GLOSSARY OF PUBLIC BENEFIT TERMS AND RESOURCES[1]

ABLE- The Achieving a Better Life Experience Act (ABLE Act), signed into law on 12/19/14, is federal legislation that allows individuals with disabilities to open tax-free savings accounts to cover qualified expenses such as education, housing, and transportation. 26 U.S.C. § 529A.

ADLs- Activities of Daily Living (ADLs) includes tasks such as eating, toileting, grooming, dressing, bathing, transferring, and continence. 42 U.S.C. § 1396n(k)(6).

CDB- Childhood Disability Benefits (CDBs) are payable to some adults who are children of workers covered by Social Security. To be eligible, the adult child must be unmarried, age 18 or older, and has had a disability before the age of 22. POMS DI 10115.001; 20 C.F.R. § 404.350(b).children with disabilities when recipients will be rolled over to CDB, based on the parent's

CDB benefits are not means-tested.

COBRA- The Consolidated Omnibus Budget Reconciliation Act of 1985 allows eligible workers, their spouses, and their dependents to maintain previously existing health coverage for a period of time following certain "triggering events" provided they continue to pay the premiums. COBRA provides for 18 months of additional coverage; most states have adopted regulations allowing coverage to extend to 29 months.

CHIP- The Children's Health Insurance Program (CHIP) is an insurance program jointly funded by the state and federal government and administered by the states that provides health coverage to low-income children and, in some states, to pregnant women in families who earn too much income to qualify for Medicaid but cannot afford to purchase private health insurance coverage. 42 U.S.C. Ch. 7, Subchapter XXI. For more information visit Medicaid.gov.

MEDICARE PART D DONUT HOLE- Under Medicare Part D, the coverage gap (a.k.a. the "donut hole") is a period where an individual pays higher cost sharing for prescription drugs. In 2015, the coverage gap begins after an individual spends $2,960 on covered drugs, and once in the coverage gap, individuals will pay 45% of the costs for covered brand-name prescription

[1] With thanks and appreciation to my law clerk, Kristina Ferguson, for her outstanding work on this presentation.

drugs. 42 U.S.C. § 1395w-114. Under the Affordable Care Act, the donut hole is expected to be eliminated by 2020. For more information visit Medicare.gov.

CMS- Centers for Medicare and Medicaid (CMS) is the federal agency part of the Department of Health and Human Services (HHS) that administers Medicare, Medicaid, CHIP, and parts of the Affordable Care Act (ACA). CMS was formally known as Health Care Financing Administration (HCFA). . For more information visit CMS.gov.the Health Care Financing Administr

CSRA- Community Spouse Resource Allowance (CSRA) was created under the Medicare Catastrophic Coverage Act (MCCA), which was passed by Congress in 1988 to prevent spousal impoverishment for the Community Spouse (the spouse still living in the community and not in a long term care facility). Under CSRA rules, a certain amount of the couple's combined resources is protected for the community spouse. In 2015, the maximum resource standard for the community spouse is $119,220. 42 U.S.C. § 1396r-5. For more information visit Medicaid.gov.

CUSTODIAL CARE- Custodial care includes non-skilled personal care, like help with activities of daily living (ADLs) bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. Medicare does not pay for custodial care, except within the scope of services for hospice care. POMS HI 00620.130. Medicaid covers long term care services, including custodial care in nursing homes and at home. 42 U.S.C. § 1396d(7)-(8).

(d)(4)(A) SNT - A self-settled, first party "(d)(4)(A)" SNT is a trust that meets the statutory requirements as proscribed under 42 U.S.C. § 1396p(d)(4)(A). The trust must be for the sole benefit of the beneficiary, and subject to a state Medicaid pay-back provision. Upon the beneficiary's death or the termination of the trust, if funds remain, an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State Medicaid plan must be reimbursed to the State. When the SNT is established and funded, the beneficiary must be under 65 and the trust may only be established by a parent, grandparent, guardian, or court. The trust is treated as an exempt asset for Medicaid eligibility purposes, and a transfer to the trust, by a Medicaid applicant, is an exempt transfer. 42 U.S.C. § 1396p(c)(3)(A).

(d)(4)(C) POOLED SNT- A pooled SNT established under 42 U.S.C. § 1396p(d)(4)(C) is managed and created by a non-profit association, that maintains separate accounts for multiple beneficiaries. All beneficiaries' funds are pooled for investment purposes and the pooled trust serves as Trustee, managing distributions in accordance with federal and state laws and regulations. The beneficiary must have a disability as defined in 42 U.S.C. § 1382c(a)(3). The accounts in the trust are established solely for the benefit of the individual, and can be established by the parent, grandparent, legal guardian, court, or by the individual herself. Upon the beneficiary's death, of the remaining account, an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State plan will be paid to the State.

Note regarding Medicaid Payback trusts (d)(4)(A) and (d)(4)(C): Federal estate recovery programs provide that estate recovery applies only when payment of Medicaid assistance was made for the benefit of recipients who are 55 and older and only for assistance covering nursing homes, HCBS, related hospital and prescription drug services or Medicare cost sharing. However, the creation and funding of a payback Special Needs Trust creates a right of reimbursement for all Medicaid benefits received during the beneficiary's lifetime. "Medicaid payback may also not be limited to any particular period of time, i.e. payback cannot be limited to the period after establishment of the trust." 42 U.S.C. § 1396p(b).

DEEMING- is the process of considering another person's income and resources to be available to an individual applying for or receiving government benefits, if that person is responsible for the applicant's or recipient's income. 20 C.F.R. §§ 416.1160, 416.1202. POMS SI 01310.001. SSI Handbook 2167.

DISABILITY- Having a disability determination approved by the Social Security Administration (or another authorized agency in very limited circumstances) is a pre-requisite for a SNT. A disability for Social Security purposes is defined as the inability to engage in substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment that can be expected to result in death or to last for a continuous period of no less

than 12 months. There are special rules that apply for workers over the age of 44 whose disability is based on blindness. 42 U.S.C. § 423(d)(1).

DME- Durable Medical Equipment (DME) are equipment and supplies ordered by a health care provider that can withstand repeated use and are primarily and customarily used to serve a medical purpose. Coverage for DME may include oxygen equipment, wheelchairs, crutches, or blood testing strips for diabetics. POMS HI 00610.200. For more information visit Healthcare.gov.

ESTATE RECOVERY- Under the congressional mandate that every state adopt a program to recover Medicaid expenditures from the estates of first party Medicaid recipients, states can attach liens to personal or certain real property to seek recovery for Medicaid expenses. 42 U.S.C. § 1396p(b)(1).

The Federal Poverty Level (FPL) is an income level used to determine eligibility for certain programs and benefits. The FPL is determined annually by HHS and defines the amount of annual income which constitutes "poverty" in the United States. For 2016, the FPL is not going to reflect a cost-of-living adjustment and will remain the same as the 2015 figures. The FPL for individuals is $11,770, and $24,250 for a family of 4. For more information visit Healthcare.gov. or SSA.gov.

HCBS- The Home and Community-Based Services (HCBS) program is a Medicaid state waiver program that provides services to functionally disabled elderly individuals. Services may include, but are not limited to, home health aide services, personal care services, nursing care services, respite care, and adult day care. 42 U.S.C. § 1396t. Although HCBS waivers are optional, nearly all states (with the exception of Arizona) offer at least one HCBS waiver program. To determine whether a proposed change in service or service provision would be beneficial, some waivers are established for a limited period of time. For more information visit CMS.gov.

HHS- The Department of Health and Human Services (HHS) is the federal agency that administers over 100 programs, including Medicare, Medicaid, and TANF, and promulgates regulations under congressional authority. For more information visit HHS.gov.

HOMESTEAD- Under SSI/Medicaid resource rules, an individual's home is an excluded resource for purposes of determining SSI/Medicaid resource eligibility. The home is defined as property in which the individual has an ownership interest and that serves as his or her principal place of residence. It can include the shelter in which he or she lives; the land on which the shelter is located; and related buildings on such land. An individual's principal place of residence is the dwelling the individual considers his or her established or principal home and to which, if absent, *he or she intends to return*. It can be real or personal property, fixed or mobile, and located on land or water. POMS SI 01130.100.

IADLs- Instrumental Activities of Daily Living (IADLs) include, but are not limited to, meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community. 42 U.S.C. § 1396n(k)(6).

ICF/ID- Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/ID) is an optional state Medicaid benefit, offered by all states, to individuals in need of and receiving, active treatment services. ICF/IDs provide comprehensive and individualized health care and rehabilitation services to individuals to promote their functional status and independence. 42 C.F.R. § 440.150.

ISM- In Kind Support and Maintenance (ISM) is unearned income in the form of food or shelter or both. SSI eligibility and payment amounts are determined by whether a recipient is receiving ISM and the value of the ISM. The SSA uses two rules for determining the value of ISM—the one-third reduction rule and the presumed value rule. POMS SI 00835.001.

LTCSSS- Long Term Care Supports and Supports and Services (LTCSS) are medical and non-medical services (such as assistance with ADLs) that can be provided in an institutional, home or

community settings to individuals who have a chronic illness or disability. For more information visit longtermcare.gov.

MAGI- Modified Adjusted Gross Income (MAGI) is gross income adjusted for deductions and then modified by adding some deductions including tax-exempt social security, interest or foreign income back in. MAGI is used to calculate cost assistance for individuals enrolled in the health care marketplace under the ACA. POMS HI 001101.010. For more information visit IRS.gov. and HealthCare.gov.

MEDICAID EXPANSION- The ACA provides states with the ability to expand their state Medicaid programs to cover adults under 65 with income up to 138% of the FPL. Originally, Medicaid expansion was mandated under the ACA, but in *NFIB v. Sebelius*, 132 S.Ct. 2566 (2012), the Supreme Court held that expansion is optional for the states. States who expand Medicaid by using this income-only criteria have all budget increases attributed to expansion paid 100% by the federal government from 2014-2016, instead of the usual cost-sharing provision in 42 U.S.C. § 1396a. Federal cost-sharing is expected to be reduced to a minimum of 90% by 2020 under the ACA. Currently Medicaid expansion has been adopted by 30 and the District of Columbia. Nineteen states have chosen not to expand Medicaid at this time, and expansion is currently in discussion in one state. 42 U.S.C. § 1396a(a)(10)(A)(i). For more information visit Healthcare.gov.

MEDICAID MCOs- Medicaid Managed Care Organizations (MCOs) are entities contracted by the States that agree to provide comprehensive services to Medicaid beneficiaries. Approximately 80% of Medicaid enrollees are served through a managed care delivery system. MCOs serve beneficiaries on a risk basis through a network of employed or affiliated providers. The term MCO generally includes HMOs, PPOs, and Point of Service plans. For more information visit Medicaid.gov.

MEDICAID- A joint federal and state program that provides health coverage for people with low incomes and limited resources. Though federal law requires states to cover certain mandatory populations and provide mandatory benefits, states have flexibility in providing

coverage to other populations and can choose to provide optional benefits. Medicaid is the only federal public benefits program which covers the costs of long term non-acute care (custodial care). 42 U.S.C. Ch. 7, Subchapter XIX. For more information visit Medicaid.gov.

MEDICARE WAITING PERIOD FOR SSDI AND CDB RECIPIENTS- SSDI entitlement begins after a 5-month waiting period following the onset of a disability. CDB eligibility begins immediately after the application is approved. Both SSDI and CDB recipients will receive Medicare benefits, but not until 24 months after they have been receiving their respective benefits. No waiting period is required for individuals who have End Stage Renal Disease or ALS (Lou Gehrig's disease), or those who were previously entitled to a period of disability and became disabled again within five years following the month the previous disability ended. SS Handbook 502.

MEDICAID WAIVERS- States may use federally approved waivers to test new or existing ways to deliver and pay for health care services in Medicaid and CHIP. The term "waiver" refers to a deviation in the existing state Medicaid plan. There are four primary types of waivers and demonstration projects: § 1115 Research & Demonstration Projects; § 1915(b) Managed Care Waivers; § 1915(c) HCBS Waivers; and Concurrent § 1915(b) and 1915(c) Waivers. For more information visit Medicaid.gov.

MEDICALLY NECESSARY- Under Medicare, medically necessary is defined as health care services or supplies that are needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine. 42 U.S.C. § 1395y(a)(1)(A). For more information visit Medicare.gov.

MEDICARE- An exclusively federal program (unlike Medicaid) that provides health care insurance to individuals ages 65 and older, people with disabilities, people with ALS and those with End Stage Renal Disease. 42 U.S.C. Ch. 7, Subchapter XVIII. Medicare is not free and not all individuals are eligible. Individuals who did not pay Medicare taxes while working canpurchase Medicare benefits. Medicare does not pay for long term care, but

does cover brehabilitative stays in a nursing home or rehabilitation center. For more information visit Medicare.gov.

MEDICARE ADVANTAGE PROGRAM- Created under the Balanced Budget Act of 1997, the Medicare Advantage Program (a.k.a. Medicare Part C) is a type of Medicare health plan offered by private companies that contracted with Medicare to provide Part A and B benefits. The program provides an alternative means of financing or receiving Medicare coverage, and includes HMOs, PPOs, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. Advantage programs may provide more benefits than traditional parts A and B but are often less advantageous for the disability and aged communities due to strict limits on coverage for LTCSS. 42 U.S.C. Ch. 7, Subchapter XVIII, Part C.

MEDICARE OPEN ENROLLMENT PERIOD- The Medicare Open Enrollment Period is between October 15 and December 7 every year, and is the time period when Medicare recipients can change their Medicare health plans and prescription drug coverage. For more information visit cms.gov.

MEDICARE PART A- Covers hospital care, SNF care, nursing home care, hospice, and home health services. Part A is funded by payroll deduction taxes. 42 U.S.C. Ch. 7, Subchapter XVIII, Part A.

MEDICARE PART B- Part B, which is optional, primarily provides physician services, and covers medically necessary and preventative services such as clinical research, ambulance services, durable medical equipment, inpatient and outpatient mental health, limited outpatient prescription drugs, and getting a second opinion before surgery, among other things. Part B requires a payment of a monthly premium of $104.90 in 2015-16. The premium is typically deducted from the recipient's monthly Social Security check. 42 U.S.C. Ch. 7, Subchapter XVIII, Part B.

MEDICARE PART D- In 2003, the Medicare Prescription Drug, Improvement and

Modernization Act of 2003 added Part D to the Medicare program, which took effect in 2006. Part D coverage is purchased from private insurance companies who meet provider qualifications. The program provides optional source of benefits to the prescription drug coverage offered by companies approved by Medicare to Original Medicare, some Medicare Costs Plans, some Medicare Private Fee-for-Service Plans, and Medicare MSA Plans. 42 U.S.C. Ch. 7, Subchapter XVIII, Part D

MEDICARE MSA- Medical Savings Account (MSA) may be provided by a Medicare Advantage Program. When an individual elects to have a MSA, the individual will choose a high-deductible insurance plan. Any unused amount in the individual's benefit will be deposited into a savings account, which can be used for medical care until the high deductible is met. 42 U.S.C. § 1395w-28. For more information visit Medicare.gov.

MEDICARE SET-ASIDE- A Medicare Set-Aside is a trust arrangement established to hold settlement proceeds for future medical expenses. During litigation, an evaluation is done of the beneficiary's future medical needs, and the evaluation includes an amount that should be set aside for future medical care. The funds are then either placed in the Medicare Set-Aside account in one lump-sum or the account is funded with an annuity. The administrator of the Medicare Set-Aside trust may use the funds only to pay for medical care related to your personal injury, leaving Medicare or your private insurance free to provide coverage for medical expenses that are not related to your injury. Medicare set-aside companies provide services specifically intended to assist with this process. The MSA may be created as a provision of a SNT.

MEDIGAP- Medigap Insurance Policy covers items not covered by Medicare, including substantial deductibles and copayments. These policies are provided by insurance companies, and must include certain core benefits such as a deductible for hospitalization days 61 through 90 and a deductible for the "lifetime reserve" hospitalization days 91 through 150. All Medigap policies must offer one of ten predefined sets of benefits identified as standardized Plans A through N (Plans E, H, I, and K are no longer offered). 42 U.S.C. § 1395w-21.

MEDIGAP OPEN ENROLLMENT PERIOD- A six month period starting the first month that an individual is covered under Part B and is 65 or older. During this period, federal law prohibits insurance companies from denying a Medigap policy or charging higher premiums due to past or present health problems. Some states have additional open enrollment rights. 42 U.S.C. § 1395w-21. For more information visit Medicare.gov.

MMNA- The Minimum Monthly Needs Allowance (MMNA) (sometimes referred to as MMMNA for Minimum Monthly Maintenance Needs Allowance) is an allowance under Medicaid for a community spouse with inadequate income where income may be either from the Medicaid applicant or the couple's resources may be received by the spouse. 42 U.S.C. § 1396r-5(d)(3).

OASDI- Old Age, Survivors and Disability Insurance benefits (OASDI) (a.k.a. Social Security) **is a federal program that covers Social Security retirement benefits for all who qualify, as well as survivor benefits and benefits for individuals with disabilities (SSDI). OASDI is primarily funded through payroll** taxes. 42 U.S.C. Ch. 7, Subchapter II.

POMS-

POMS-The Program Operations Manual System (POMS) is the regulation manual (similar to a state Medicaid manual in some ways) used by Social Security employees to process claims for benefits that are administered by the Social Security Administration. Special Needs Trust practitioners use it to gain information regarding drafting of special needs trusts and to be updated on SSA's interpretation of the law related to SSI/Medicaid. Regular, updated versions are available https://secure.ssa.gov/apps10/poms.nsf/partlist!OpenView.

PPACA- Patient Protection and Affordable Care Act (PPACA) (a.k.a. ACA) is federal legislation enacted in March 2010. This legislation includes significant health-related provisions and reforms. Some key provisions include the elimination of all pre-existing condition exclusions for individuals applying for Medicaid, expanding the Medicaid coverage population

and prohibiting certain practices by the health care industry such as denying of coverage due to pre-existing conditions. Some individuals with disabilities may benefit from the purchase of an ACA insurance policy in lieu of creating a special needs trust. For more information visit healthcare.gov.

QC- Quarter of coverage (QC), now technically called a credit, is a calendar quarter of a year in which a worker received employment (or self-employment) income of a minimum amount, and as to which FICA was paid. 20 C.F.R. § 404.140. POMS RS 00301.200.

QDWI PROGRAM- The Qualified Disabled and Working Individuals Program is a state program that pays Part A premiums for individuals with disabilities who have gone back to work and have lost their SSDI benefits. To be eligible, the individual must be: under 65; have a disability; the State no longer pays for his or her Part A premium because the individual works above the SGA limit; is ineligible for state medical assistance; and meets the income and asset tests in the individual's state. Eligible individuals are permitted to purchase Part A and B, so long as they have a disability. 42 U.S.C. § 1396(d)(s). POMS SI 01715.005.

QI PROGRAM- The Qualified Individual (QI) program is a Medicaid benefit which helps pay Part B Medicare premiums for people who have Part A and have limited income and resources.

QMB- Qualified Medicare Beneficiary (QMB) means a Medicaid eligible individual who is entitled to Medicare Part A, is a resident of the state where applying for QMB benefits, and has limited income and resources. Benefits of QMB include payment of Part A monthly premiums, Part B monthly premiums and the annual deductible and co-insurance and deductible amounts for services covered under Medicare Parts A and B. 42 U.S.C. § 1396d(p)(1). POMS SI 01715.005.

QMB PROGRAM- The Qualified Medicare Beneficiary (QMB) Program is a state program that helps pay Part A and B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments) for people who have Part A and limited income and resources.

RESOURCES- An individual's resources are considered as one of the two "need" criteria in determining SSI eligibility. Not every asset is considered a resource—the SSA and other Federal statutes allow for certain types of exclusions. The resource limit of a Medicaid recipient has remained at $2,000 since 1989. See POMS SI 01110.000 for Resource rules.

SECTION 8 HOUSING- The housing choice voucher program Section 8 of the Housing Act of 1937 (42 U.S.C. § 1437f) provides the U.S. Department of Housing and Urban Development (HUD) to assist low income families, the elderly, and individuals with disabilities to afford housing in the private market. Under the housing choice voucher program—the main Section 8 program which is administered locally by public housing agencies (PHAs)—individuals are able to find their own housing so long as the housing meets requirements of the program. For more information visit HUD.gov.

SGA- Substantial Gainful Activity (SGA) means the performance of significant physical and/or mental activities in work for pay or profit, or in work of a type generally performed for pay or profit, regardless of the legality of the work. However, activities involving self-care, household tasks, hobbies, clubs, and social programs are generally not considered to be SGA. POMS DI 10501.001.

SLMB- Specified Low Income Medicare Beneficiaries (SLMB) are individuals who meet the QMB eligibility standards except for income. However, their income cannot exceed 120 percent of the FPL. POMS SI 01715.005.

SNAP- The Supplemental Nutrition Assistance Program (SNAP) a/k/a "food stamps" offers nutrition assistance to millions of eligible, low-income individuals and families and provides economic benefits to communities. The Food and Nutrition Service works with State agencies, nutrition educators, and neighborhoods to ensure that those eligible for nutrition assistance can make informed decisions about applying for the program and can access benefits. For more information visit fns.usda.gov. POMS SI 01801.000.

SNF- A Skilled Nursing Facility (SNF) is an institution which primarily provides skilled nursing

and related services to residents who require medical, nursing, or rehabilitation care. 42 U.S.C. § 1395i-3. POMS HI 00401.2600.

SNT- Special Needs Trusts are trusts that are created for the benefit of an individual who is or may become disabled and contains terms and conditions recognized under state and federal law that exempt the trust assets from being counted toward the beneficiary's eligibility for public assistance.

SOCIAL SECURITY ACT- The Social Security Act, enacted in 1935, and now codified in 42 U.S.C. Chapter 7, created the Social Security system in the U.S that continues to provide benefits for workers, victims of industrial accidents, unemployment insurance, dependent mothers and children, the blind, and the physically handicapped. Title 42 of the United States Code deals with public health, social welfare, and civil rights.

SPELL OF ILLNESS- Most Medicare benefits are limited in duration, with the most common benefit period being the "spell of illness." Readmission to the same level of care within 60 days of discharge will lead to treatment as continuing "spell of illness." Readmission more than 60 days after discharge (even if for treatment of the same condition) will be treated as a new admission, with new co-payments and time limitations. 42 U.S.C. § 1395x(a).

SSA- Social Security Administration (SSA) is the federal agency that, among other things, determines initial entitlement to and eligibility for Medicare benefits. For more information visit ssa.gov.

SSDI- Social Security Disability Income (SSDI) pays benefits to people who can't work because they have a medical condition that's expected to last at least one year or result in death. To be eligible for SSDI benefits, the recipient must have earned sufficient income during a certain time period, typically 40 quarters (may be less for younger workers who becomedisabled). SSDI recipients receive Medicare benefits, but must wait 24 months from the date of SSDI entitlement to cash income before coverage begins.

SSI- Supplemental Security Income (SSI) is a monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 or older. 42 U.S.C. Ch. 7, Subchapter XVI. For more information visit SSA.gov.

STATE MEDICAID MANUALS- Each state provides a manual for its state Medicaid program. State manuals are used to determining Medicaid eligibility and on-going coverage. CMS provides a State Medicaid Manual (SMM), which is available to all State agencies. The SMM offers mandatory, advisory, and optional Medicaid policies and procedures to Medicaid State agencies.

STATE PLANS FOR AID TO PERMANENTLY AND TOTALLY DISABLED- Under 42 U.S.C. Ch. 7, Subchapter XIV, funds are authorized to states for plans for aid to the permanently and totally disabled. The term "aid to the permanently and totally disabled" means money payment to needy individuals eighteen years old or older who are permanently and totally disabled, but does not include any such payments to or care in behalf of an individual who is an inmate of a public institution or any individual who is a patient in an institution for tuberculosis or mental disease.

TANF- In 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) created Temporary Assistance to Needy Families (TANF) as a replacement for Aid to Families with Dependent Children. TANF is a block grant program that provides cash assistance to needy families and is intended to encourage adult members of such families to seek work. 42 U.S.C. Ch. 7, Subchapter IV. For more information visit acf.hhs.gov.

TRICARE- TRICARE is a health care program for active-duty and retired uniformed services members and their families. TRICARE is managed by the U.S. Department of Defense Military Health System, which created the TRICARE Management Activity (TMA). For more information visit Tricare.mil.