrelated individual)	\$10,991									
Younger than 65	11,201	11,201								
65 and older	10,326	10,326								
Two people	14,051									
Householder younger than 65	14,489	14,417	14,840							
Householder 65 and older	13,030	13,014	14,784							
Three people	17,163	16,841	17,330	17,346						
Four people	22,025	22,207	22,570	21,834	21,910					
Five people	26,049	26,781	27,170	26,338	25,694	25,301				
Six people	29,456	30,803	30,925	30,288	29,677	28,769	28,230			
Seven people	33,529	35,442	35,664	34,901	34,369	33,379	32,223	30,955		
Eight people	37,220	39,640	39,990	39,270	38,639	37,744	36,608	35,426	35,125	
Nine people or more	44,346	47,684	47,915	47,278	46,743	45,864	44,656	43,563	43,292	41,624

Source: U.S. Census Bureau. Poverty Thresholds.

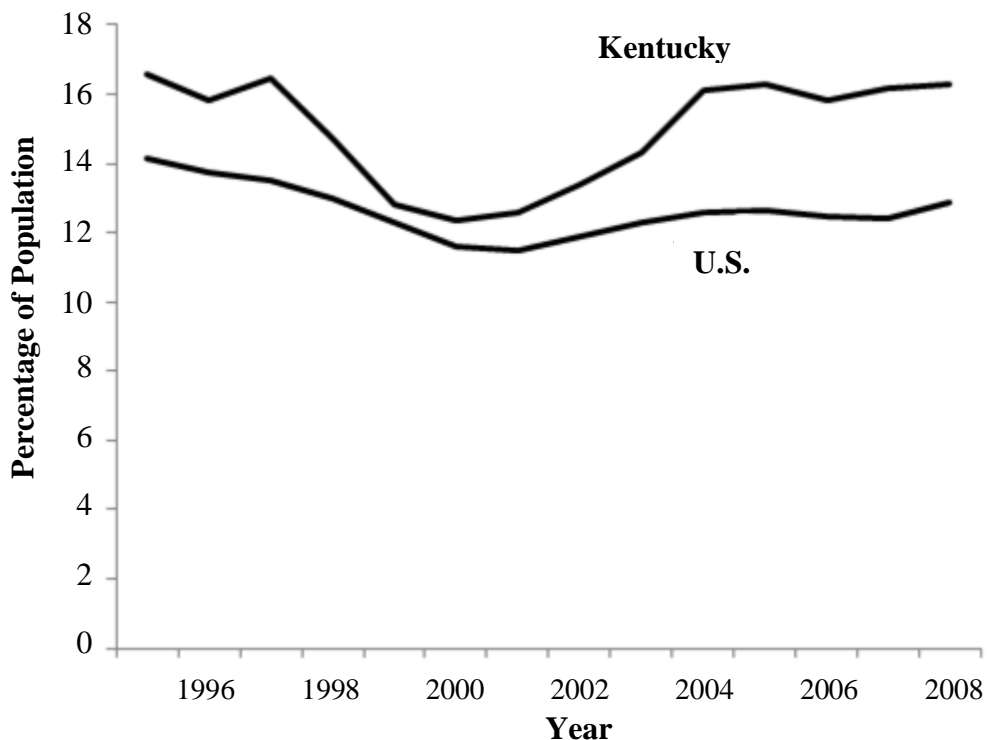
Additionally, because the poverty thresholds are the same for every state, poverty rates do not reflect differences in the cost of living between different states. For example, consider a single parent with two children. If this family earns \$17,346 per year, it would be classified as living in poverty regardless of which state the family lives in. However, the family's income would purchase more goods and services in a state with a low cost of living than it would in a state with a high cost of living. As wages tend to be lower in states with a low cost of living, using the same poverty thresholds for all states results in these states having somewhat higher poverty rates. Some families living in low-cost states are classified as living in poverty even though they may actually have higher standards of living than some families considered above poverty living in high-cost states. Therefore, if the cost of living in Kentucky is lower than the average cost of living in the U.S., a larger percentage of Kentucky residents could be classified as living in poverty than in the rest of the nation. However, there are no official cost of living figures available by state, so it is difficult to determine the extent to which the cost of living in Kentucky influences the proportion of the population living below the poverty level relative to other states.

Poverty in Kentucky and the United States

In 2008, the U.S. Census Bureau estimated that approximately 16.5 percent of Kentucky residents and 12.7 percent of the nation's residents were living in poverty. Kentucky had the 5th

highest poverty rate in the nation. Figure 1.A shows the poverty trend in Kentucky compared to that of the U.S. since 1995. Kentucky has traditionally had a higher poverty rate than that of the U.S. overall. From 1998 to 2002, the gap between Kentucky's poverty rate and the nation's decreased somewhat. After 2002, the gap increased. It is not clear what accounted for the smaller gap during these years.

Figure 1.A
Percentage of People With Incomes At or Below the Poverty Level
2-year Averages, 1995-2008



Source: U.S. Census Bureau. Small Area Income and Poverty Estimates.

Table 1.2 shows the poverty rates for individuals with different demographic characteristics. Rates for both Kentucky and the U.S are provided. As the table shows, young individuals are more likely to be affected by poverty in Kentucky than are those in the U.S. overall. Twenty-three percent of children in Kentucky are living at or below poverty compared to 18.1 percent of children in the U.S. This disparity becomes less prominent with the older age group. Poverty rates for individuals of retirement age in Kentucky are more similar to that of the U.S., with only 11.9 percent living in poverty, compared to 9.6 percent in the U.S. Approximately 27 percent of individuals in Kentucky without a high school diploma fall at or below the poverty line. This is more than 4 percentage points higher than the 22.3 percent of individuals in the U.S. As with age, the gap between Kentucky and the rest of the U.S. tends to decrease in size with higher levels of education. Kentuckians with a 4-year college degree have poverty rates similar to individuals in the rest of the U.S., with only 4.9 percent of Kentuckians in poverty, compared to 4 percent of those in the U.S. Individuals of all races are more likely to fall at or below the

poverty line in Kentucky than individuals in the rest of the U.S.; however, minorities seem to be disproportionately more likely to be living in poverty than whites in Kentucky.

Table 1.2
Poverty by Demographic Characteristics, 2006-2008 Averages

	% of Individuals Who Fall Below Poverty Threshold	
	Kentucky	U.S.
Totals	16.5%	12.7%
Age		
Younger than 18	23.0	18.1
18 to 24	23.2	17.8
25 to 44	14.9	11.1
45 to 64	12.0	8.6
65 and older	11.9	9.6
Education		
Children younger than 15	24.0	18.8
No high school diploma	26.6	22.3
High school or equivalent	15.0	12.1
College, less than 4-year degree	10.5	8.7
Bachelor's degree or higher	4.9	4.0
Race		
White alone	14.9	10.7
Black or African American alone	34.1	24.5
American Indian or Alaska Native	40.0	26.6
Asian, Hawaiian or Pacific Islander	22.9	11.0
Two or more races	22.9	16.6

Source: U.S. Census Bureau. Current Population Survey. Annual Social and Economic Supplement 2006-2008.

Table 1.3 presents data on individuals living below the poverty line for both Kentucky and the U.S. While Table 1.2 showed poverty rates for different groups of individuals, Table 1.3 shows the distribution of those living in poverty across family, insurance, and labor force status. For example, 9.3 percent of Kentuckians living at or below the poverty line live in a family headed by a single father. Individuals living at or below the poverty line in Kentucky are less likely to be living in a family headed by a single mother than individuals in the rest of the U.S. Individuals living below the poverty line in Kentucky have similar health coverage rates to those in the rest of the U.S., though they seem to be more likely to have government-sponsored health coverage

than those in other states. Individuals affected by poverty in Kentucky also seem less likely to be participating in the labor force than those in the rest of the U.S.

Table 1.3
Characteristics of Individuals Living Below the Poverty Line, 2006-2008 Averages

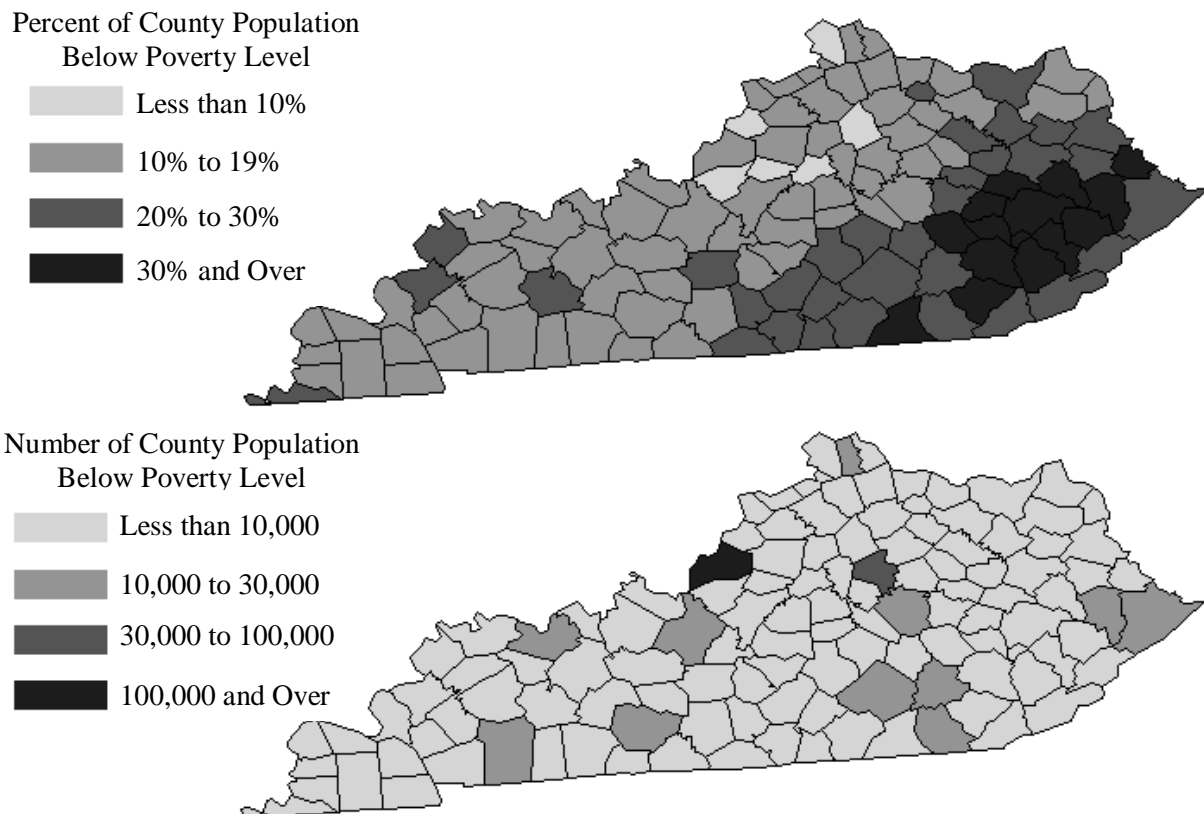
	Percent of Individuals	
	Kentucky	U.S.
Family Status		
Family Headed by Single Father	9.3	5.6
Family Headed by Single Mother	30.6	36.5
Married-Couple Primary Family	32.9	33.3
Individuals Not Living in Families	27.2	24.6
Total	100%	100%
Health Coverage		
Individuals With Health Coverage	69.6	69.0
Private Insurance	18.8	21.9
Government Insurance (Medicare and/or Medicaid)	57.2	53.2
Uninsured	30.4	31.0
Total	100%	100%
Labor Status		
Children or Armed Forces	28.3	30.3
Working	17.3	20.3
With Job, Not at Work	0.7	0.9
Unemployed, Looking for Work	6.2	5.3
Unemployed, On Layoff	0.6	0.5
Not in Labor Force	47.0	42.8
Total	100%	100%

Source: U.S. Census Bureau. Current Population Survey. Annual Social and Economic Supplement 2006-2008.

Poverty in Kentucky

Figure 1.B shows the geographic distribution of poverty across Kentucky. Two measures of poverty are shown. The first measure is the percentage of people within a county with family incomes at or below the poverty thresholds. The first map shows that the eastern area of Kentucky exhibits the highest poverty within the state. The second measure of poverty is simply an estimate of the number of people with family incomes at or below the poverty thresholds. The second map shows a different geographic distribution than the distribution of poverty rates. Generally, the largest numbers of people living in poverty are located in the state's urban areas. In total, approximately 28 percent (194,705) of the state's population who are living in poverty are located in Boone, Campbell, Fayette, Jefferson, Kenton, and Warren Counties (U.S. Census. Small).

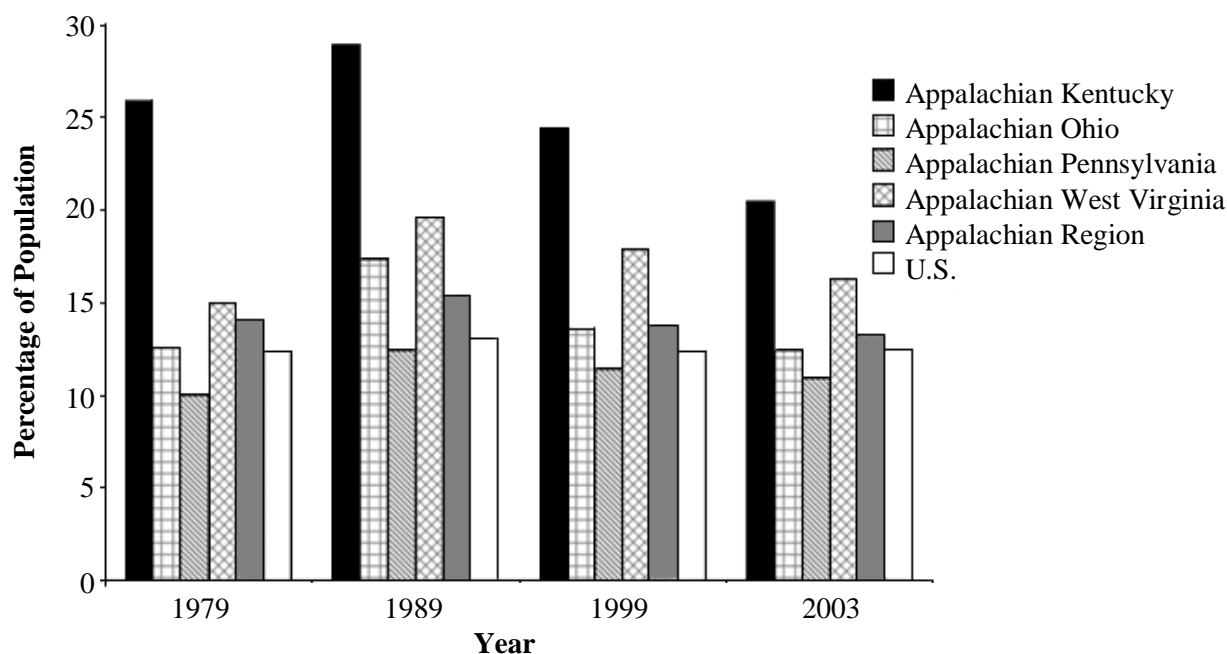
Figure 1.B
Percent and Number of County Population Below Poverty Level, 2007



Source: Compiled by staff using data from the U.S. Census Bureau Small Area Income and Poverty Estimates 2007.

As Figure 1.C shows, the Appalachian region of Kentucky leads the rest of Appalachia in terms of poverty. More than 20 percent of the Appalachian counties in Kentucky have poverty rates over 20 percent, which is persistently higher than ranges for the Appalachian regions of Ohio, Pennsylvania, and West Virginia.

Figure 1.C
Poverty Rates in Appalachia, 1979-2003



Source: Ziliak and Fording.

Suggested Policy Options

Researchers from the University of Kentucky Center for Poverty Research presented the task force with several long-term policy options for combating poverty in Kentucky. They noted that increased investment in human, health, financial, and physical capital can lead to higher household incomes for all Kentuckians (Ziliak and Fording). They focused on four specific areas of investment: expanded educational opportunities, tax modernization with work and saving incentives, health and welfare reform, and basic infrastructure.

Expanded Educational Opportunities

One policy option related to education is to increase access to preschool and prekindergarten for disadvantaged children. Early childhood education has been shown to have long-term payoffs in terms of higher graduation rates, higher employment and earnings, and reduced crime. Targeting families eligible for free and reduced-price lunch is likely to yield a higher payoff than universal programs. There is evidence from both the medical profession as well as social science that shows there are growth changes that occur in the first few years of the child's life. Many changes

occur because of the nutrition and health of the mother and the subsequent health and nutrition programs that the child has available, such as the Women, Infants, and Children program (Ziliak and Fording).

The researchers stated that there is a growing gap between high school graduates and dropouts and between college graduates and high school graduates. Dropout rates are high, especially among African Americans and Hispanics in urban areas, but they are also high among whites in parts of rural America including Appalachia. GED recipient scores are comparable to high school graduates on cognitive tests, yet they earn 20 percent less on average in the labor market, which suggests a significant role for noncognitive social skills. The estimated economic benefit of additional schooling beyond high school is nearly 10 percent. The overall benefits are higher if social returns from better health, lower crime, and higher marital stability are included.

The policy options for lowering the proportion of high school dropouts include conditional cash transfers to encourage children to stay in school, internship opportunities for teenagers, and expanded after-school and summer programs. The researchers noted that a high school diploma or GED alone will not address the growing need for a skilled work force. Additional investment, including need-based financial assistance, is needed for vocational education programs, community colleges, and universities. Incentives are important to keep graduates of these programs in Kentucky.

Tax modernization

The researchers noted that a modernized tax system could provide a more stable funding stream and encourage work and saving. Low-income workers and families could benefit from a state earned income tax credit (EITC), child care subsidies and tax credits, individual development accounts, and automatic retirement savings enrollment. Currently, 23 states and the District of Columbia supplement the federal EITC with a state EITC. The federal EITC injected \$630 million into Kentucky economy in 2005. An estimated 62 percent of poor families in Kentucky contain at least one worker. A state EITC could assist more than 360,000 working poor individuals in Kentucky (Ziliak and Fording).

Health and Welfare Reform

The researchers noted that health and welfare policy options include increasing jobs programs; modifying eligibility for public assistance programs; increasing outreach efforts for food stamps; supporting the Women, Infants, and Children nutrition program; and targeting assistance efforts to individuals with multiple barriers to self-sufficiency. Additionally, health care reform could address the increasing needs of seniors for prescription medication and the impact of rising health care premiums on household income.

Assistance programs like Kentucky Homeplace can help individuals find needed health care resources. Funded with state dollars, Homeplace was developed by the University of Kentucky Center for Rural Health-Hazard as a demonstration project and currently serves 58 rural counties in eastern and western Kentucky. The mission of the program is to provide access to medical,

social, and environmental services. The program does not directly provide services. The objectives of the program are to:

- Provide access to medical, social and environmental services by networking with a service provider at the lowest cost possible.
- Decrease uncompensated hospitalization and emergency room visits by educating individuals to access appropriate health care.
- Act as a liaison on behalf of individuals and their families by networking with multi-disciplinary agencies.
- Promote a better quality of life by providing education on primary and preventative care.
- Identify health trends, socio-cultural and economic barriers to bridge the gaps between uninsured and underserved individuals and the health care delivery system to find solutions by collecting and analyzing data (Center).

The July 1, 2008-Jan 12, 2009, Homeplace impact report shows that 8,976 clients were served and 215,171 services were provided, with medications valued at \$12,010,927 and services valued at \$1,018,816 (Center).

Basic Infrastructure

The researchers noted that basic infrastructure improvements that could boost the economic competitiveness of the state and raise earning capacities include improvements in public transportation, increased access to broadband and cell technology, and enhanced environmental quality. Supporting access to technology in low-income and rural areas could help small businesses be more competitive.

Recommendations

Address Educational Needs. Consider improving efforts to address educational needs, encourage the value of education, and increase access to vocational education.

Tax Changes. Consider tax changes at the local and state level to improve the economic base.

High-speed Telecommunication (Broadband). Consider improving access to high speed telecommunication in rural areas to attract more technologically advanced industries.

Earned Income Tax Credit. Consider the possibility of a state earned income tax credit for low-income families.

Kentucky Homeplace. Consider maintaining funding for Kentucky Homeplace, a health care assistance program for the rural poor.

Chapter 2

Childhood Poverty

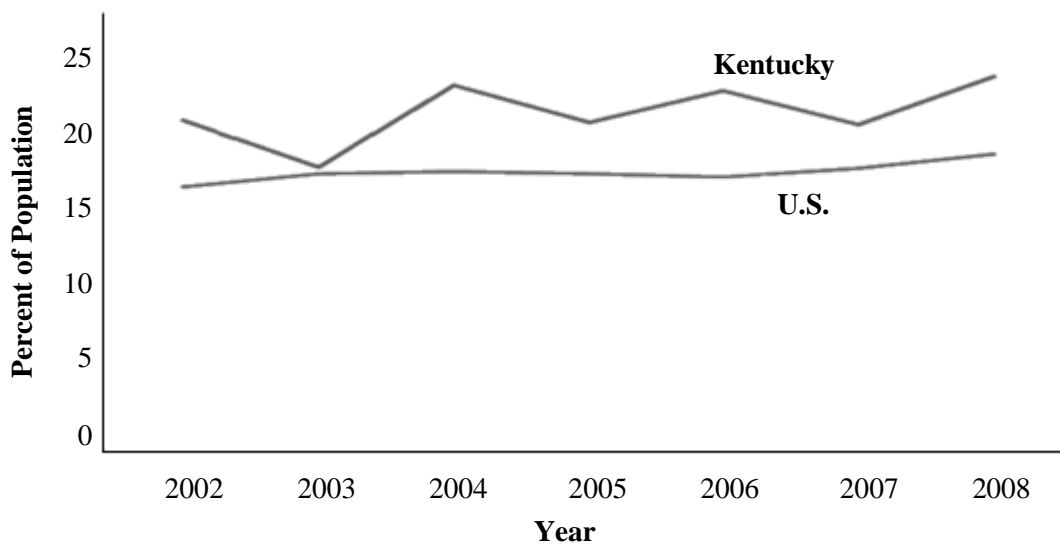
Introduction

This chapter reviews some poverty statistics on children younger than 18 from Kentucky and the United States and provides an overview of government programs for children in poverty. Four programs presented to the task force are summarized: the Access for Babies and Children to Dentistry Initiative, the Health Access Nurturing Development Services program, the Head Start program, and the Kentucky Preschool Program.

Childhood Poverty in Kentucky

The percentage of Kentucky’s children living in families with incomes below the poverty level has historically been higher than in the U.S. Figure 2.A shows the percentage of children in poverty in Kentucky compared to that of the U.S. since 2002. While there was change overtime, a gap of about 5 percentage points remained in 2008. For the most part, a gap is present regardless of race and parental characteristics of children in Kentucky compared to the U.S. (Ziliak. University).

Figure 2.A
Poverty Trends, Children
2002-2008



Source: Ziliak. University.

Table 2.1 shows the poverty rate for children by race, parental education, and parental employment status for Kentucky and the U.S. A larger percentage of white and black children live in poor families in Kentucky compared to the U.S. However, a lower percentage of children in other race categories live in poor families. Also, a larger percentage of children live in poverty in Kentucky regardless of parental education. Finally, a larger percentage of children whose parents are not employed or employed part time or part year live in poverty in Kentucky than in the U.S.

Table 2.1
Children in Poverty by Race, Parental Education, and Parental Employment
2006-2008 Averages

Percentage in Poverty	Kentucky	U.S.
Race		
White	19 %	14 %
Black	50 %	34 %
Other	21%	32%
Parental Education		
Less than high school	57%	51%
High school	38%	28%
Some college or more	14%	11%
Parental Employment Status		
Not employed	79%	74%
Employed part time or part year	54%	42%
Employed full time, year- round	10%	11%

Source: U.S. Census Bureau. Current Population Survey.

Government Assistance for Children

Table 2.2 shows the number and percentage of children in Kentucky and the U.S. receiving benefits for some of the major government assistance programs including health care benefits, cash assistance, child care subsidies, and nutrition programs. In Kentucky, these programs are administered by the Cabinet for Health and Family Services.

Table 2.2
Number and Percentage of Children Receiving Public Assistance
by Public Assistance Program
2007-2009

Program	Kentucky total < 18 years (1,020,000)	U.S. total < 18 years (74,510,000)
Health Care Benefits—June 2008 monthly enrollment		
Medicaid	330,200 (32%)	22,672,100 (30%)
	K-CHIP	CHIP
	53,555 (5%)	4,848,221 (7%)
Cash Assistance		
	K-TAP 2008	TANF 2008
Child recipients	47,518 (5%)	3,030,506 (4%)
Child Care Subsidy		
2007 average monthly recipients	29,400 (3%)	1,705,200 (2%)
Nutrition Programs		
WIC (2008 average monthly number)	106,540 (37% of children < 5 years)	6,551,319 (32% of children <5 years)
SNAP households (fiscal year 2008)	278,000	12,465,000

Sources: Kaiser. Kaiser State Health Facts. Kentucky: CHIP; Kaiser. Kaiser State Health Facts. Kentucky: Monthly; U.S. Dept. of Agriculture. States Food; U.S. Dept. of Agriculture. WIC Program; U.S. Dept. of Health and Human Services. Table 1 Child Care; U.S. Dept. of Health and Human Services. TANF: Total Number.

Health Care Benefits

Adequate health care for children is important for normal growth and development both physically and academically. Medicaid is a state-administered health benefit program that children may be eligible for if they are U.S. citizens or lawfully admitted immigrants. Eligibility for children is based on the child’s status, not the parent’s. As Table 2.2 shows, the percentage of children receiving Medicaid benefits is somewhat higher in Kentucky compared to the U.S. As of June 2008 monthly enrollment figures, 32 percent of Kentucky’s children received Medicaid benefits, compared to 30 percent for the U.S. overall (Kaiser. Kaiser State Health Facts. Kentucky: Monthly).

When children are not eligible for Medicaid, they may be eligible for health care benefits under the State Children’s Health Insurance Program (SCHIP) that is jointly financed by the federal and state governments. The Kentucky Children’s Health Insurance Program (KCHIP) is Kentucky’s version of SCHIP and provides free or low-cost health insurance for children younger than 19 who do not have health insurance and whose family income is below 200 percent of the federal poverty level. As the table shows, the average monthly percentage of children enrolled in the Children’s Health Insurance Program slightly higher for the U.S. than for Kentucky.

Cash Assistance

Cash assistance can help children in families that are struggling with self-sufficiency. The Kentucky Transitional Assistance Program (K-TAP), which is funded with state general funds and funds from the federal Temporary Assistance to Needy Families (TANF) Block Grant, provides temporary monthly assistance. As Table 2.2 shows, in December 2008, a slightly higher average monthly percentage of Kentucky's children received K-TAP benefits compared to those who received state TANF benefits in other states. However, data for 2006 show that the average monthly K-TAP payment per family was \$216, and the average payment across all states was \$372 (Commonwealth. Dept. for Community Based; U.S. Dept. of Health. TANF 8th).

Child Care Subsidy

While not a direct benefit to children, the federal Child Care and Development Block Grant assists low-income families, families receiving temporary public assistance, and those who are transitioning from public assistance in obtaining child care so they can work or attend training or education. The current maximum income eligibility is 150 percent of the federal poverty guideline. Except for children receiving special protective services for domestic violence and families with a monthly income below \$900, all families pay part of their child care expenses. A total of 79,748 children, or 3 percent of those younger than 18, in Kentucky received child care subsidies in 2008. The average monthly percentage of Kentucky children who received child care subsidies was slightly higher than in the U.S.

Nutrition programs

Nutrition programs provide children with food benefits. The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a federal government nutritional program that provides nutritional foods to low-income pregnant women, new mothers, infants, and children younger than 5 living in households at or below 185 percent of the federal poverty line. As Table 2.2 shows, in 2008, a larger percentage of Kentucky children up to age 5 were served by WIC than were served in the U.S. The average monthly percentage for Kentucky was 37 percent of children younger than 5; for the nation, 32 percent of children younger than 5 received WIC benefits (U.S. Dept. of Agriculture. WIC).

Food benefits may also be available to households meeting basic income and other requirements via the Supplemental Nutrition Assistance Program (formerly food stamps) administered by the U.S. Department of Agriculture. This average food benefit in 2008 per family in Kentucky was \$215, which was slightly lower than the average benefit of \$222 per family in the U.S (U.S. Dept. of Agriculture. States).

The U.S. Department of Agriculture also provides another possible source of food benefits for low-income children through the National School Lunch Program, which operates in public and nonprofit private schools and residential child care institutions. The purpose of the program is to provide nutritionally balanced, low-cost or free lunches to children each school day. The National School Breakfast Program provides cash assistance to states to operate nonprofit breakfast programs in schools and residential childcare institutions.

Family Resource and Youth Services Centers

Family Resource and Youth Services Centers, established with the passage of the Kentucky Education Reform Act of 1990, provide a variety of services and programs for low-income children. The goal is to address the nonacademic needs of all children and their families who reside in the community served by the school in which the center is located. The centers are funded with grants to schools from the state based on the percent of the student population that is eligible for federal free and reduced-price breakfast and lunch. Kentucky has 824 centers, serving 1,165 schools, which represents 98 percent of schools eligible. The total student population in Kentucky is 615,917, with about 47 percent eligible for free school meals. While the centers are located in schools, the Cabinet for Health and Family Services is primarily responsible for their operation (Commonwealth. Family).

Early Childhood Development Initiatives

In addition, Kentucky allocated 25 percent of the Phase I Tobacco Settlement dollars to the Early Childhood Development Authority in 2000 House Bill 706 to fund early childhood development initiatives. The authority distributes funds among several initiatives that involve numerous state agencies. The goal of these initiatives is to increase access to health care and early childhood education for low-income families. Some of these initiatives are summarized in Appendix A.

Programs Presented to the Task Force

Access for Babies and Children to Dentistry Initiative

The Deputy Commissioner of the Department for Public Health in the Cabinet for Health and Family Services discussed the Access for Babies and Children to Dentistry (ABCD) initiative. He stated that untreated cavities can cause pain, dysfunction, absence from school, and low birth weight, which are all problems that can greatly reduce a child's capacity to succeed in school and in life. He reported that tooth decay affects one-fourth of the children in the United States between the ages of 2 and 5, but in Kentucky it affects nearly half of the children in that age group (Davis). Barriers to oral health for children include an insufficient number of dentists, a reluctance of dentists to treat children, and a lack of dentists in rural areas. The 3-year ABCD initiative received three federal grants totaling approximately \$2 million. One was from the Health Resources and Services Administration and two were from the Appalachian Regional Commission. The initiative has a three-step approach: pediatric training for general dentists to foster more comfort in treating children, local oral health coalitions in 40 Kentucky counties to define gaps in treatment, and portable equipment to increase accessibility. The partners are the Department for Local Government, the Appalachian Regional Commission, the Cabinet for Health and Family Services, the University of Kentucky and the University of Louisville, the Kentucky Dental Association, and local health departments.

Within the past 2 years the Department for Medicaid Services has raised the reimbursement for dental practitioners who see children by approximately 30 percent. The new reimbursement rates and training programs should bring more practitioners into the Medicaid program allowing more children to be seen. The Deputy Commissioner said that more can be done through the entire

health care system to educate families about the importance of oral health care in their children. The Department for Public Health has a partnership with the University of Kentucky College of Dentistry in which dental students travel in the college's mobile units to schools in eastern and western Kentucky to treat children.

Kentucky's Health Access Nurturing Development Services Program

A representative of the Department for Public Health discussed Kentucky's Health Access Nurturing Development Services (HANDS) Program, which is a voluntary, intensive home visitation program for first-time mothers and fathers regardless of income. The program serves children from prenatal to age 2 and is designed to improve both health and social outcomes. The program was created in 2000 House Bill 706 as one of the early childhood development initiatives.

The goals of the program are positive pregnancy outcomes, optimal child growth and development, children living in healthy and safe homes, and family self-sufficiency. The program serves approximately 11,000 families each year. Of those, 41 percent have less than a high school education, 34 percent have a high school education, 80 percent are headed by a female, 10 percent are African American, 10 percent are Hispanic, and 88 percent receive Medicaid (English). Families are screened by a nationally proven tool that examines at-risk factors, families then are assessed by professionals in 10 focus areas, and then they begin home visitation.

Home visitations focus on medical homes, immunizations, well-child checks, child safety checklists, and developmental screenings. There is a parent-child interactive curriculum called Growing Great Kids that focuses on basic care, child development, nurturing parent-child relationships, and strengthens base support to families.

As of June 2009, the HANDS program was available in all Kentucky counties. Since the program started, the total number of families who have received services is 47,237; the total number of assessments made is 48,318; the total number of professional or paraprofessional home visits is 1,066,759; and the total number of services provided is 1,115,077 (English).

In 2008, REACH of Louisville, Inc., an independent evaluator selected through a request for proposals, conducted an evaluation of the HANDS program. Outcomes for the program included decreased child abuse, decreased emergency room visits, decreased hospital days, less special education requirements, fewer school dropouts, less risky behaviors in adolescence, fewer arrests as teens, higher rates of high school graduation, increased employment, and increased home ownership.

The evaluation also reported

- The rate of premature births among HANDS mothers with six or more prenatal home visits was 30 percent lower than the rate among HANDS mothers with no prenatal visits.
- The rate of low-birth weight births among HANDS mothers with six or more prenatal home visits was 33 percent lower than the rate among HANDS mothers with no prenatal visits.

- The rate of very low-birth weight births among HANDS mothers with six or more prenatal home visits was 55 percent lower than the rate among HANDS mothers with no prenatal visits.
- The infant mortality rate for families served by the HANDS program was 70 percent lower, emergency room visits were 50 percent lower, child abuse and neglect was 29 to 40 percent lower, and there are fewer developmental delays reported than among non-HANDS families.
- HANDS families are showing progress in education and employment (REACH).

In 2009, Kentucky received \$12 million in federal Medicaid funds for the HANDS program. Tobacco Settlement Agreement funds were used to pay the state-required Medicaid match of \$5.2 million and the \$3.3 million to serve non-Medicaid families. In order to serve all families with children, not just first-time parents, an additional \$7 million state-required Medicaid match would be required to receive an additional \$21 million in federal Medicaid dollars in fiscal year 2011. Approximately 13,541 additional Medicaid families could benefit from the program with these additional funds (English).

Head Start

Head Start is a federal program that awards grants to states to provide child development services to economically disadvantaged preschool children and families. The program provides comprehensive services including literacy, dental, vaccination, and parent education.

In 2008, more than 900,000 children nationwide and approximately 16,000 children from Kentucky were served. In 2008, there were about 285,000 children younger than 5 living in Kentucky, with 79,000 living in poverty. Approximately 40 percent, or 31,600, of these children were ages 3 and 4. This implies that Head Start in Kentucky serves only about half of the eligible population of children (Ziliak. University).

There is an ongoing debate whether prekindergarten programs should be targeted to the disadvantaged or whether they should be universal. Many favor targeting the disadvantaged because of cost effectiveness and evidence that children from low-income families face severe deficits in both cognitive and noncognitive skills. Head Start is not an entitlement program and has restricted resources. Costs of the program per child are not available for Kentucky; however, the costs differ across the nation based on services offered and range from approximately \$7,000 to \$9,000 per child (Ziliak. University).

Kentucky Preschool Program

The Director of the Office of Early Childhood Development in the Department of Education discussed the Kentucky Preschool Program established by the Kentucky Education Reform Act of 1990. The state-funded program focuses on the child's physical, intellectual, social, and emotional development, including interpersonal, intrapersonal, and socialization skills. All 3- and 4-year-olds with disabilities and 4-year-olds whose family income is no more than 150 percent of poverty are eligible to participate in the program. A small number of children who do not meet these eligibility requirements also participate, but their participation is funded by the district or tuition rather than by the state. Currently, 24,000 children are being served with state funds. Of these children,

55 percent have disabilities and 45 percent are from low-income families (Bridges). The estimated cost of the preschool program in Kentucky is \$4,229 per student (Jepsen).

The Director discussed two early childhood pilot collaborative projects in Anderson County and Fayette County. The primary purpose is to promote partnerships between Kentucky's Preschool Program, Head Start, and private child care to expand high-quality preschool services without additional funding. The projects will be located in various early childhood settings and will receive technical assistance and support from the Kentucky Department of Education. Each county receives up to \$100,000 of Phase I Tobacco Settlement funds allocated by the Early Childhood Development Authority for 2 years beginning in 2009. The counties must provide a one-to-one match of these funds. Each county designed a collaborative plan to meet the needs and resources of that county. Anderson County's plan supports increasing overall quality, specifically that of its child care teaching staff to conduct on-going assessment and individualized planning. Fayette County's plan addresses the high number of 3- and 4-year-old dual language learners and strives to increase the skills of its early childhood professionals. This collaboration may provide a model for further expansion of preschool programs (Bridges).

The Director also discussed the STARS for KIDS NOW voluntary quality rating system for child care centers and family child care homes. This system uses a scale of 1 through 4 stars to identify levels of quality based on staff-to-child ratios, group size, curriculum, parent involvement, training/education of staff, regulatory compliance, and personnel practices. They are required to have learning centers such as science, math, art, computer, and literacy. Currently, all four rating system levels surpass the minimum state licensing requirements. One goal of the Office of Early Childhood Education is that the state would require the first level of the rating system as a minimum licensing standard to increase the quality of early child care. In October 2009, 25 percent of child care programs statewide participated in the rating system: 651 child care centers and 119 family child care homes (Bridges).

Recommendations

Oral Health care. Consider improving the dental reimbursement structure in KCHIP and Medicaid to encourage dental care provider participation, increasing training for pediatric dentistry, and increasing public education on the importance of oral health care.

Health Access Nurturing Development Services Program. Consider increasing access to the HANDS program by serving families with multiple children in addition to first-time, at-risk parents.

Preschool Programs. Consider expanding collaboration projects that combine child day care, preschool, and Head Start programs to address early childhood education and school readiness.

Child Care Centers. Consider efforts to encourage child care centers to participate in STARS for KIDS NOW, Kentucky's voluntary quality rating system to improve access to quality child care programs.

Chapter 3

Financial Literacy and Bank Financing

Introduction

This chapter discusses two financial components that significantly affect those who are in poverty: financial literacy and access to bank financing for low-income people. The chapter also provides an overview of the three programs considered by the task force: the Federal Deposit Insurance Corporation's Money Start program, the Kentucky financial education program Jump\$tart, and the FDIC small-dollar loan pilot program.

Traditional Banking

Increasing financial literacy is a vital component in addressing the needs of persons in poverty. One aspect of financial literacy is having a traditional banking relationship, which includes checking and savings accounts. In 2007, approximately 10 percent of families did not have a checking account and 47 percent did not have a savings account (Federal Reserve). Another significant component of traditional banking relationships is savings. Many low-income persons live paycheck to paycheck, with every dollar of income spent and nothing saved. One report indicated that the proportion of families that saved in the preceding year was about 57 percent (Federal Reserve). Personal savings can be an important hedge against job loss and other personal financial difficulties. When a person has no personal savings and a financial hardship occurs, borrowing may become a necessity. If credit is not available, the problem could be magnified.

Financial Literacy Programs

A second aspect of financial literacy is knowledge of money management. There are many financial literacy programs available, and many are tailored to low-income persons. Two specific programs are discussed below.

Money Smart

Money Smart is a free financial education program sponsored by the Federal Deposit Insurance Corporation. Approximately 1,400 organizations nationally are members of the Money Smart Alliance. The following are listed as alliance members in Kentucky: Training & Technical Assistance Services, Western Kentucky University; Office of Financial Institutions, Frankfort; the University of Kentucky; Eclipse Bank, Louisville; Members First Federal Credit Union, Louisville (Federal Deposit. Money).

Money Smart's curriculum is available in multiple media formats and multiple languages; does not have a licensing fee or copyright restrictions; and is designed for the unbanked and underbanked. FDIC distributes the curriculum to potential instructors, provides technical assistance, links sites interested in delivering financial education with potential instructors, provides train-the-trainer resources, and provides publications (Reynolds).

Jump\$tart

The public information officer of the Kentucky Jump\$tart Coalition for Personal Financial Literacy emphasized that all Kentuckians need to have the financial literacy necessary to make informed financial decisions. Jump\$tart seeks to improve money management skills beginning with young people. The program targets the educational decision makers and communicators, such as government and administration officials, parents, educators, school board officials, personal finance media, and organizations represented as coalition members (May).

Jump\$tart has been encouraging the Kentucky Department of Education to require a new math class that is based on financial literacy that would count as a fourth math credit. There are only three states that require a full class in financial literacy for students to graduates: Utah, Missouri, and Tennessee. Schools in Kentucky have the option to offer financial literacy as an elective. There is currently a pilot project for this class in 13 high schools in Kentucky: Bracken County, Bullitt Central, Clinton County, DuPont Manual, Estill County, Fleming County, Garrard County, Green County, Greenwood, Hart County, Henry County, Monroe County ATC, and Russell County (May). Currently, the financial literacy elective does not count as one of the main math classes.

Every other year, the Jump\$tart Coalition surveys 12th-grade students to test their knowledge of personal finance and to get a better understanding of their experience with and attitudes about managing money. The overall score for Kentucky in 2008 was 47 percent, and the national score was 48 percent. Ten high schools in Kentucky participated in the survey in 2008: John Hardin, Warren Central, Anderson County, Western Hills, Franklin Simpson, McCreary Central, Louisville Male Traditional, Russell Independent, Lyon County, and Grayson County Technology Center (May).

Bank Financing

Traditional Bank Financing

Banks and financial institutions that attempt to maximize their profits tend to concentrate their business offerings to those products that are the most profitable while being the least risky. Local banks in particular have long made loans that were based on a relationship between the banker and the local customer. Operating capital of a small business is often acquired through short-term loans that anticipate repayment from the proceeds and profits of the business. Individual loans, whether secured or not, are based on the repayment ability of the borrower. Most loans are either secured if they are borrowed for the purchase of an identifiable asset such as a home, vehicle, or

piece of machinery; or the loans are unsecured if they are for operating capital or for personal use.

Unsecured loans were once a staple of most locally owned banks. These banks have become scarce as banking laws have changed. Federal law changes in 1994 authorized interstate banking. Prior to this change, banks operating in Kentucky were required to be organized and located within Kentucky. Additional changes adopted in 2000 allowed banks to locate branches statewide and nationwide, resulting in many small banks being bought, absorbed, or facing new competition that altered the way they could profitably conduct business.

According to the Kentucky Department of Financial Institutions, there were 287 banks headquartered in Kentucky in 1994. By the beginning of 2009, that number had decreased to 180. Banks that once needed local loans to be profitable often became branches of national banks where large loans to large entities are easier to make, and more secure. A small borrower, who used to be able to go to the local bank for a loan, may now fall below the bank's minimum standards for a loan. But the market or need for this kind of loan has not decreased.

Small-dollar Loans

Small-dollar loans typically are defined as short-term loans of up to \$1,000 that often have higher interest rates than more conventional loans. With many small-town banks now being owned or operated by larger regional or national financial institutions, many local customers have fewer credit options because they do not meet the more stringent criteria to be eligible for credit. This lack of credit availability has resulted in the emergence of credit lenders outside the traditional bank or finance company. The most notable of these are payday lenders making deferred deposit loans.

A deferred deposit loan usually takes the form of a loan where the borrower gives the lender a check, either currently dated or post dated, that will be deposited at a stated date in the future. The borrower's check is written to include the principal of the loan, a stated amount of interest, and a fee for the loan process. According to the FDIC, the annual percentage rate in these transactions is more than 400 percent per year (Bertrand). These transactions require the entire amount due to be paid at the agreed upon date. If the borrower cannot pay the loan, the lender may extend the loan, but new interest and fees will be added.

When relating this issue to income levels, it becomes obvious that lower income persons who have no other source of credit are the predominant users of deferred deposit loans, and they are also the income level least likely to be able to afford the significant cost of credit associated with these loans. A more reasonably priced source of credit could provide a significant source of stability to the borrower's finances.

The Small-Dollar Loan Pilot Program

The FDIC and several other organizations asked banks to revisit the small-loan market, with the intent being to develop a small-loan market that is both profitable to the financial institution and that provides credit to a market that has been perceived as neglected. With this in mind, the

FDIC implemented the Small-Dollar Loan Pilot Program, a 2-year initiative that began in February 2008. This pilot program was designed to demonstrate the role that affordable small-dollar loans can play in replacing high-cost financial products as part of a bank business plan to reach out to underserved communities.

The FDIC pilot program was intended for loans of up to \$1,000 with longer repayment periods. Annual percentage rates must be below 36 percent with no or low origination fees and no prepayment penalties. The loan application and underwriting process are streamlined. Also included must be an automatic savings component and a financial education component (Federal Deposit. "Affordable"). The goal is to simplify and streamline the application process so that more people will have the opportunity to begin building a good credit history.

Financial institutions could submit applications to participate in the pilot program. The FDIC reviewed the applications to ensure that the institutions met certain criteria including regulatory compliance. Also considered were the size of the institution, geographic location, and age of the institution in order to select a representative sample of institutions (Reynolds).

In February 2008, 31 banks were selected to participate in the pilot program, including two from Kentucky: Kentucky Bank in Paris and Citizens Union Bank in Shelbyville. Kentucky Bank has 16 branches with \$679 million in assets, and Citizens Union Bank has 20 branches with \$634 million in assets (Reynolds).

There have been 24,000 loans made since the pilot began. Some institutions have reported profits on small-dollar loans with interest rates averaging between 13 to 14 percent (Reynolds). The FDIC does not track the money, but most is spent for consumer purposes. It has also been noted that banks outside the pilot program have begun to issue three types of loans.

The pilot program will end early in 2010. Banks can continue the program but are not required to do so. The possible incentives to continue in the program include positive consideration under the Community Reinvestment Act, business development opportunities, and short-term and long-term community goodwill. Banks assume more risk with the small-dollar loans, and the loans are more likely to be delinquent than all loans overall. However, the charge-off rate is consistent with all loans (Reynolds).

Other proposed methods to address the small-dollar loan issue include encouraging nonbanks and nontraditional lenders to develop more equitable loan methods for small loans, including providing interest rates that are comparable to the maximum rates charged by banks and by regulated financial institutions. Regulating nontraditional lenders by requiring rates and terms that are comparable to regulated banks has also been proposed. These proposals have met significant resistance and have not been successful in Kentucky.

Recommendations

Small-dollar Lending. Consider efforts to facilitate affordable small-dollar loan programs to replace high-cost financial products to help integrate underserved communities into the financial mainstream.

Financial Literacy. Consider the integration of financial literacy education into school curriculums and the use of free resources for delivering financial education to adults.

Chapter 4

Transportation

Introduction

This chapter summarizes the relationship between transportation and poverty and provides an overview of the efforts of two agencies to serve the transportation needs of the low-income population: the Transit Authority of River City and the Leslie, Knott, Letcher, Perry Community Action Council, Inc.

Access to Transportation

Low-income individuals who lack reliable transportation face greater costs to access education and employment, which might help them to emerge from poverty. A 2008 Brookings Institution study found that the working poor spend 6.1 percent of their income on commuting compared to 3.8 percent for other workers (Esfahani). Low-income families are less likely to own a vehicle and are, therefore, less able to travel to work, school, and other services. These individuals often rely on limited public transit services that may make it more difficult for them to access education, employment, child care services, groceries, and other needs (Sanchez). Low-income individuals who live in urban centers may also need to engage in a “reverse commute.” Because most economic development is being created outside metropolitan areas, many entry-level service jobs are now located far from the city center where low-income individuals historically reside. Therefore, those affected by poverty frequently find themselves commuting to the suburbs in search of this type of work (Roberto).

Programs to assist individuals with transportation needs include mass transit systems, paratransit systems, and assistance with personal automobile access. Mass transit systems may be more cost effective in urban areas because higher population density allows bus systems to maintain set schedules and transport a relatively large number of people at the same time, reducing the cost per person. Paratransit, which involves van pools and on-demand services similar to taxi services, may be more effective in rural areas (Sanchez).

Federal funding through the Job Access and Reverse Commute (JARC) program provides assistance with these types of services. JARC awards competitive grants to state and local governments and nonprofits to develop and operate transportation programs. The JARC program will be discussed in greater detail later in this chapter. Funding supplied by these grants must be matched by other funds at a rate of up to 50 percent, though this match can be met with TANF or with Welfare-to-Work funds through the Kentucky Transportation Cabinet. In fiscal year 2009, nearly \$2.4 million was awarded to projects in Kentucky.¹ As an example of a typical program funded through these grants, Adaptive Enterprise of Bowling Green provides free transportation

¹ Originally, in FY 2009, \$872,919 was awarded to projects in Kentucky. This figure is typical of funding for previous years. The 2009 funding was later revised because of the 2009 Omnibus Appropriations Act, and JARC funding to Kentucky projects was increased.

to and from work for low-income individuals in surrounding areas such as Franklin, Russellville, Horse Cave, and Scottsdale. This program received \$297,000 in JARC grants to fund 2 years of service beginning in September 2006. Federal funding is also available through the Rural Transit Assistance Program that provides funding for programs in areas with populations of fewer than 50,000 individuals. These funds, commonly referred to as “5311 funds” from the reference to the federal statute, are allocated by the Transportation Cabinet to provide transportation assistance to individuals in rural areas (KRS 96A.095). While some of these funds go to local governments, the majority of the funding goes to nonprofit organizations that provide low-cost paratransit services.² According to the Executive Staff Advisor at the Kentucky Transportation Cabinet’s Office of Transportation Delivery, the largest recipient of these funds is Rural Transit Enterprises Coordinated, which provides service throughout 12 counties in southern Kentucky.³ In FY 2009, more than \$13 million in 5311 funds were awarded to Kentucky (Bourne).

Reliable personal automobiles may provide low-income individuals with transportation that has fewer restrictions than public transportation. However, personal automobiles traditionally have been included as assets in formulas used to determine eligibility for assistance programs, which may penalize those who own an automobile. Exempting vehicles from such formulas would increase the probability of vehicle ownership by low-income individuals by 20 percent (Sullivan). Kentucky is one of the states that already provide an exemption for vehicles owned by TANF recipients.

Another program that may help increase automobile ownership is assistance with low-interest automobile loans for low-income households. The Ways to Work program is one example. Under this program, JARC funds are used to subsidize low-interest loans. Approximately 27,000 families nationally were given loans under this program to purchase or repair an automobile. Studies showed that 72 percent of borrowers under this program saw their incomes rise in less than a year, suggesting they may have had access to better jobs. Individuals also were more likely to end their dependence on public assistance programs, as 87 percent were no longer receiving public assistance after they paid off the loan. However, this program is less likely to help those without access to a job or education because applicants are required to have been working for at least 6 months or be enrolled in school (Gutierrez-Mayka). While Ways to Work is a federal program, some authors have suggested that TANF funds can be used for low-income car loan programs and that states should consider incorporating programs like this as part of the state TANF plan (Blumenberg).

Transit Authority of River City

Public transportation provides much needed access to jobs, health care, and education; increases mobility for people with disabilities and older adults; and offers relief from high fuel costs. The

² The city of Frankfort received \$455,000 for public transit operations for fiscal year 2009.

³ Similar programs include Leslie, Knott, Letcher, Perry Community Action Partnership; Federated Transportation Services of the Bluegrass; Blue Grass Community Action Partnership; and Pennyryle Allied Community Services, each providing some form of paratransit services for individuals in certain regions of Kentucky. Federated Transportation Services of the Bluegrass recently expanded to Lewis County, where it operates three buses that each travel approximately 500 miles per day.

mission of Transit Authority of River City (TARC) is to explore and implement transportation opportunities that enhance the social, economic, and environmental well-being of the Greater Louisville community. In 2009, TARC served 15.1 million customers with 255 buses and trolleys and 89 paratransit vehicles on 65 routes in five counties. TARC programs include job-hunting trips, ticket assistance for the Coalition for the Homeless, Bikes on Board work trips, assistance at job fairs, and travel for training to the Kentucky Refugee Ministries and Catholic Charities. TARC reported that 15 percent of riders go to school and 56 percent go to jobs. A TARC monthly pass is \$42. There is a half-fare for all Medicaid trips, but there is no program that picks up people on an emergency basis. Individuals who ride transit can save on average \$9,190 annually based on the November 9, 2009, national average gas price and the national unreserved monthly parking rate (Walfort).

Leslie, Knott, Letcher, Perry Community Action Council, Inc.

The Leslie, Knott, Letcher, Perry Community Action Council, Inc. is a community action service and planning agency that helps develop the human and natural resources in the four-county area. Although the council's primary focus is the poor, it involves all segments of the community in an effort to alleviate poverty. The council began in 1966 with transportation and nutrition programs in Leslie, Knott, Letcher, and Perry counties. Currently, the council has 5 transportation programs across 56 counties. The council is one of the few regional agencies that provide services to all ages. For in-county transportation, the fee is \$5 for the first 5 miles per round trip, \$10 for 6 miles or more per round trip. For out-of-county transportation, the fee is 80 cents per mile per round trip.

The council also provides public and human services transportation delivery (HSTD), which provides services to eligible Medicaid recipients for no fee. Public trips must originate or end in the service area. In 2008, there were 706,763 HSTD trips (Acker-Hogg).

Funding sources for the programs include several listed in U.S. Code Chapter 53—Public Transportation: the federal Elderly and Persons with Disabilities Formula Program (section 5310), the Rural and Non-urbanized Rural Public Transportation Program (section 5311), the Job Access Reverse Commute (JARC) program (section 5316), the New Freedom grant (5317), and the National Center for Senior Transportation (Acker-Hogg).

Obstacles to better transportation include mountainous terrain, lack of adequate infrastructure, lack of adequate area services, population in outlying areas, and lack of resources. Nationally more than 1.6 million rural households do not have vehicles, with the highest proportion in the South, Appalachia, the Southwest, and Alaska. Rural communities that have high rates of carless households are characterized by persistent poverty.

Recommendation

Public transportation. Consider efforts to continue improving access to public transportation for low-income populations and include transportation delivery plans in poverty programs.

Chapter 5

Homelessness

Introduction

This chapter highlights the latest figures on homelessness in Kentucky and provides an overview of needs for the homeless population including mental health services as well as services targeted to homeless veterans.

Kentucky's Homeless Population

Each year, various agencies, including the Kentucky Interagency Council on Homelessness and the Kentucky Housing Corporation, conduct a count of the homeless population across the state. For the purposes of the count, Kentucky is geographically divided into three geographic groupings. Each group is called a Continuum of Care, and the three in Kentucky are Fayette County, Jefferson County, and the Balance of State. Each group conducts its own count independently (Kentucky Interagency).

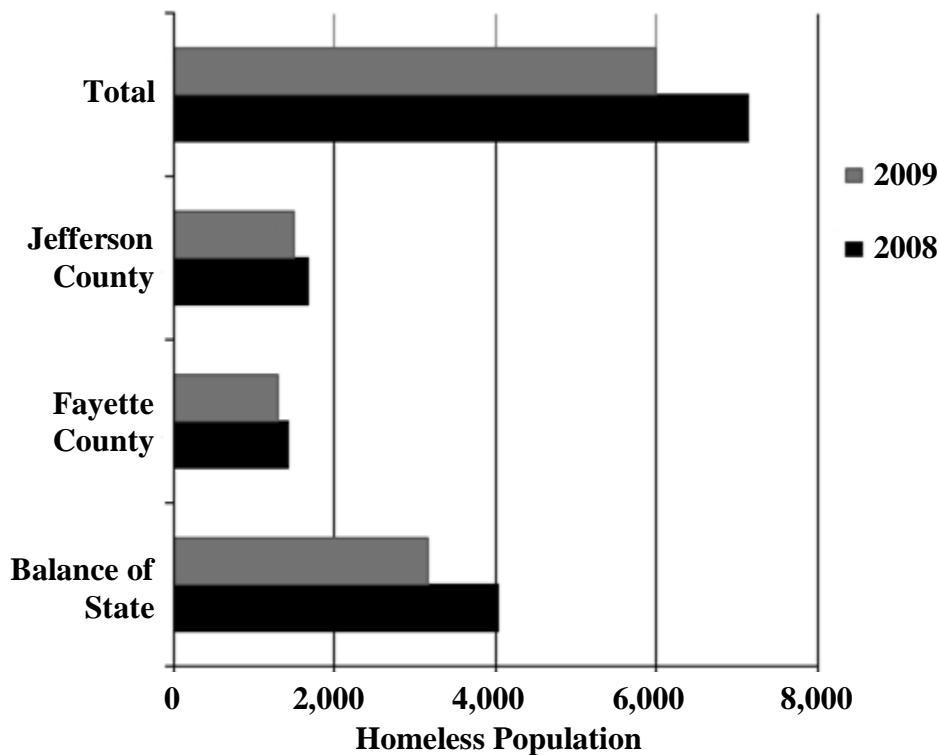
The latest count, conducted between January 29, 2009, and February 19, 2009, reported nearly 6,000 people—more than 1,600 of them children—as homeless. This is a significant number because it exceeds the populations of at least four counties in the Commonwealth. The Fayette and Jefferson County areas together accounted for almost half of the total number of homeless in the state. Over 1,500 of those counted reported a chronic problem with substance abuse, and more than 1,200 identified themselves as having a severe mental illness. The count also reported that 10 percent of the state's homeless population are veterans (Kentucky Interagency).

The count identified two categories of homeless: sheltered and unsheltered. Data from the 2009 count showed that 88.3 percent of the state's homeless population were sheltered in emergency shelters or transitional forms of housing, while the remaining 12 percent found shelter in cars, parks, campgrounds, abandoned buildings, and other places not meant for human habitation.

The count also reported that almost 6,800 precariously housed people in the balance of the state were in danger of becoming homeless. Although this population does not fall under the definition of homeless by the U.S. Department of Housing and Urban Development, there is a higher possibility for this population to become homeless because of worsening economic factors.

The 2009 count showed a significant increase (62.4 percent) from the count in 2008 in demand for homeless services as reported by 200 participating agencies across the state. However, it cannot be concluded that the overall rate of homelessness in Kentucky is on the increase because a 2008-2009 comparison of the data as shown in Figure 5.A points to a decrease in the homeless population.

Figure 5.A
Total Homeless Individuals in Kentucky, 2008-2009



Source: Kentucky Interagency.

Based on the 2009 count figures, Kentucky stands to receive more than \$17 million from the Department of Housing and Urban Development in homeless assistance grants. These grants go to organizations that participate in local homeless assistance planning groups.

Homelessness and Mental Health

For many decades, social science researchers have known that poverty and mental illness are strongly related. The poorer the person, the stronger likelihood his or her chances are of having some sort of mental disorder (Hudson).

Given Kentucky's relatively high poverty rates, it is not surprising that Kentucky ranked 49th for the prevalence and treatment of mental health issues (Mark). The American Foundation for Suicide Prevention ranks Kentucky 13th in the United States for rate of suicides. Kentucky earned an "F" on the National Alliance on Mental Illness 2009 Report Card.

One national report cited several statistically significant predictors of depression and suicide rates: mental health resources, barriers to treatment, mental health treatment utilization, and socioeconomic characteristics. The findings indicate that

- the higher the number of psychiatrists, psychologists, and social workers per capita in a state, the lower the suicide rate.
- the lower the percentage of the population reporting that they could not obtain health care because of costs, the lower the suicide rate and the better the state's depression status.
- the lower the percentage of the population that reported unmet health care needs, the better the state's depression status.
- the higher the number of antidepressant prescriptions per capita in the state, the lower the suicide rate.
- the more educated the population and the greater the percentage with health insurance, the lower the suicide rate and depression (Mark).

Kentucky's Mental Health Regions

Federal regulation mandates that states permit recipients to obtain services from any qualified Medicaid provider (42 CFR § 431.51). In Kentucky, mental health provider participation in Medicaid is limited to the 14 regional mental health and mental retardation centers licensed by the state, which are listed in Appendix B. The centers are funded through two sources: Medicaid and the General Fund. The federal Center for Mental Health Services provides Medicaid funds to cover the bills that are paid according to how services are provided to Medicaid recipients. The state general fund provides \$25 million for community care and support flexible dollars. The board of directors for each regional center decides how this money is spent in accordance with state guidelines. Medicaid rates have not increased since 2001 and are based on FY 1999 dollars. The mechanism is available to provide services, but funds are not.

Representatives of the Hazard/Perry County Community Ministries recommended a modification of the current delivery system that would enable a wide array of community mental health agencies to provide services. Goals of the system would include providing impoverished people with a choice of mental health providers; providing services in addition to the community mental health centers; creating a link between new service providers and Medicaid; providing a wider array of mental health services; and providing more immediate mental health services to impoverished people (Bouchard).

Individuals who do not qualify for Medicaid can get access to treatment through the Social Security Insurance/Social Security Disability Insurance Outreach, Access and Recovery (SOAR) Technical Assistance Initiative sponsored by the Departments of Health and Human Services, Housing and Urban Development, Labor, and Veterans Affairs. SOAR assists homeless people with mental illnesses or co-occurring substance use disorders to access appropriate services by helping them complete necessary paper work.

Individuals in the foster care system face another obstacle. Mental health services often cannot be provided during the 2-year gap after foster care ends at age 19 and eligibility for services begins at age 21. During this period, some become homeless, some become addicted to drugs, or others have their mental illness worsen, all of which cost the state more money than if treatment could be provided immediately.

The Commission on Services and Supports for Individuals with Mental Retardation and Other Developmental Disabilities started meeting in 2000 to come up with a long-term strategy for mental health issues. The commission's 2009 annual status report focused on efforts to prevent mental illness, promote choices in treatments, promote quality services, and increase access to treatment (Commonwealth. Cabinet).

Homeless Veterans

The U.S. Department of Veterans Affairs estimates that in Kentucky, there are 800 to 1,200 homeless veterans on any given night and there are 3,500 homeless veterans annually. Nationally, 26 percent of the homeless are veterans and 33 percent of men who are homeless are veterans. Homeless veterans are more likely than nonveterans to be age 45 or older and to have completed high school or received a GED. Most of the homeless veterans served 3 or more years and received honorable discharges. Nonetheless, about 70 percent of the homeless veterans suffer from substance abuse problems and 45 percent suffer from mental illness (Commonwealth. Dept. of Veterans).

The Kentucky Department of Veterans Affairs provides counseling; skilled nursing care at state veterans' centers; dignified interment at state veterans' cemeteries; and special programs for women veterans, homeless veterans, and others. The department's mission is to ensure Kentucky's 345,000 veterans and their families receive all eligible benefits and services. The Kentucky Homeless Veterans Program was created in 2000 to develop a statewide network of services that provide treatment for addictions such as alcohol, drugs, and gambling; and for services that lead to permanent housing and employment. The Homeless Veterans Trust Fund provides prevention and intervention funds. In 2008, total trust fund expenditures were \$35 million, providing assistance to 139 veterans and 70 family members. In 2009, the total trust fund expenditures were \$48 million, providing assistance for 166 veterans and 75 family members (McKiernan).

State and federal strategies to assist homeless veterans include maximizing federal resources such as the U.S. Department of Veterans Affairs Compensation and Pension Service, the U.S. Department of Veterans Affairs Grant and Per Diem Program for transitional housing, the U.S. Department of Housing and Urban Development and the U.S. Department of Veterans Affairs Supported Housing Program, the U.S. Department of Labor Homeless Veterans Reintegration Project, the U.S. Department of Labor Incarcerated Veterans Transition Program, and the Kentucky Housing and Emergency Assistance Reaching the Homeless.

Barriers to assisting homeless veterans include stringent federal guidelines for eligibility, lack of services to dependent family members, lack of employment opportunities, limited housing subsidies, and substance abuse. Also, it normally takes 12 months for a claim to be processed. Societal and community benefits of substance abuse treatment for veterans outweigh costs by 4 to 1, reduce burdens to the government, reduce criminal activity by up to 77 percent, increase employment, improve physical and mental health, reduce medical costs, and provide significant immediate and long-term savings (McKiernan).

Representatives of the Kentucky Department of Veterans Affairs indicated that it would be helpful to have a public service announcement encouraging veterans to obtain their Certificate of Release or Discharge from Active Duty (DD Form 214) and to call to see if they are eligible for services and benefits. The DD Form 214 is available online, but the homeless population generally does not have access to or experience with computers. Shelters could be more diligent to find out if individuals are veterans or dependent family members of veterans to make sure they access all available services. It is speculated that a great number of Kentucky veterans do not realize they are eligible for benefits (McKiernan).

Recommendations

Mental Health Services for the Homeless. Consider improvements to the current mental health system in order to better serve the needs of the poor and homeless population including increasing the array of services available.

Homeless Veterans. Consider efforts to reduce barriers to providing services and treatment to homeless veterans.

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Appendix A

Kentucky's Early Childhood Initiatives

Program	Purpose	Activity
Healthy Babies Campaign	<p>Public Awareness/Education Campaign</p> <ul style="list-style-type: none"> • Fetal Alcohol Syndrome • Substance abuse impacts on pregnancy and childrearing • Importance of smoking cessation and healthy lifestyle choices 	Ads ran summer 2008; maintain toll-free number
Folic Acid Campaign	Prevent high incidence of two common and serious birth defects: spina bifida and anencephaly	75,962 women of childbearing age received folic acid counseling and supplementation
Substance Abuse Treatment Program for Pregnant and Postpartum Women – KIDS NOW Plus	<ul style="list-style-type: none"> • Identify pregnant women in community at risk for using alcohol, tobacco, and other drugs; mental health disorders; and domestic violence • Provide referrals, prevention services, case management 	597 women received 3850 face-to-face contacts from a case manager (7.4 per); 880 pregnant women received a prevention service
Early Hearing Detection and Intervention Program	Early detection of infants at risk for hearing loss and early intervention for those diagnosed	54,490 hearing screen report forms submitted to program; 7,220 at-risk; referred for follow-up; 10 children reported with permanent hearing loss

Newborn Metabolic Blood Screening	Every infant must have a newborn blood spot performed between 24-48 hours of age	56,890 infants screened: 622 with positive screens referred for definitive diagnosis, 106 confirmed as positive carriers; second-tier testing for cystic fibrosis is in process of implementation
Immunization Program for Underinsured Children	Achieve 100% immunization coverage by age 3	4,292 immunization services provided to underinsured children
Oral Health Education and Prevention Program	Prevent early childhood caries through early screening, educating caregivers, fluoride mouthwash, and referrals to dentist as necessary	27,000 provided through local health departments and others; 10 trainings for pediatricians/staffs; refresher courses offered; 4 group presentations
Health Access Nurturing Development Services (HANDS) Voluntary Home Visiting Program	Voluntary home visitation for at-risk first-time parents to promote healthy growth and development	11,171 families received services; 6,181 assessments conducted; 63,397 professional home visits conducted; 81,575 paraprofessional home visits conducted
Healthy Start in Child Care	Provide personnel to train and educate early care and education staff and parents in health, safety, nutrition, and the benefits of early intervention	6,021 phone consultations, 691 on site consultations, 76 playground inspections provided; 2,896 classes on health, safety, and nutrition presented to 48,245 child care providers, parents, and children in collaboration with the Child Care Resource and Referral Agencies; collaboration with Early Childhood Mental Health Specialist, 795 referred

First Steps: Kentucky's Early Intervention System	Support and services to infants and toddlers with developmental disabilities and/or delays and their families	12,982 total children served, at an average cost per child of \$2,215; administrative structures developed at each Point of Entry (POE) office; performance contracting system in place with POE contractors; state improved on federal report card from "Needs Intervention" to "Needs Assistance"
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Source: Commonwealth of Kentucky. Department of Education. Division of Early Childhood Development. "Kentucky's Early Childhood Initiative Summary, FY 2009." Handout. Meeting of the Early Childhood Development Authority. Frankfort. Oct. 23, 2009.

Appendix B

Kentucky Regional Mental Health and Mental Retardation Regions

Region 1—Four Rivers Behavior Health

Counties Served: Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, Marshall, McCracken

Region 2—Pennyroyal Regional Center

Counties Served: Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd, Trigg

Region 3—River Valley Behavior Health

Counties Served: Daviess, Hancock, Henderson, McLean, Ohio, Union, Webster

Region 4—Lifeskills, Inc.

Counties Served: Allen, Barren, Butler, Edmonson, Hart, Logan, Metcalfe, Monroe, Simpson, Warren

Region 5—Communicare, Inc.

Counties Served: Breckinridge, Grayson, Hardin, Larue, Marion, Meade, Nelson, Washington

Region 6—Seven Counties Services, Inc.

Counties Served: Bullitt, Henry, Jefferson, Oldham, Shelby, Spencer, Trimble

Region 7—NorthKey

Counties Served: Boone, Campbell, Carroll, Gallatin, Grant, Kenton, Owen, Pendleton

Region 8—Comprehend, Inc.

Counties Served: Bracken, Fleming, Lewis, Mason, Robertson

Region 10—Pathways, Inc.

Counties Served: Bath, Boyd, Carter, Elliot, Greenup, Lawrence, Menifee, Montgomery, Morgan, Rowan

Region 11—Mountain Comp. Care Center

Counties Served: Floyd, Johnson, Magoffin, Martin, Pike

Region 12—Kentucky River Community Care, Inc

Counties Served: Breathitt, Knott, Lee, Leslie, Letcher, Owsley, Perry, Wolfe

Region 13—Cumberland River

Counties Served: Bell, Clay, Harlan, Jackson, Knox, Laurel, Rockcastle, Whitley

Region 14—Adanta

Counties Served: Adair, Casey, Clinton, Cumberland, Green, McCreary, Pulaski, Russell, Taylor, Wayne

Region 15—Bluegrass

Counties Served: Anderson, Bourbon, Boyle, Clark, Estill, Fayette, Franklin, Garrard, Harrison, Jessamine, Lincoln, Madison, Mercer, Nicholas, Powell, Scott, Woodford

Source: Commonwealth of Kentucky. Department of Mental Health, Developmental Disabilities, and Addiction Services. Cabinet for Health and Family Services. <<http://mhmr.ky.gov/cmhc/cmhcinfo.asp>> (accessed Jan. 1, 2009).