



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAY 10 2000

The Honorable Rod Grams
United States Senate
Washington, DC 20510-2304

Dear Senator Grams:

Thank you for your letter concerning the resettlement of HIV-positive refugees to the State of Minnesota. I understand your concern about the impact that HIV-positive refugees who come to Minnesota to rejoin their families may have on the Hennepin County area.

The United States has made a commitment to providing permanent resettlement to help refugees make a new, safe home in America. The Refugee Act of 1980 authorized federal assistance for the resettlement process. State Refugee Coordinators designated by the Governor manage coordinated assistance and services to refugees entering a State. Voluntary agencies help to decide where refugees should be resettled and provide private resources to refugees to help them resettle in their new communities.

Last year, the Office of Refugee Resettlement (ORR) awarded over \$10 million, including discretionary grants, to Minnesota for programs to assist refugees. ORR provides unmatched federal funds to pay Refugee Cash Assistance (RCA) to those refugees who are not eligible for Temporary Assistance to Needy Families (TANF), and to pay Refugee Medical Assistance (RMA) to refugees who are not eligible for Medicaid. RCA and RMA are available for the first eight months refugees are in the United States. Refugees are eligible for the same federally-funded programs as citizens.

Minnesota has received discretionary funds to help ease the impact that refugees have on State and local resources. For example, Hennepin County has received special funding to assist with the large number of Somali refugees, and funds for the public schools to help refugee parents become involved with their children's education. Hennepin County also has received discretionary grants to help support unanticipated refugee arrivals, including those who were initially resettled elsewhere and chose to move to that area. A detailed account of ORR funding to Minnesota for refugee resettlement is enclosed.

Page 2 - The Honorable Rod Grams

Refugees with HIV/AIDS come to the United States, after they are granted waivers by the Immigration and Naturalization Service (INS). Many times, the opportunity to live in the United States is the only thing that prevents them from being separated from their families and left to endure further persecution.

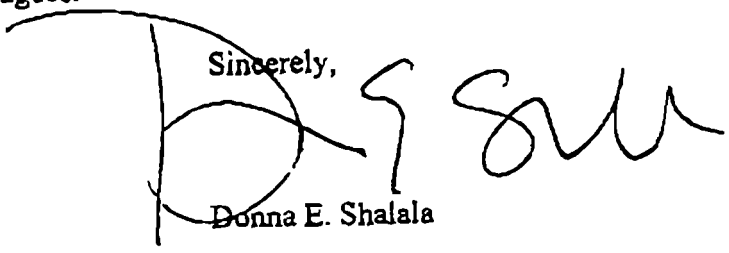
We expect that most refugees with HIV/AIDS and their families will be eligible for Medicaid. Those who are not eligible for Medicaid will be eligible for Ryan White CARE services after their eight months of eligibility for Refugee Medical Assistance. In addition, services not covered by Medicaid or RMA can be provided under Ryan White CARE programs. The Health Resources and Services Administration has indicated that Ryan White CARE grantees in the Twin Cities have substantial available funds.

ORR is activating a program in Hennepin County to assist with the resettlement of refugees with HIV/AIDS and their families funded at \$150,000. We recently have received word that the first family reunion case has been approved for admittance by the INS and should be arriving within two to three months in Hennepin County to join their relatives. The grantee for the program is one of the voluntary agencies which resettles refugees in Hennepin County. We are assured that no refugees with HIV/AIDS will be resettled in Minnesota unless they have family members there.

ORR would be happy to follow up with Minnesota about the opportunity to apply for additional discretionary grants, which might help to ease the impact of the HIV-positive refugees on local resources. There is ample time for Minnesota to apply for these funds and we will assist them with the application process.

I hope that Minnesota will continue its exemplary record as a community that welcomes and extends a helping hand to refugees.

Sincerely,



Donna E. Shalala

Enclosures

Refugee
Wed 10am?

● Eugenia Chough

04/03/2000 09:24:15 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc: Irene Bueno/OPD/EOP

Subject: Refugee conference call on Wed?

While we are waiting for the redraft of the HHS letter to Grams, we would like to have a conference call to make sure we're all on the same page. Specifically, we'd like to know how the HIV resettlement decision was made, what we know about the population, why MN is concerned, etc. What time on Wednesday between 9 and 1:30pm will work best for attendees? I'll send a followup email tomorrow at around noon.

Barbara, could you please forward this to Kathleen Thompson, and Scott, please forward to Jan Belz?

Thanks.

✓ Absmitt@osophs.dhhs.gov
Message Sent To:

Wendy L. Patten/NSC/EOP@EOP
✓ s.busby@state.gov @ inet
~~dsmith@os.dhhs.gov @ inet~~ 690-0697(301) 431774
✓ llimon@acf.dhhs.gov @ inet
barbara.l.strack@usdoj.gov @ inet

✓ jan - j.belz@state.gov

✓ Maryb -

wed. 10am

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456-68799

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ROD GRAMS
MINNESOTA

COMMITTEES

BANKING, HOUSING, AND URBAN AFFAIRS

FOREIGN RELATIONS

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United States Senate

WASHINGTON, DC 20510-2304

By fax

WASHINGTON OFFICE:

PH. 202-224-3244
FAX 202-228-0856
TDD: 202-224-9522

MINNESOTA OFFICE:

2013 SECOND AVENUE NORTH
ANOKA, MN 55303
PH. 612-427-5921
FAX 612-427-8872
TDD: 612-427-6802

March 2, 2000

Commissioner Doris Meissner
Immigration and Naturalization Service
U.S. Department of Justice
425 Eye Street, NW
Washington, DC 20536

Dear Commissioner Meissner:

Recently, I have been contacted by the Board Chairman of Hennepin County who is concerned about the financial burden a potential influx of refugees with human immunodeficiency virus (HIV) would place on the County, particularly on medical services. Hennepin County serves many indigent and Medicaid patients in the Minneapolis metropolitan area, and its resources are already stretched thin due to its willingness to accept many refugee and immigration populations in the past. Some believe over 40% of the Somali refugees in this country live in Hennepin County due to secondary migration.

What is of great concern to me is the INS decision on June 16, 1999 that no documentation of individual eligibility will be required for those refugees identified as HIV-positive who wish to obtain a waiver and enter the United States. This policy change, in essence, eliminated the need to obtain consent from local governments for any cost incurred from relocation of the HIV-positive refugee.

I was disappointed this requirement was rescinded and wonder why suddenly the ability of local governments to absorb the medical costs of any refugee with a serious illness no longer matters. Since there was not even any consultation requirement, Hennepin County was caught completely off-guard with no knowledge of these potential refugees. In fact, my staff was told several months ago there were no plans to bring any HIV-positive refugees to Minnesota.

I strongly oppose this kind of unfunded mandate on local governments. The Administration should be working to address any new financial burden imposed on local governments. At the very least, local governments must be consulted initially and have the right to address cost concerns. I also believe they should be able

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to object. if they cannot absorb the expected medical costs.

I would also appreciate knowing under what authority this substantive administrative change was made.

Thank you for your assistance in this matter. I look forward to hearing from you in the very near future.

Sincerely,



Rod Grams
United States Senator

RG:acc

cc: Senators Orin Hatch and Spencer Abraham
Commissioner Randy Johnson
Enclosure

03/02/00 THU 12:50 FAX

004

FEB 22 '00 05:27PM HENNEPIN CO COMMISS

P.2

RANDY JOHNSON
 CHAIR



PHONE: 612-348-7885
 FAX: 612-348-5295
 TDD: 348-7708

BOARD OF HENNEPIN COUNTY COMMISSIONERS
A-8400 GOVERNMENT CENTER
MINNEAPOLIS, MINNESOTA 55487-0240

February 22, 2000

Hon. Rod Grams
 257 Dirksen
 Senate Office Building
 Washington, DC 20510

Dear Senator Grams

I was surprised to learn very recently that 20 refugee families where at least one person is HIV positive will be coming to Minnesota due to a recent change in federal policy by the Immigration and Naturalization Service. That change eliminated the need for the federal government to document that such immigrants will not place a financial burden on local or state governments without the prior consent of those governments.

Dr. Alan Lifson, Chief of Acute Disease Prevention Services for the Minnesota Department of Health, sent the enclosed letter to the Centers for Disease Control and Prevention questioning the timing of this federal decision and raising other concerns.

We share Dr. Lifson's concerns about timing, lack of housing, difficulty in preserving confidentiality, and facilitating medical care.

As the level of government that actually delivers most services to refugees, Hennepin County also has particular concerns.

As you know, in Minnesota the counties have the responsibility to provide health care to people who are indigent and not covered by health insurance. We do this through the Hennepin County Medical Center and a system of health clinics that we support in large part through property taxes.

HCMC is already in financial crisis. Total uncompensated care rose from \$22 million in 1996 to over \$34 million in 1999. HCMC's net income was minus \$10 million in 1999 --- the first year that net income was negative. Our operating cash balance on January 1 was approximately \$7 million, --- down from \$60 million two years earlier and much less than the industry's prudent standard for a large hospital.

A large part of HCMC's financial condition is a direct result of federal policies, and resettling HIV-positive refugees without full federal reimbursement will push us to the financial breaking point.

The Balanced Budget Act reduced HCMC's Medicare reimbursements by \$7.0 million in 1999 and we project this reduction to reach more than \$8 million in 2001. The reduction will total nearly \$40 million between 1997-2002. Enclosed is additional detail on these federal funding reductions.

E-MAIL ADDRESS:
 randy.johnson@hennepin.mn.us

WEB PAGE:
<http://www.hennepin.mn.us/medic5.html>

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FEB 22 00 05:27PM HENNEPIN CO COMMISS

P 3

Medical Assistance (Medicaid) payments now cover only about 58% of our costs for outpatient care.

As you know, under The Emergency Medical Treatment and Active Labor Act ("EMTALA") passed as part of the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), HCMC must provide "an appropriate medical screening examination to determine whether an emergency medical condition exists ... for all individuals who present to the emergency department" or almost any other HCMC department.

In addition to this, the need to provide interpretive services for our recent immigrants --- all of whom are here as a result of federal policies --- cost over \$2.4 million in 1999.

It has been suggested that refugee assistance for this group of immigrants will apply for the first eight months after their arrival. This is obviously an inadequate period of time. It has also been suggested that the county could use Ryan White funds, but we are already using the entire appropriation.

We recognize that resettling HIV-positive refugees is a difficult problem for the federal government. Hennepin County is willing to "do our share." Nearly all refugees coming to Minnesota settle in Hennepin or our neighboring Ramsey County. We have one of the highest resettlement rates of refugees from Vietnam and Laos. In 1998, 1,132 refugees settled in Hennepin County; in 1999, the number was 2,642. The pattern of secondary migration for Somalians after arriving in the United States suggests that Hennepin today probably has more Somali refugees than any county in the nation.

Policing our borders and determining immigration policy are clearly and exclusively federal responsibilities. Paying for the results of those policies also must be a federal responsibility and not passed on to a handful of local governments.

Very truly yours,



Randy Johnson
Chair, Hennepin County Board of
Commissioners

Enc

Administration for Children and Families
Office of Refugee Resettlement

370 L'Enfant Promenade, SW
Washington, DC 20447-0001

Page

Date: 17 MARCH 2000

FAX: (202) 401-5487

To: ~~XXXXXXXXXX~~ IRENE BUENO	From: DAVID SMITH
Phone: 456 6558	Phone: 301 443 6279

ORR Facsimile Introductions:

FAX machine number: (202) 456 5581 -

or SPEED-DIAL number: _____

Please Confirm
Transmission at: _____

Message: Attached is San Francisco letter,
a statement from MN Legislators, DHHS
proposed reply including an attachment
of last year's funding to CMN.
Please let us have any comments ASAP.
Send response to DKR. If I'm not here,
They will forward to me at my office.

ROD GRAMS
MINNESOTA

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WASHINGTON OFFICE:

RECEIVED
Mar 13 2000 10:04:48 WSH 02
OFFICE OF THE SECRETARY
CORRESPONDENCE
CONTROL CENTER

PH 202-224-3744
FAX 202-228-0900
TDD 202-724-9622

MINNESOTA OFFICE:

2013 SECOND AVENUE NORTH
ANOKA, MN 55203
PH 612-427-5821
FAX 612-427-4572
TDD: 612-427-5000

March 7, 2000

The Honorable Donna Shalala
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201-0004

Dear Secretary Shalala:

Attached is a bipartisan letter signed by all of the members of the State Senate and House of Representatives in the Hennepin County area. The letter follows up concerns I have expressed to HHS officials that Hennepin County officials were not consulted regarding the settlement of HIV-positive refugees in the Minneapolis area. As you may know, these local officials are all very concerned about the financial strain the planned location of 20 or more HIV-positive refugees will have on local health, social services, education and welfare costs. Secondary migration will likely bring more of these refugees to Hennepin County, as has been the case in the past with other refugee populations.

As you know, Minnesota has been more than willing to accept refugees in the past and has successfully absorbed a great many of them. But the settlement of HIV-positive refugees--without the ability of local governments to communicate concerns about costs until just before the first settlement was expected--does not seem reasonable to me. I have communicated my opposition to INS for its decision to withdraw the requirement local governments be consulted before these decisions are made, but I believe your department must also be questioned for its role in the resettlements.

Clearly there is no way refugee resettlement assistance is adequate to pay long-term medical costs for the HIV-positive family members. Ryan White funds are already fully used by Hennepin County. These resettlements should not occur without assurance that local communities can afford to cover their medical and other costs. The solution is not to communicate that Congress is to blame for cutting refugee resettlement programs. The task is to treat this as the unfunded mandate it is by reprogramming funds to cover local costs that cannot be met.

The solution definitely is not throwing the problem on the backs of local communities forcing them to raise taxes to make up shortfalls.

Please let me know how the Department intends to address the financial concerns of officials serving Hennepin County.

Thank you for your prompt attention to this request.

Sincerely,



Rod Grams
United States Senator

RG:acc

Enclosure

RECEIVED --
Mar 13 2000 10:04:48 WSS 02
OFFICE OF THE SECRETARY
CORRESPONDENCE
CONTROL CENTER

LINDA BERGLIN
 Senator 61st District
 309 State Capitol Building
 75 Constitution Avenue
 St. Paul, MN 55155-1606
 Phone: (612) 286-4261



Senate

State of Minnesota

March 1, 2000

Minnesota Congressional Delegation Members:

As state legislators, we were surprised to read in the media that Minnesota would begin receiving refugee families where at least one person was HIV positive. We understand that up to 20 families would be located in Minnesota now, and others will likely follow. We understand Minneapolis/Hennepin County is the designated site for these families.

It is disappointing that the Immigration and Naturalization Service would decide to provide waivers to HIV positive individuals and decide where to relocate them without involving state and local units of government in the program planning. We are concerned about unfunded costs that will be incurred by the state and local governments as a result of that decision.

The resettlement of refugees, especially HIV positive refugees, requires addressing complex health care, housing, education, public health, economic assistance and other family support issues. These supports will likely be ongoing and increasingly expensive for HIV positive refugees. Current federal refugee assistance is inadequate to support the demands placed on the system by non-HIV positive refugees resettling in our area, let alone the long-term, on-going issues that confront families faced with a difficult and terminal health challenge.

The Hennepin County Medical Center (HCMC) and the county's public health system that screens, treats and provides ongoing care to refugees is already under enormous stress:

- Last year the number of refugees to Minnesota grew from 1,867 to 3,892, with about 70 percent settling in Hennepin County. We were unprepared for this increase and our public health department has been unable to screen and address communicable disease of refugees already here. Finding interpreters, transportation and child care services often required in providing health care continues to be a unreimbursed challenge.

COMMITTEES: Chair, Human Resources / Finance / Crime Prevention / Health and Family Security / Judiciary / Rules and Administration / Health and Family Security Budget Division / Commission on the Economic Status of Women / Co-Chair, Legislative Oversight Commission on Health Care Access



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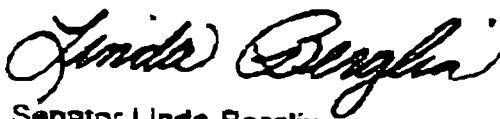
- Because of our commitment to providing the needed supports to refugee families, Hennepin is also a major site of relocation of refugees originally settled elsewhere in the United States. This secondary internal migration has put severe strains on the ability of our health care, social service and education systems to even secure necessary translation support, let alone fund the additional time and services they require to be successfully integrated into our community.
- You recently received a letter from Randy Johnson, Chair of the Hennepin County Board of Commissioners, detailing the precarious finances of HCMC. Federal reimbursement policy changes and HCMC's providing safety net services to this large number of refugees have contributed to HCMC's financial problems. HCMC is an essential resource to our community. Imposing new costs, as much as \$50,000 per year per HIV positive case, is unacceptable.
- Federal Refugee Assistance is inadequate. Eight months of assistance simply is not adequate for refugees. It is wholly inadequate for HIV positive refugees.

Hennepin County points out that these burdens are helping push their health care system to the financial breaking point. Uncompensated care demands already are at record levels.

As state legislators, we cannot provide the resources to meet these needs and do not think Hennepin County property taxes should be increased to cover the cost. The federal government must cover the short- and long-term costs of its foreign policy decisions. This is an unfunded mandate to our state and local system of health and human service supports.

We have not taken a position on the merits of the federal refugee decisions, but we are united in our concern about how this federal policy is being implemented. We believe this must be done in a planned way, with the involvement of all levels of government that are affected. At a minimum, the federal government must fully (not temporarily) fund the health, social service, education and welfare costs of the refugees it decides to admit.

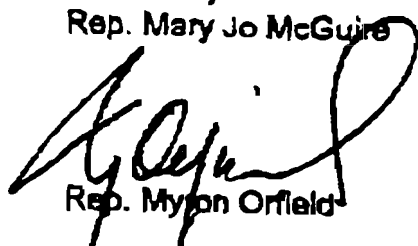
Sincerely,


Senator Linda Berglin

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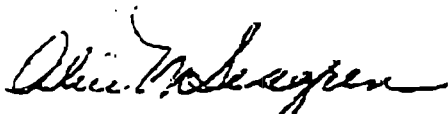
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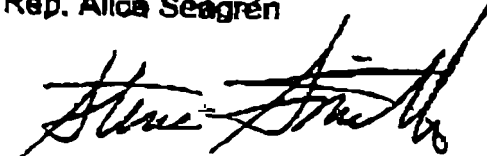
Rep. Myron Orfield



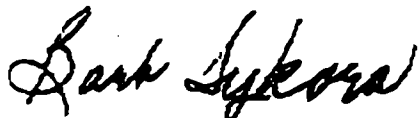
Rep. Ann Rest



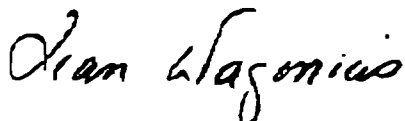
Rep. Alice Seagren



Rep. Steve Smith



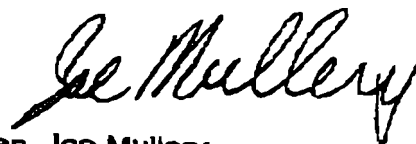
Rep. Barb Sykora



Rep. Jean Wagenius



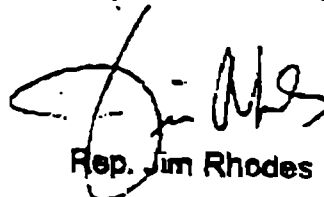
Rep. Ken Wolf



Rep. Joe Mullery



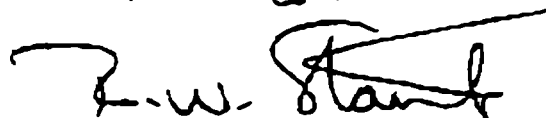
Rep. Erik Paulsen



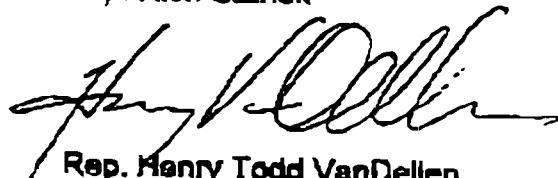
Rep. Jim Rhodes



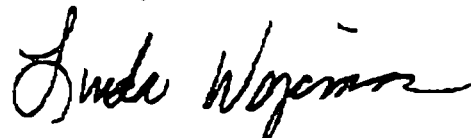
Rep. Wes Skoglund



Rep. Rich Stanek



Rep. Henry Todd VanDellen



Rep. Linda Wejman



Rep. Tom Workman

R. Adams

Margaret Anderson Kelliher
Rep. Margaret Kelliher Anderson

Rep. Margaret Kellher Anderson


Rep. Len Biernat

John Wilson

Hil-Caruth

Karen Clark

Ch. Roberts

Bethy Johnson

Paul Hesson

Rep. Gregory Gray

Rep. Gregory Gray

Lee Dufield

Rep. Gregory Gray

Philip Kahn

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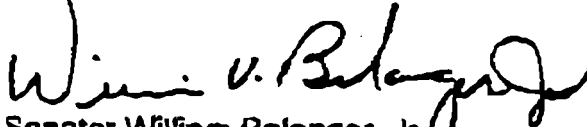
Peggy Lipp

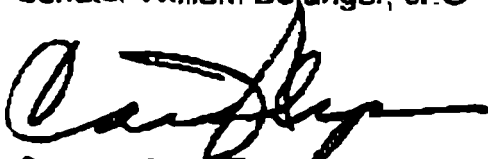
Arthur W. Leadner

Darlene Luther

Rep. Darlene Luther

Page -3-


Senator William Belanger, Jr.


Senator Carol Flynn

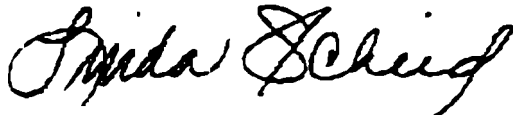
Senator Dave Johnson

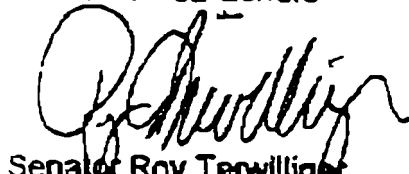

Senator Steve Kelley

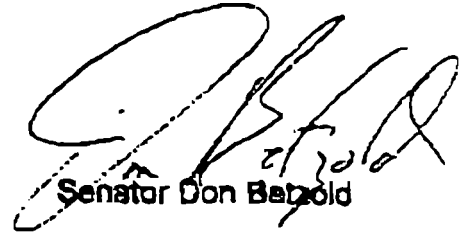

Senator John Marty


Senator Gen Olson

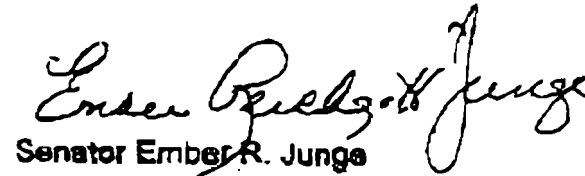

Senator Jane Rasmus


Senator Linda Scheid


Senator Roy Terwilliger


Senator Don Batbold


Senator Linda Higgins

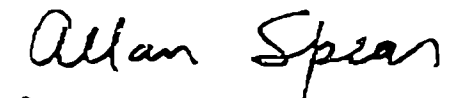

Senator Ember R. Junga


Senator Warren Limmer


Senator Edward Oliver


Senator Lawrence Fogemiller


Senator Martha Robertson


Senator Alan Spear

The Honorable Rod Grams
United States Senate
Washington, DC 20510-2304

Dear Senator Grams:

The United States has an enduring commitment to providing permanent resettlement to help refugees to make a new home in America. Refugees are people who have had to flee their homes because of persecution that threatens their life and liberty. The United States brings refugees here because they cannot return to their homes and because there is no other durable alternative for them. Refugees with HIV/AIDS can resettle in the U.S., if they are granted waivers by the Immigration and Naturalization Service. Many times our willingness to bring them to the United States is the only thing that prevents them from being separated from their families and left to die.

Prior to 1980, the resources for refugee resettlement were provided by individuals, churches and other community-based organizations. They sponsored refugees to come to their communities, where volunteers used donations to help them to become established. The Refugee Act of 1980 authorized federal assistance for the resettlement process. However, voluntary agencies continued to decide where refugees would be resettled and continued to provide private resources to refugees in their new communities. Governors were asked to designate a State Refugee Coordinator to manage coordinated assistance and services to refugees entering the State. The federal government provided to the States 100 percent federal funds for cash assistance for the first 36 months a refugee was in the U.S. For refugees, who were not eligible for Medicaid, 100 percent federal funds were provided for 36 months for medical coverage that replicated the coverage available under Medicaid. States also received 100 percent federal funds for social services for refugees

Page 2 - The Honorable Rod Grams

Over time, the Congress repeatedly reduced funds for cash and medical assistance. Today, 100 percent funds are available for cash assistance to refugees who are not eligible for TANF and for refugees who are not eligible for Medicaid for the first eight months the refugee is in the country. Social services for refugees continue to be fully funded by the federal government. Recently, the Congress reaffirmed the eligibility of refugees for Medicaid programs for the first seven years they are in the U.S. (P.L. 104-193, Sec.402(b)(2)(A), as amended by Sec.5302(b) of P.L. 105-33).

Over the years, Minnesota has provided the welcoming and supportive communities that are so important to successful resettlement of refugees. We, at HHS, have financially supported Minnesota's efforts, both with formula funds related to the number of refugees Minnesota receives and with discretionary funds to provide special assistance. Last year, the Office of Refugee Resettlement (ORR) provided over \$10 million of unmatched funds to Minnesota for programs to assist refugees to resettle. These funds, which are detailed in an attachment to this letter, included several grants targeted to relieve impact on Hennepin County. They included targeted assistance to the county as a highly impacted jurisdiction, as well as, special funding to assist with Somalis refugees and special funding for unanticipated refugee arrivals, including those who were initially resettled elsewhere and chose to move to the county. ORR also provided funding for Hennepin County public schools impacted by refugee children to help refugee parents to become involved with their childrens' schools.

Your letter expressed a special concern about HIV+ refugees who might come to Minnesota to rejoin their families. HIV+ refugees come to the U.S. only when they receive waivers from the Immigration and Naturalization Service (INS). My Department concurs with the INS waiver policy. HIV+ refugees, who are granted INS waivers, can receive medical treatment in the U.S. that can prolong their productive years. Many of these refugees will be able to work and with

medical care will be able to continue to contribute and pay taxes. Federal programs, such as the Ryan White CARE Act,

Page 3 - The Honorable Rod Grams

have made available substantial resources in local communities to assist individuals to learn to manage their disease, to provide free or low cost drugs and take effective measures to protect the public health. In addition, ORR is considering funding one of the voluntary agencies, which resettles refugees in the Twin Cities, to provide case management and supportive services to assure that HIV+ refugees receive appropriate care and that the public health is protected.

ORR offers through its discretionary grants programs other funding opportunities to ease the impact of these refugees on State and local resources. Minnesota may find of particular interest, ORR's programs for Community and Family Integration Services and for Unanticipated Arrivals. There is ample time for Minnesota to apply for these funds and under the circumstances their proposals would be quite appropriate. If Minnesota is interested in applying, they should call Carmel Clay-Thompson at 202 443 9246.

I hope that Minnesota will continue its exemplary record as a community that welcomes and extends a helping hand to refugees who have lost everything and can never go home.

Sincerely,

Donna E. Shalala

Attachment

Discretionary Grants to Minnesota – FY 1999

Grantee:	Program:	Funds Awarded:
Somali Women Association	Assist Somali community organizations	\$155.000
MN Dept. of Human Services	Elderly	\$250.000
Regents University of Minnesota	Mental Health	\$168.144
Center for Victims of Torture	Mental Health	\$200.000
World Relief Corporation	Preparation for citizenship	\$ 77,500
International Institute of MN	Assist newly arriving and secondary migrant Africans from Somalia and Ethiopia	\$250.528
Hennepin County Welfare Dept.	Assist newly arriving and secondary migrant Africans from Somalia and Ethiopia	\$250.000
MN Dept. of Human Services	Employment	\$119.533
MN Dept. of Health & Human Services	Health screening	\$125.178
MN Dept. of Children/Families Learning	Assistance to school districts (K-12) for impact of refugee children	\$1,000.000
Association for Advancement Of Hmong Women	Community and Family Strengthening and Integration	\$250.000
International Institute of MN	Community and Family Strengthening	\$88.473
TOTAL		\$2,934.356

**FUNDING GRANTED TO THE MINNESOTA REFUGEE PROGRAM BY
THE OFFICE OF REFUGEE RESETTLEMENT**

FY-1999

Formula Funds

Cash, Medical and Administrative funds:	\$3,851,703
Social Services and Impact Aid:	4,052,371
Total Formula	\$7,904,074

Discretionary Funds

\$2,934,356

TOTAL FUNDING, FY-1999

\$10,838,430

MINNESOTA PERFORMANCE RESULTS FOR FY-1999

The Office of Refugee Resettlement (ORR) works in partnership with the States to improve employment and self-sufficiency outcomes for refugees. Each year States establish outcome goals on the following six performance measures and report performance toward meeting their goals on a quarterly basis.

ORR Performance Measures

Entered Employments – defined as the entry of a refugee into unsubsidized employment.

Terminations Due to Earnings – defined as the termination of a cash assistance case (RCA, TANF, General Assistance) due to earned income.

Reductions Due to Earnings – defined as a reduction in the amount of cash assistance that a case receives as a result of earned income.

Average Wage at Placement – calculated as the sum of the hourly wages for the full-time placements divided by the number of individuals placed in full-time employment.

Job Retentions – defined as the number of persons working for wages (in any unsubsidized job) on the 90th day after placement. This is a measure of continued participation in the labor market, not retention of a specific job.

Health Benefits – defined as percentage of entered employments that provide health benefits.

Minnesota's Performance for FY 1999

Minnesota exceeded its goal for entered employments by 9%, and increased the number of entered employments achieved in FY 1999 by 23%.

Minnesota exceeded its cash assistance terminations goal by 18%.

Minnesota missed meeting its cash assistance reduction goal by 22% in FY 1999. This should be viewed within the overall favorable context of increased welfare terminations, which means more refugee families left welfare, rather than staying on welfare with a reduced grant.

Minnesota achieved an average wage at employment entry of \$8.07, a 3% increase over last year's average wage of \$7.84.

76.5% of refugees placed in jobs retained their employment for 90 days, compared with only 68.8% the previous year.

92% of all full-time job placements had health benefits, compared to 77.2% in the previous year.

FACT SHEET

Refugees Who Test HIV-Positive - Clarification of Waiver Requirements

On June 16, 1999, the Immigration and Naturalization Service (INS) issued guidance to its overseas offices amending the documentation requirements for waiver requests filed by approved refugees who have tested positive for HIV. HIV-positive refugees will continue to submit waiver applications, Form 1-602, and establish that their admission to the United States will not compromise the public health. Under the new guidance, INS will recognize that these refugees meet one of the requirements for a waiver - that no cost would be incurred by any level of government agency without the prior consent of that agency - without the need for individualized proof.

This clarification is based on a May 21, 1999, letter from the Department of Health and Human Services (HHS) to the INS stating that the U.S. Government's provision of services to HIV-positive individuals, "provides adequate support for refugees who are HIV-positive upon their admission to the United States and during their transition to full participation in our society."

Based on this statement, the new guidance instructs INS officers to consider a refugee's eligibility for federally-funded health care programs - such as Medicaid, Refugee Medical Assistance and the variety of services provided under the Ryan White CARE Act - to meet the prior consent requirement. No documentation of individual eligibility for HIV treatment or health coverage in the United States is required to supplement Form 1-602.

The decision to grant or deny a waiver remains a discretionary one, and will continue to be made on a case-by-case basis.

Background

Immigration law specifies that an approved refugee applicant who subsequently tests positive for HIV is inadmissible to the United States. However, the law also includes a waiver provision - a refugee's inadmissibility may be waived for humanitarian purposes, to assure family unity or for reasons in the public interest. To apply for a waiver, HIV-positive refugees are required to establish that:

- their admission to the United States would not endanger the public health; and
- no cost would be incurred by any level of government agency without the prior consent of that agency.

In the past, a very small number of refugees overseas could obtain prior consent regarding HIV-related costs. As a result, many HIV-positive individuals who had a well-founded fear of persecution were unable to submit waiver requests and could not

(more)

Refugees Who Test HIV-Positive - Clarification of Waiver Requirements

Page 2

resettle in the United States. Some of these refugees are separated from family members who are resettled in the United States. Others are at increased risk in their host countries because of their medical condition.

Concern for the protection of such individuals, coupled with the extended availability of federally-funded health care services to refugees who test HIV-positive, prompted the Administration to reevaluate the filing requirements for I-UV waiver requests.

--- INS ---

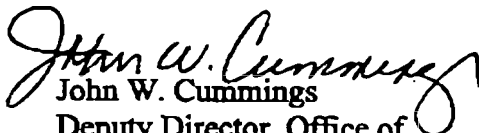


**U.S. Department of Justice
Immigration and Naturalization Service**

425 I Street NW
Washington, DC 20536

JUN 16 1999

MEMORANDUM FOR ALL OVERSEAS OFFICES

FROM: 
John W. Cummings
Deputy Director, Office of
International Affairs

SUBJECT: Guidance Regarding Waivers for HIV+ Refugees

This memorandum supplements the guidance you have already received regarding the filing and adjudication of waiver requests submitted by HIV+ approved refugee applicants who are inadmissible under section 212(a)(1)(A)(i). See attached memoranda issued on September 30, 1993 and April 6, 1994.

To file a waiver request, approved refugee applicants who test HIV+ must currently submit Form I-602, supported by documentation that establishes that:

- (1) the danger to the public health of the United States created by his/her admission to the United States would be minimal;
- (2) the possibility of the spread of the disease created by his/her admission to the United States would be minimal; and
- (3) there would be no cost incurred by any level of government agency in the United States without the prior consent of that agency.

Effective as of this date, District Directors/Officers in Charge shall consider a refugee's eligibility for federally-funded programs such as Medicaid, Refugee Medical Assistance, and the variety of services provided under the Ryan White CARE Act as sufficient to meet the third of these filing requirements – i.e., proof that no cost will be incurred by any level of government agency in the United States without the prior consent of that agency. No documentation of individual eligibility for HIV+ treatment or health care coverage in the United States is required to supplement Form I-602. Waiver requests must, however, continue to be documented to show that the refugee has been counseled to ensure that he or she understands how HIV is transmitted and is aware of the precautions which must be taken to prevent its spread.

This change in the evidentiary requirements for HIV+ waiver requests made by refugees is based on a recent letter from the Surgeon General to Commissioner Meissner. In that letter, the Surgeon General states that the United States Government's provision of services to HIV+ individuals "provides adequate support for refugees who are HIV-positive upon their admission to the United States and during their transition to full participation in our society." The Service has determined that, with respect to refugees seeking a waiver, this commitment from the federal government to provide adequate support to HIV+ refugees meets the consent component of the waiver requirement.

The preceding guidance applies only to refugee cases. For individuals seeking admission to the United States as immigrants, the third prong may still be supported by such documentation as: proof of health insurance coverage under a plan held by a family member, evidence of financial resources necessary to cover projected medical costs of HIV treatment, statements from specific private/government health care and research facilities assuming responsibility for treatment, and statements of consent from local or state health care officials. For those applicants who will receive publicly funded medical treatment for HIV/AIDS from any local, state or federal agency, the head of the agency (or his or her designee) must issue the formal consent.

If you require additional guidance on specific HIV+ waiver requests filed by approved refugee applicants, please contact the Refugee Division at 202-305-2662.

Attachments

Memorandum



CO-100\8.3.2

Subject

Waiver Requests from Refugees who
Test Positive for Human Immuno-
deficiency Virus

Date

SEP. 30 1993

To

All INS Overseas Offices

From

Office of
International
Affairs

This memorandum is a reminder of the HIV+ waiver procedures currently in place and the documentation that must accompany an I-602 filed by an approved refugee applicant who tests positive for the human immunodeficiency virus. Form I-602 will continue to be used for refugee waivers until such time as the new waiver form, I-724, becomes available.

Responsibilities of the District Director/Officer in Charge in HIV+ Cases

Section 207(c)(3) of the Immigration and Nationality Act provides that the Attorney General, in her discretion, may waive certain grounds of inadmissibility for refugees, including section 212(a)(1)(A)(i) which excludes aliens who have been determined to have a communicable disease of public health significance. Waivers may be granted for humanitarian purposes, to assure family unity, or when it is in the public interest. In such cases, 8 CFR 207.3(b) specifies that an Application by Refugee for Waiver of Grounds of Excludability, Form I-602, is filed with the Officer in Charge before whom the application for refugee status (I-590) is pending.

The District Director/Officer in Charge must first weigh the facts in each case and determine whether humanitarian, family unity or public interest grounds exist. Once that determination has been made, the District Director/Officer in Charge will determine whether discretion is to be exercised. Under existing guidelines--wires of 7/6/87 (CO 234-P), 3/2/88 (CO 234-P, and 8/8/88 (CO 234-C)--Immigration and Naturalization Service (INS) officers may not exercise the discretionary authority of the Attorney General unless the approved refugee applicant is able to establish that:

(1) the danger to the public health of the United States created by his/her admission to the United States would be minimal;

Page 2

(2) the possibility of the spread of the disease created by his/her admission to the United States would be minimal; and

(3) there would be no cost incurred by any level of government agency in the United States without the prior consent of that agency.

Documentation Required to Accompany Form I-602

Before accepting an HIV+ waiver request for adjudication, a District Director/Officer in Charge should determine whether the refugee has met the preceding requirements. Waiver requests submitted without documentation that addresses each of these requirements are not properly filed and should be returned to the applicant or his/her representative.

While there are no uniform documentation requirements, the supporting materials for an I-602 should establish to the Officer in Charge's satisfaction that the refugee has been medically counseled, i.e., understands how HIV is transmitted and is aware of the precautions which must be taken to prevent its spread. It is expected that such counseling would be conducted and documented by panel physicians working with the U.S. refugee program at refugee processing posts.

Proof that no cost would be incurred by any government agency without its consent could include, but not be limited to 1) health insurance coverage under a plan held by a family member already in the United States; 2) evidence of financial resources commensurate with the projected medical costs of HIV+ treatment such as letters from a family member's employer, bank statements, recent pay stubs, or recent tax forms; 3) statements of consent from local or state health care officials with responsibility for the area in which the HIV+ applicant, if admitted, would resettle; and 4) statements from specific private or government health care and research facilities assuming responsibility for treatment.

Once the waiver application has been properly documented and filed, the District Director/Officer in Charge must put his/her decision regarding the waiver request in writing. This decision, whether an approval or denial, is to be certified to the Office of Administrative Appeals (AAU) using Form I-290C. Please note that the applicant must be afforded the appropriate period of time to respond to the certification before the entire record of proceeding (application, documentation, decision, and response of the applicant) is forwarded to the AAU.

When AAU has made a final decision, the record of proceeding will be returned to the District Director/Officer in Charge for preparation of the approval notice, if appropriate, and final processing.

Page 3

If you require additional guidance on specific HIV+ waiver requests, you should contact the Refugee Division of the Office of International Affairs. As needed, Refugee Division staff will contact AAU for their guidance.

John W. Cummings
Acting Director



Subject Additional Guidance Regarding
 Waiver Requests from Refugees who Test
 Positive for Human Immuno-deficiency
 Virus

Date

APR 6 1994

To All INS Overseas Offices

From HQIAO

As stated in my memorandum to you of September 30, 1993 (copy attached), an Immigration and Naturalization Service (INS) officer may not exercise the discretionary authority of the Attorney General to waive the exclusion of an HIV+ approved refugee applicant unless the applicant is able to establish:

- (1) the danger to the public health of the United States created by his/her admission to the United States would be minimal;
- (2) the possibility of the spread of the disease created by his/her admission to the United States would be minimal; and
- (3) there would be no cost incurred by any level of government agency in the United States without the prior consent of that agency.

It has come to my attention that there may be some confusion regarding the documentation needed to meet the third of these requirements for the submission of a waiver request. The following guidance restates the types of evidence that INS Headquarters has determined will satisfy the consent requirement.

Proof that no cost would be incurred by any government agency without its consent can include, but is not limited to:

- (1) health insurance coverage under a plan held by a family member already in the United States;
- (2) evidence of financial resources commensurate with the projected medical costs of HIV+ treatment such as letters from a family member's employer, bank statements, recent pay stubs, or recent tax forms;
- (3) statements of consent from local or state health care officials with responsibility for the area in which the HIV+ applicants, if admitted, would resettle; or

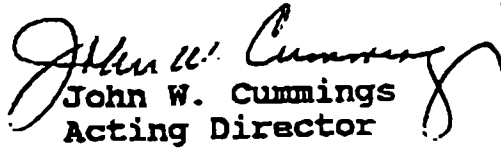
All INS Overseas Offices
Page 2

(4) statements from specific private or government health care and research facilities assuming responsibility for treatment.

An applicant meeting any one of these criteria or providing similar materials/documentation will be viewed as having satisfied the third requirement for the submission of an I-602 waiver request.

It is our understanding that some voluntary agencies believe that INS requires a Form I-134, Affidavit of Support, to be submitted with an I-602 from an HIV+ approved refugee applicant. We ask that you advise the agencies with which you deal that it is INS policy in HIV+ waiver cases to accept documentation in the forms just described. The submission of an I-134 is not required. Individuals or organizations wishing to submit an I-134 as proof of "financial resources commensurate with the projected medical costs of HIV+ treatment" may, of course, do so, but should be advised that an I-134 is not the only evidence that will satisfy the requirement that no cost be incurred by any government agency without its prior consent.

Should you have any questions regarding the preceding discussion, please contact the Refugee Division of the Office of International Affairs. As needed, the Refugee Division staff will contact the Administrative Appeals Unit for their guidance.


John W. Cummings
Acting Director

Attachment

cc: Administrative Appeals Unit



CO-100\8.3.2

Subject

Waiver Requests from Refugees who
Test Positive for Human Immuno-
deficiency Virus

Date

SEP. 30 1993

To

All INS Overseas Offices

From

Office of
International
Affairs

This memorandum is a reminder of the HIV+ waiver procedures currently in place and the documentation that must accompany an I-602 filed by an approved refugee applicant who tests positive for the human immunodeficiency virus. Form I-602 will continue to be used for refugee waivers until such time as the new waiver form, I-724, becomes available.

Responsibilities of the District Director/Officer in Charge in HIV+ Cases

Section 207(c)(3) of the Immigration and Nationality Act provides that the Attorney General, in her discretion, may waive certain grounds of inadmissibility for refugees, including section 212(a)(1)(A)(i) which excludes aliens who have been determined to have a communicable disease of public health significance. Waivers may be granted for humanitarian purposes, to assure family unity, or when it is in the public interest. In such cases, 8 CFR 207.3(b) specifies that an Application by Refugee for Waiver of Grounds of Excludability, Form I-602, is filed with the Officer in Charge before whom the application for refugee status (I-590) is pending.

The District Director/Officer in Charge must first weigh the facts in each case and determine whether humanitarian, family unity or public interest grounds exist. Once that determination has been made, the District Director/Officer in Charge will determine whether discretion is to be exercised. Under existing guidelines--wires of 7/6/87 (CO 234-P), 3/2/88 (CO 234-P, and 8/8/88 (CO 234-C)--Immigration and Naturalization Service (INS) officers may not exercise the discretionary authority of the Attorney General unless the approved refugee applicant is able to establish that:

- (1) the danger to the public health of the United States created by his/her admission to the United States would be minimal;

Page 3

If you require additional guidance on specific HIV+ waiver requests, you should contact the Refugee Division of the Office of International Affairs. As needed, Refugee Division staff will contact AAU for their guidance.

**John W. Cummings
Acting Director**

Talking Points: Change in HIV Waiver Filing Requirements for Refugees
June 16, 1999

- To be resettled in the United States, an individual who has been determined to qualify for classification as a refugee under section 101(a)(42) of the INA also must be otherwise admissible. For refugees, the INA permits the Attorney General to waive many grounds of inadmissibility for humanitarian reasons, to assure family unity, or for other reasons in the public interest.
- An approved refugee applicant who tests positive for HIV is inadmissible to the United States under section 212(a)(1)(A)(I) of the INA. The INA authorizes the Attorney General to waive this ground of inadmissibility for certain immigrants, including refugees.
- The INS policy for filing waiver requests requires all eligible immigrants who test HIV+ to submit documentation establishing that their admission to the United States will not endanger the public health and that no cost will be incurred by any level of government agency without the prior consent of that agency. These requirements also extend to refugees.
- The filing requirements, set out in 1987, were based directly on guidelines issued by the INS for the consideration of waiver requests made by HIV+ legalization applicants. For legalization applicants, who were already living in the United States, the prior consent requirement was not necessarily difficult to establish. For refugees, however, it was often difficult to obtain the necessary prior consent from outside the United States.
- Only the few refugees who individually could show proof of coverage under health insurance held by family members already in the United States or who could document their eligibility for HIV treatment programs could meet the prior consent prong of the INS waiver filing requirements. As a result, many persons who were found by INS officers to have a well-founded fear of persecution and then tested HIV+ were unable to submit waiver requests.
- Some of these refugees are separated from family members who are resettled in the United States. Others are at increased risk in their host countries because of their medical condition.
- These concerns, along with changes in the treatment of HIV+ individuals, led to a reevaluation of INS' filing requirements for HIV waiver requests.
- On June 16, INS Headquarters issued amended guidance to our overseas offices regarding the filing of HIV waiver requests and the types of evidence necessary to meet the prior consent requirement. The new guidance does not alter the current requirements.

- This means that the INS will continue to ask refugees who test HIV+ to provide individualized proof that their admission to the United States will not endanger the public health but will no longer require these refugees to establish *individually* prior consent by government agencies with regard to health care. The INS instead will consider a refugee's eligibility for federally-funded health care programs to meet the prior consent filing requirement.
- These programs include Medicaid, Refugee Medical Assistance and the variety of services provided under the Ryan White CARE Act.
- This procedural change is based on a recent letter from the Surgeon General to Commissioner Meissner. In his letter, the Surgeon General states that the U.S. Government's provision of services to HIV+ individuals "provides adequate support for refugees who are HIV-positive upon their admission to the United States and during their transition to full participation in our society."
- This change in the filing requirements should allow all approved refugee applicants who test HIV+ and who can establish that they do not pose a risk to the public health to submit waiver requests and have those requests decided by INS.
- The decision to ultimately grant or deny the waiver remains discretionary, however, and is unaffected by the new guidance. Under section 207 of the INA, a refugee's inadmissibility may be waived only for humanitarian purposes, to assure family unity or for reasons in the public interest. Waiver decisions will continue to be made on a case-by-case basis.

If asked:

INS estimates that there are between 200-300 approved refugee applicants worldwide who have tested HIV+ following their refugee determinations over the last several years. Over this period, INS has approved over 80,000 refugees each year.

06/17/88 THU 14:31 FAX 202 505 0134 HQUPP 012

Questions regarding Guidance on Waiver Procedures for Refugees Who Test HIV+

Background: Refugees are subject to the medical grounds of inadmissibility listed in section 212 (a)(1)(A) of the INA, including HIV infection, a communicable disease of public health significance. In 1987, INS first issued guidance on filing requirements for waiver requests of refugees who test HIV+. On June 16, INS issued additional guidance.

Q. What is the current INS policy for refugees who test HIV+?

A. To submit an application for a waiver of grounds of inadmissibility due to HIV infection, INS guidance requires that an approved refugee applicant submit documentation establishing that:

- (1) the danger to the public health of the United States created by his/her admission to the United States would be minimal;
- (2) the possibility of the spread of the disease created by his/her admission to the United States would be minimal; and
- (3) there would be no cost incurred by any level of government agency in the United States without the prior consent of that agency.

Properly filed waiver applications are decided on a case-by-case basis and may be approved for humanitarian or public interest reasons or to assure family unity.

Q. What exactly is the change in procedure?

A. In the past, the third requirement only could be met through documentation of individual eligibility for HIV+ treatment or health care coverage in the United States. Effective June 16, INS will consider the federally-funded programs and services available to refugees who test HIV+ to be sufficient to satisfy the third filing requirement – i.e., proof that no cost will be incurred by any level of government agency in the United States without the prior consent of that agency.

INS will continue to require individual evidence that the first 2 filing requirements have been met. These must be satisfied through documentation demonstrating that the refugee has been counseled to ensure that he or she understands how HIV is transmitted and has understood and agrees to undertake all precautions necessary to prevent its spread.

This procedural change relates to waiver filing requirements only. The waiver adjudication procedures remain unchanged. As provided by statute, the Attorney General has the discretionary authority to grant a waiver for humanitarian purposes, to assure family unity or when it is otherwise in the public interest.

Q. Why is INS making this change now?

A. In 1987, when INS initially drafted the waiver filing requirements for approved refugee applicants who test HIV+, less was known about the nature and effective treatment of the disease. Over the past 12 years, HIV treatment programs have multiplied and the Department of Health and Human Services now believes that a nationwide HIV healthcare network is in place. The Surgeon General has advised the INS that the United States' provision of services to HIV+ individuals "provides adequate support for refugees who are HIV-positive upon their admission to the United States and during their transition to full participation in our society."

Q. Do we know now how many refugees who have been screened for refugee status by the United States have tested positive for HIV?

A. We estimate that a total of between 200 and 300 approved refugee applicants have tested HIV+ following their refugee determinations over the past several years. In each of these years, we estimate that more than 80,000 refugees were preliminarily approved for resettlement and then underwent medical screening.

Q. Does this mean that all HIV+ immigrants can now come to the United States?

A. No. The June 16 guidance applies only to waiver filing requirements in refugee cases. For individuals seeking admission to the United States as immigrants, waiver filing requirements remain unchanged. The INS will continue to adjudicate all waiver requests on a case-by-case basis.

Q. Why does the new guidance apply only to refugees and not to other HIV+ immigrants?

A. The new guidance applies only to refugees because they are eligible for the federal health programs identified in the Surgeon General's letter. Other categories of immigrants are not necessarily eligible for these programs. The INS may adopt other changes to the HIV+ waiver rules for non-refugees in future guidance.

Q. What are the federally-funded treatment programs available to refugees who test HIV+?

A. According to the Department of Health and Human Services (HHS), a variety of programs are available to refugees who test positive for HIV.

00/17/88 THU 14:52 FAX 202 305 0134 HQOFF HQ 014

The Refugee Medical Assistance (RMA) program provides for the health care of low-income refugees not covered by Medicaid (primarily single adults and couples without children) upon their admission to the United States. This coverage includes primary health care and some ancillary support services and is substantially equivalent to those services provided by Medicaid.

Some refugees will be immediately eligible for Medicaid. All states extend Medicaid eligibility to individuals meeting certain financial and categorical criteria (i.e., a member of a group such as pregnant women, dependent children, disabled persons and the aged).

In addition to RMA and Medicaid, refugees also may be eligible for a variety of services supported through the Ryan White CARE Act, which is administered by HHS. These services include primary care, prescription drug benefits, case management, and translation services. A basic level of HIV related care is available to refugees in most communities through CARE Act funded services.

(Any additional questions on availability of services and funding should be referred to HHS.)

Q. Why should U.S taxpayers have to pay for the treatment of refugees who test HIV+?

A. It is consistent with our humanitarian traditions and our international obligations for the United States to offer refuge to many of the world's persecuted people. Prospective medical costs are not a consideration when determining eligibility for refugee status in the United States. In fact, by law refugees are exempt the public charge restrictions that other immigrants face.



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary
Office of Public Health and Science

Assistant Secretary for Health
Surgeon General
Washington, D.C. 20201

MAY 21 1999

The Honorable Dennis Meisner
Commissioner
Immigration and Naturalization Service
425 I Street, N.W.
Washington, D.C. 20536

Dear Mr. Meisner:

On behalf of the Secretary of Health and Human Services Donna Shalala, let me thank you for your attention to the health needs of refugees seeking entry to the United States. I understand that you are interested in obtaining information related to the programs that refugees who test positive for the human immunodeficiency virus (HIV), are eligible to receive including the Medicaid program, the Refugee Medical Assistance (RMA) program, and the Ryan White CARE Act (RWCA).

RMA provides for the health care of low-income refugees during their first eight months in the United States for those individuals not covered by Medicaid (primarily, single adults and couples without children). This coverage includes primary health care and some ancillary support services and is substantially equivalent to those services provided by Medicaid.

All States extend Medicaid eligibility to pregnant women with incomes below 185 percent of the Federal poverty level; children less than age 6 in families with income below 133 percent of the Federal poverty level; children between ages 6 and 15 in families with incomes below 100 percent of the Federal poverty level; and, by 2002, children between ages 16 and 18 in families with incomes below 100 percent of the Federal poverty level. Many States currently provide coverage to all children under age 19 and to a higher percent of the Federal poverty level than required under Federal law.

In addition to the groups eligible for Medicaid described in the preceding paragraph, an individual may be eligible for Medicaid if aged or determined to be disabled. To be determined disabled, the individual must at a minimum meet the disability definition used by Social Security Administration for the Supplemental Security Income program. This definition requires that the applicant be unable to work because of a physical or mental condition which has lasted or is expected to last for 12 months or result in death. An individual who is HIV-positive but without specific manifestations of AIDS or evidence that because of his/her condition is unable to work will not be found disabled.

05/24/99 MON 12:08 FAX 202 305 0134

HQOPP

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05/21/99 FRI 15:50 FAX 202 4015783

CHIEF OF STAFF

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003**Page 2 - The Honorable Doris Meissner**

Once an individual is found to meet the Medicaid financial and categorical criteria (i.e. a member of a group such as pregnant women, dependent children, disabled persons and the aged), the applicant, if an alien, must meet the restrictions on eligibility of aliens. All aliens entering the United States on or after August 22, 1996, are barred from receipt of Medicaid, except for treatment of an emergency medical condition, for five years after entry. Refugees and certain other groups are exempt from this bar for seven years after entry to the United States. Therefore, a Medicaid eligible refugee may receive full Medicaid benefits.

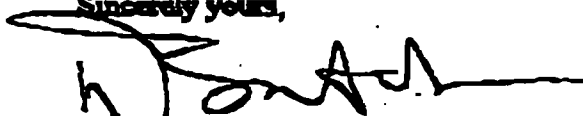
In addition to RMA and Medicaid, refugees may also be eligible for a variety of services supported through the Ryan White CARE Act (RWCA), which is administered by the Health Resources and Services Administration of the Department of Health and Human Services. These services include primary care, prescription drug benefits, case management, and translation services. Though the range and availability of CARE Act funded services varies from area to area, we are confident that a basic level of HIV-related care is available in most communities. Ryan White CARE Act funds are not restricted from serving refugees or immigrants.

Our Office of Refugee Resettlement is working with your staff and those from other agencies of HHS to develop a pilot program for serving HIV-positive refugees. This prospective initiative may include training of private resettlement agency staff in HIV-related issues, support for accessing community-based HIV resources, and other components to improve awareness of and access to the broad array of publicly and privately supported programs for individuals living with HIV and AIDS. We look forward to developing this pilot and jointly assessing the benefits of an enhanced service program that will utilize service providers and materials that are linguistically and culturally appropriate for the refugee populations.

In our view, the country's commitment to providing services to HIV-positive individuals provides adequate support for refugees who are HIV-positive upon their admission to the United States and during their transition to full participation in our society.

Thank you again for your continuing efforts to provide for those individuals most in need. We stand ready and willing to continue our work together on their behalf.

Sincerely yours,



David Satcher, M.D., Ph.D.

Assistant Secretary for Health and
Surgeon General



**U.S. Department of Justice
Immigration and Naturalization Service**

425 I Street NW
Washington, DC 20536

JUN 16 1999

MEMORANDUM FOR ALL OVERSEAS OFFICES

FROM:

John W. Cummings
John W. Cummings
Deputy Director, Office of
International Affairs

SUBJECT:

Guidance Regarding Waivers for HIV+ Refugees

This memorandum supplements the guidance you have already received regarding the filing and adjudication of waiver requests submitted by HIV+ approved refugee applicants who are inadmissible under section 212(a)(1)(A)(i). See attached memoranda issued on September 30, 1993 and April 6, 1994.

To file a waiver request, approved refugee applicants who test HIV+ must currently submit Form I-602, supported by documentation that establishes that:

- (1) the danger to the public health of the United States created by his/her admission to the United States would be minimal;
- (2) the possibility of the spread of the disease created by his/her admission to the United States would be minimal; and
- (3) there would be no cost incurred by any level of government agency in the United States without the prior consent of that agency.

Effective as of this date, District Directors/Officers in Charge shall consider a refugee's eligibility for federally-funded programs such as Medicaid, Refugee Medical Assistance, and the variety of services provided under the Ryan White CARE Act as sufficient to meet the third of these filing requirements – i.e., proof that no cost will be incurred by any level of government agency in the United States without the prior consent of that agency. No documentation of individual eligibility for HIV+ treatment or health care coverage in the United States is required to supplement Form I-602. Waiver requests must, however, continue to be documented to show that the refugee has been counseled to ensure that he or she understands how HIV is transmitted and is aware of the precautions which must be taken to prevent its spread.

This change in the evidentiary requirements for HIV+ waiver requests made by refugees is based on a recent letter from the Surgeon General to Commissioner Meissner. In that letter, the Surgeon General states that the United States Government's provision of services to HIV+ individuals "provides adequate support for refugees who are HIV-positive upon their admission to the United States and during their transition to full participation in our society." The Service has determined that, with respect to refugees seeking a waiver, this commitment from the federal government to provide adequate support to HIV+ refugees meets the consent component of the waiver requirement.

The preceding guidance applies only to refugee cases. For individuals seeking admission to the United States as immigrants, the third prong may still be supported by such documentation as: proof of health insurance coverage under a plan held by a family member, evidence of financial resources necessary to cover projected medical costs of HIV treatment, statements from specific private/government health care and research facilities assuming responsibility for treatment, and statements of consent from local or state health care officials. For those applicants who will receive publicly funded medical treatment for HIV/AIDS from any local, state or federal agency, the head of the agency (or his or her designee) must issue the formal consent.

If you require additional guidance on specific HIV+ waiver requests filed by approved refugee applicants, please contact the Refugee Division at 202-305-2662.

Attachments

Memorandum



CO-100\8.3.2

Subject

Waiver Requests from Refugees who
Test Positive for Human Immuno-
deficiency Virus

Date

SEP. 30 1993

To

All INS Overseas Offices

From

Office of
International
Affairs

This memorandum is a reminder of the HIV+ waiver procedures currently in place and the documentation that must accompany an I-602 filed by an approved refugee applicant who tests positive for the human immunodeficiency virus. Form I-602 will continue to be used for refugee waivers until such time as the new waiver form, I-724, becomes available.

Responsibilities of the District Director/Officer in Charge in HIV+ Cases

Section 207(c)(3) of the Immigration and Nationality Act provides that the Attorney General, in her discretion, may waive certain grounds of inadmissibility for refugees, including section 212(a)(1)(A)(i) which excludes aliens who have been determined to have a communicable disease of public health significance. Waivers may be granted for humanitarian purposes, to assure family unity, or when it is in the public interest. In such cases, 8 CFR 207.3(b) specifies that an Application by Refugee for Waiver of Grounds of Excludability, Form I-602, is filed with the Officer in Charge before whom the application for refugee status (I-590) is pending.

The District Director/Officer in Charge must first weigh the facts in each case and determine whether humanitarian, family unity or public interest grounds exist. Once that determination has been made, the District Director/Officer in Charge will determine whether discretion is to be exercised. Under existing guidelines--wires of 7/6/87 (CO 234-P), 3/2/88 (CO 234-P, and 8/8/88 (CO 234-C)--Immigration and Naturalization Service (INS) officers may not exercise the discretionary authority of the Attorney General unless the approved refugee applicant is able to establish that:

- (1) the danger to the public health of the United States created by his/her admission to the United States would be minimal;

Page 2

(2) the possibility of the spread of the disease created by his/her admission to the United States would be minimal; and

(3) there would be no cost incurred by any level of government agency in the United States without the prior consent of that agency.

Documentation Required to Accompany Form I-602

Before accepting an HIV+ waiver request for adjudication, a District Director/Officer in Charge should determine whether the refugee has met the preceding requirements. Waiver requests submitted without documentation that addresses each of these requirements are not properly filed and should be returned to the applicant or his/her representative.

While there are no uniform documentation requirements, the supporting materials for an I-602 should establish to the Officer in Charge's satisfaction that the refugee has been medically counseled, i.e., understands how HIV is transmitted and is aware of the precautions which must be taken to prevent its spread. It is expected that such counseling would be conducted and documented by panel physicians working with the U.S. refugee program at refugee processing posts.

Proof that no cost would be incurred by any government agency without its consent could include, but not be limited to 1) health insurance coverage under a plan held by a family member already in the United States; 2) evidence of financial resources commensurate with the projected medical costs of HIV+ treatment such as letters from a family member's employer, bank statements, recent pay stubs, or recent tax forms; 3) statements of consent from local or state health care officials with responsibility for the area in which the HIV+ applicant, if admitted, would resettle; and 4) statements from specific private or government health care and research facilities assuming responsibility for treatment.

Once the waiver application has been properly documented and filed, the District Director/Officer in Charge must put his/her decision regarding the waiver request in writing. This decision, whether an approval or denial, is to be certified to the Office of Administrative Appeals (AAU) using Form I-290C. Please note that the applicant must be afforded the appropriate period of time to respond to the certification before the entire record of proceeding (application, documentation, decision, and response of the applicant) is forwarded to the AAU.

When AAU has made a final decision, the record of proceeding will be returned to the District Director/Officer in Charge for preparation of the approval notice, if appropriate, and final processing.

Page 3

If you require additional guidance on specific HIV+ waiver requests, you should contact the Refugee Division of the Office of International Affairs. As needed, Refugee Division staff will contact AAU for their guidance.

John W. Cummings
Acting Director

Memorandum

subject Additional Guidance Regarding
Waiver Requests from Refugees who Test
Positive for Human Immuno-deficiency
Virus

Date

APR 6 1994

To All INS Overseas Offices

from HQIAO

As stated in my memorandum to you of September 30, 1993 (copy attached), an Immigration and Naturalization Service (INS) officer may not exercise the discretionary authority of the Attorney General to waive the exclusion of an HIV+ approved refugee applicant unless the applicant is able to establish:

- (1) the danger to the public health of the United States created by his/her admission to the United States would be minimal;
- (2) the possibility of the spread of the disease created by his/her admission to the United States would be minimal; and
- (3) there would be no cost incurred by any level of government agency in the United States without the prior consent of that agency.

It has come to my attention that there may be some confusion regarding the documentation needed to meet the third of these requirements for the submission of a waiver request. The following guidance restates the types of evidence that INS Headquarters has determined will satisfy the consent requirement.

Proof that no cost would be incurred by any government agency without its consent can include, but is not limited to:

- (1) health insurance coverage under a plan held by a family member already in the United States;
- (2) evidence of financial resources commensurate with the projected medical costs of HIV+ treatment such as letters from a family member's employer, bank statements, recent pay stubs, or recent tax forms;
- (3) statements of consent from local or state health care officials with responsibility for the area in which the HIV+ applicants, if admitted, would resettle; or

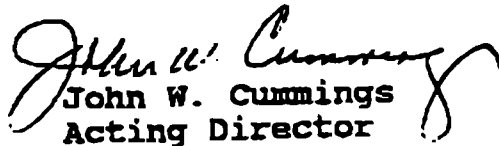
All INS Overseas Offices**Page 2**

(4) statements from specific private or government health care and research facilities assuming responsibility for treatment.

An applicant meeting any one of these criteria or providing similar materials/documentation will be viewed as having satisfied the third requirement for the submission of an I-602 waiver request.

It is our understanding that some voluntary agencies believe that INS requires a Form I-134, Affidavit of Support, to be submitted with an I-602 from an HIV+ approved refugee applicant. We ask that you advise the agencies with which you deal that it is INS policy in HIV+ waiver cases to accept documentation in the forms just described. The submission of an I-134 is not required. Individuals or organizations wishing to submit an I-134 as proof of "financial resources commensurate with the projected medical costs of HIV+ treatment" may, of course, do so, but should be advised that an I-134 is not the only evidence that will satisfy the requirement that no cost be incurred by any government agency without its prior consent.

Should you have any questions regarding the preceding discussion, please contact the Refugee Division of the Office of International Affairs. As needed, the Refugee Division staff will contact the Administrative Appeals Unit for their guidance.


John W. Cummings
Acting Director

Attachment

cc: Administrative Appeals Unit



CO-100\8.3.2

Subject

Waiver Requests from Refugees who
Test Positive for Human Immuno-
deficiency Virus

Date

SEP. 30 1993

To

All INS Overseas Offices

From

Office of
International
Affairs

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The District Director/Officer in Charge must first weigh the facts in each case and determine whether humanitarian, family unity or public interest grounds exist. Once that determination has been made, the District Director/Officer in Charge will determine whether discretion is to be exercised. Under existing guidelines--wires of 7/6/87 (CO 234-P), 3/2/88 (CO 234-P, and 8/8/88 (CO 234-C)--Immigration and Naturalization Service (INS) officers may not exercise the discretionary authority of the Attorney General unless the approved refugee applicant is able to establish that:

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Page 3

If you require additional guidance on specific HIV+ waiver requests, you should contact the Refugee Division of the Office of International Affairs. As needed, Refugee Division staff will contact AAU for their guidance.

**John W. Cummings
Acting Director**

Talking Points: Change in HIV Waiver Filing Requirements for Refugees
June 16, 1999

- To be resettled in the United States, an individual who has been determined to qualify for classification as a refugee under section 101(a)(42) of the INA also must be otherwise admissible. For refugees, the INA permits the Attorney General to waive many grounds of inadmissibility for humanitarian reasons, to assure family unity, or for other reasons in the public interest.
- An approved refugee applicant who tests positive for HIV is inadmissible to the United States under section 212(a)(1)(A)(I) of the INA. The INA authorizes the Attorney General to waive this ground of inadmissibility for certain immigrants, including refugees.
- The INS policy for filing waiver requests requires all eligible immigrants who test HIV+ to submit documentation establishing that their admission to the United States will not endanger the public health and that no cost will be incurred by any level of government agency without the prior consent of that agency. These requirements also extend to refugees.
- The filing requirements, set out in 1987, were based directly on guidelines issued by the INS for the consideration of waiver requests made by HIV+ legalization applicants. For legalization applicants, who were already living in the United States, the prior consent requirement was not necessarily difficult to establish. For refugees, however, it was often difficult to obtain the necessary prior consent from outside the United States.
- Only the few refugees who individually could show proof of coverage under health insurance held by family members already in the United States or who could document their eligibility for HIV treatment programs could meet the prior consent prong of the INS waiver filing requirements. As a result, many persons who were found by INS officers to have a well-founded fear of persecution and then tested HIV+ were unable to submit waiver requests.
- Some of these refugees are separated from family members who are resettled in the United States. Others are at increased risk in their host countries because of their medical condition.
- These concerns, along with changes in the treatment of HIV+ individuals, led to a reevaluation of INS' filing requirements for HIV waiver requests.
- On June 16, INS Headquarters issued amended guidance to our overseas offices regarding the filing of HIV waiver requests and the types of evidence necessary to meet the prior consent requirement. The new guidance does not alter the current requirements.

- This means that the INS will continue to ask refugees who test HIV+ to provide individualized proof that their admission to the United States will not endanger the public health but will no longer require these refugees to establish *individually* prior consent by government agencies with regard to health care. The INS instead will consider a refugee's eligibility for federally-funded health care programs to meet the prior consent filing requirement.
- These programs include Medicaid, Refugee Medical Assistance and the variety of services provided under the Ryan White CARE Act.
- This procedural change is based on a recent letter from the Surgeon General to Commissioner Meissner. In his letter, the Surgeon General states that the U.S. Government's provision of services to HIV+ individuals "provides adequate support for refugees who are HIV-positive upon their admission to the United States and during their transition to full participation in our society."
- This change in the filing requirements should allow all approved refugee applicants who test HIV+ and who can establish that they do not pose a risk to the public health to submit waiver requests and have those requests decided by INS.
- The decision to ultimately grant or deny the waiver remains discretionary, however, and is unaffected by the new guidance. Under section 207 of the INA, a refugee's inadmissibility may be waived only for humanitarian purposes, to assure family unity or for reasons in the public interest. Waiver decisions will continue to be made on a case-by-case basis.

If asked:

INS estimates that there are between 200-300 approved refugee applicants worldwide who have tested HIV+ following their refugee determinations over the last several years. Over this period, INS has approved over 80,000 refugees each year.

Questions regarding Guidance on Waiver Procedures for Refugees Who Test HIV+

Background: Refugees are subject to the medical grounds of inadmissibility listed in section 212 (a)(1)(A) of the INA, including HIV infection, a communicable disease of public health significance. In 1987, INS first issued guidance on filing requirements for waiver requests of refugees who test HIV+. On June 16, INS issued additional guidance.

Q. What is the current INS policy for refugees who test HIV+?

A. To submit an application for a waiver of grounds of inadmissibility due to HIV infection, INS guidance requires that an approved refugee applicant submit documentation establishing that:

- (1) the danger to the public health of the United States created by his/her admission to the United States would be minimal;
- (2) the possibility of the spread of the disease created by his/her admission to the United States would be minimal; and
- (3) there would be no cost incurred by any level of government agency in the United States without the prior consent of that agency.

Properly filed waiver applications are decided on a case-by-case basis and may be approved for humanitarian or public interest reasons or to assure family unity.

Q. What exactly is the change in procedure?

A. In the past, the third requirement only could be met through documentation of individual eligibility for HIV+ treatment or health care coverage in the United States. Effective June 16, INS will consider the federally-funded programs and services available to refugees who test HIV+ to be sufficient to satisfy the third filing requirement – i.e., proof that no cost will be incurred by any level of government agency in the United States without the prior consent of that agency.

INS will continue to require individual evidence that the first 2 filing requirements have been met. These must be satisfied through documentation demonstrating that the refugee has been counseled to ensure that he or she understands how HIV is transmitted and has understood and agrees to undertake all precautions necessary to prevent its spread.

This procedural change relates to waiver filing requirements only. The waiver adjudication procedures remain unchanged. As provided by statute, the Attorney General has the discretionary authority to grant a waiver for humanitarian purposes, to assure family unity or when it is otherwise in the public interest.

Q. Why is INS making this change now?

A. In 1987, when INS initially drafted the waiver filing requirements for approved refugee applicants who test HIV+, less was known about the nature and effective treatment of the disease. Over the past 12 years, HIV treatment programs have multiplied and the Department of Health and Human Services now believes that a nationwide HIV healthcare network is in place. The Surgeon General has advised the INS that the United States' provision of services to HIV+ individuals "provides adequate support for refugees who are HIV-positive upon their admission to the United States and during their transition to full participation in our society."

Q. Do we know now how many refugees who have been screened for refugee status by the United States have tested positive for HIV?

A. We estimate that a total of between 200 and 300 approved refugee applicants have tested HIV+ following their refugee determinations over the past several years. In each of these years, we estimate that more than 80,000 refugees were preliminarily approved for resettlement and then underwent medical screening.

Q. Does this mean that all HIV+ immigrants can now come to the United States?

A. No. The June 16 guidance applies only to waiver filing requirements in refugee cases. For individuals seeking admission to the United States as immigrants, waiver filing requirements remain unchanged. The INS will continue to adjudicate all waiver requests on a case-by-case basis.

Q. Why does the new guidance apply only to refugees and not to other HIV+ immigrants?

A. The new guidance applies only to refugees because they are eligible for the federal health programs identified in the Surgeon General's letter. Other categories of immigrants are not necessarily eligible for these programs. The INS may adopt other changes to the HIV+ waiver rules for non-refugees in future guidance.

Q. What are the federally-funded treatment programs available to refugees who test HIV+?

A. According to the Department of Health and Human Services (HHS), a variety of programs are available to refugees who test positive for HIV.

The Refugee Medical Assistance (RMA) program provides for the health care of low-income refugees not covered by Medicaid (primarily single adults and couples without children) upon their admission to the United States. This coverage includes primary health care and some ancillary support services and is substantially equivalent to those services provided by Medicaid.

Some refugees will be immediately eligible for Medicaid. All states extend Medicaid eligibility to individuals meeting certain financial and categorical criteria (i.e., a member of a group such as pregnant women, dependent children, disabled persons and the aged).

In addition to RMA and Medicaid, refugees also may be eligible for a variety of services supported through the Ryan White CARE Act, which is administered by HHS. These services include primary care, prescription drug benefits, case management, and translation services. A basic level of HIV related care is available to refugees in most communities through CARE Act funded services.

(Any additional questions on availability of services and funding should be referred to HHS.)

Q. Why should U.S taxpayers have to pay for the treatment of refugees who test HIV+?

A. It is consistent with our humanitarian traditions and our international obligations for the United States to offer refuge to many of the world's persecuted people. Prospective medical costs are not a consideration when determining eligibility for refugee status in the United States. In fact, by law refugees are exempt the public charge restrictions that other immigrants face.



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary
Office of Public Health and Science

Assistant Secretary for Health
Surgeon General
Washington, D.C. 20201

MAY 21 1999

The Honorable Doris Meisner
Commissioner
Immigration and Naturalization Service
425 I Street, N.W.
Washington, D.C. 20536

Dear Ms. Meisner:

On behalf of the Secretary of Health and Human Services Donna Shalala, let me thank you for your attention to the health needs of refugees seeking entry to the United States. I understand that you are interested in obtaining information related to the programs that refugees who test positive for the human immunodeficiency virus (HIV), are eligible to receive including the Medicaid program, the Refugee Medical Assistance (RMA) program, and the Ryan White CARE Act (RWCA).

RMA provides for the health care of low-income refugees during their first eight months in the United States for those individuals not covered by Medicaid (primarily, single adults and couples without children). This coverage includes primary health care and some ancillary support services and is substantially equivalent to those services provided by Medicaid.

All States extend Medicaid eligibility to pregnant women with incomes below 185 percent of the Federal poverty level; children less than age 6 in families with income below 133 percent of the Federal poverty level; children between ages 6 and 15 in families with income below 100 percent of the Federal poverty level; and, by 2002, children between ages 16 and 18 in families with income below 100 percent of the Federal poverty level. Many States currently provide coverage to all children under age 19 and to a higher percent of the Federal poverty level than required under Federal law.

In addition to the groups eligible for Medicaid described in the preceding paragraph, an individual may be eligible for Medicaid if aged or determined to be disabled. To be determined disabled, the individual must at a minimum meet the disability definition used by Social Security Administration for the Supplemental Security Income program. This definition requires that the applicant be unable to work because of a physical or mental condition which has lasted or is expected to last for 12 months or result in death. An individual who is HIV-positive but without specific manifestations of AIDS or evidence that because of his/her condition is unable to work will not be found disabled.

Page 2 - The Honorable Doris Meissner

Once an individual is found to meet the Medicaid financial and categorical criteria (i.e. a member of a group such as pregnant women, dependent children, disabled persons and the aged), the applicant, if an alien, must meet the restrictions on eligibility of aliens. All aliens entering the United States on or after August 22, 1996, are barred from receipt of Medicaid, except for treatment of an emergency medical condition, for five years after entry. Refugees and certain other groups are exempt from this bar for seven years after entry to the United States. Therefore, a Medicaid eligible refugee may receive full Medicaid benefits.

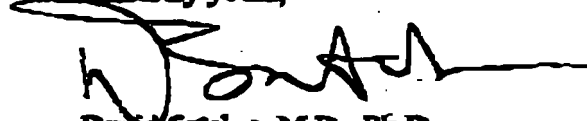
In addition to RMA and Medicaid, refugees may also be eligible for a variety of services supported through the Ryan White CARE Act (RWCA), which is administered by the Health Resources and Services Administration of the Department of Health and Human Services. These services include primary care, prescription drug benefits, case management, and translation services. Though the range and availability of CARE Act funded services varies from area to area, we are confident that a basic level of HIV-related care is available in most communities. Ryan White CARE Act funds are not restricted from serving refugees or immigrants.

Our Office of Refugee Resettlement is working with your staff and those from other agencies of HHS to develop a pilot program for serving HIV-positive refugees. This prospective initiative may include training of private resettlement agency staff in HIV-related issues, support for accessing community-based HIV resources, and other components to improve awareness of and access to the broad array of publicly and privately supported programs for individuals living with HIV and AIDS. We look forward to developing this pilot and jointly assessing the benefits of an enhanced service program that will utilize service providers and materials that are linguistically and culturally appropriate for the refugee populations.

In our view, the country's commitment to providing services to HIV-positive individuals provides adequate support for refugees who are HIV-positive upon their admission to the United States and during their transition to full participation in our society.

Thank you again for your continuing efforts to provide for those individuals most in need. We stand ready and willing to continue our work together on their behalf.

Sincerely yours,



David Satcher, M.D., Ph.D.
Assistant Secretary for Health and
Surgeon General

State Dept. sending a cable re: HIV screening, referral/counseling, limits on referral, passing names to others. But DHS info to Panel Physicians.

David Smith - problem ~~is~~ is moving. getting waivers for asylum, immigrants. confidentiality issues b/wn refug - unknown. VA, etc.

Service
State Dept informs DHS when HIV + are coming.
David Smith - Culturally competent service, language ~~the~~ capability ~~but~~ at the same time maintaining confidentiality which can be difficult
6 centers: Boston, NY, Minn, SF, San Diego, Chicago - 2 currently. 4 later - Feb.
HIV+, etc. Lutheran, Catholic.

NOT required to go to the 6 sites.
Short run solution - can only ^{handle} 100 cases.

(18K from Africa).

Working w/ ARSA - to get 4 for service.

Current state - Need more staff for testing.

USAID - guidance on drugs, formula, ^{breast feeding} ~~prevent~~, surveillance, treatment

LIFE Initiative = Global AIDS Initiative

~~What~~ What do we do for prevention [&] besides counseling?

(Service - ~~are~~ NGO provide medical services.)
- Speed up the timing of ^{promptly} ~~getting~~ getting refugees to the S. ^{some time or not at all later.} ~~Cost prohibitive~~ ^{unless safety issue}

- ~~Referral~~ Referral list in U.S.
- Panel Physicians give condoms.

(the prevalence of HIV - ^{South} ~~South~~ ^{India} ~~India~~ ^{mainly} Central ~~Africa~~ Africa - South Africa, Botswana, Tanzania)
50 kills 1/2 people w/ HIV.)

- Give info on prevention to refugees at camp/3rd entry + panel phys

Some countries are beginning to test - not necessarily change ~~the~~ b/c of US

- Don't provide special med. serv just to HIV - rather add on to current med systems

Next Steps

- Info for Panel Physicians - next 2 wks - Cont cell

- Other orgs - preventive services - FBI, MD, etc. - Stan get info to refugee sys.

AGENDA: REFUGEE MEETING

White House Office of National AIDS Policy

January 12, 2000

2:00 p.m. – 4:00 p.m.

- 2:00 – 2:10: Welcome and Introductions
Todd Summers, White House Office of National AIDS Policy
- 2:10 – 2:40: What is the refugee process?
Craig White Terry Rusch, Department of State
David Smith, Department of Health and Human Services
- 2:40 – 3:10: What is happening now?
Agency/NGO input on role and activities with respect to HIV prevention and care services provided to refugees after notification and before relocation
- 3:10 – 3:40: Discussion/Q and A
What can we do better?
- 3:40 – 4:00: Wrap-up

TENTATIVE ATTENDEE LIST

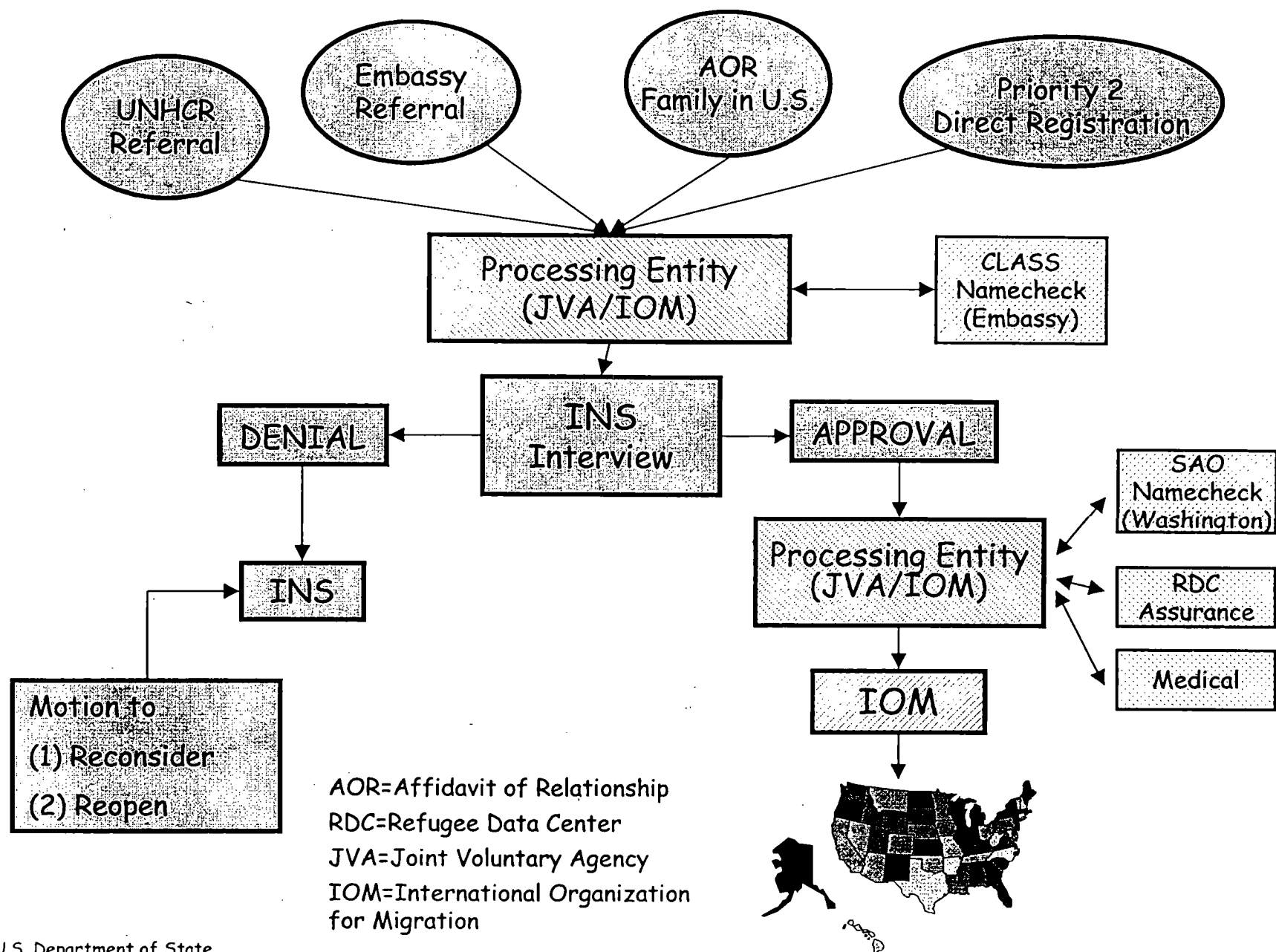
1. Irene Bueno – White House
2. Todd Summers – White House
3. Wendy Patten – National Security Council
4. Terry Rusch – Department of State
5. Craig White – Department of State
6. Jan Belz – Department of State
7. Kelly Gauger – Department of State
8. Scott Busby – Department of State
9. Cliff Cortez – Agency for International Development
10. David B. Smith – Department of Health and Human Services
11. Lavinia Limon – Department of Health and Human Services
12. Richard Keenlyside – Centers for Disease Control & Prevention
13. Susan Cookson – Centers for Diseases Control & Prevention
14. Janelle Jones – Immigration and Naturalization Service
15. Christine Petrie – International Rescue Committee
16. Eileen Reilly – CAMBA, Inc.
17. Joanne Oplustil – CAMBA, Inc.
18. Shelley Preston – Immigration and Refugee Services of America
19. Pat Maloof – National Conference of Catholic Bishops
20. Dick Hogan – National Conference of Catholic Bishops
21. Anamaria Bulatovic – Doctors without Borders

~~UNHCR~~
UNCHR

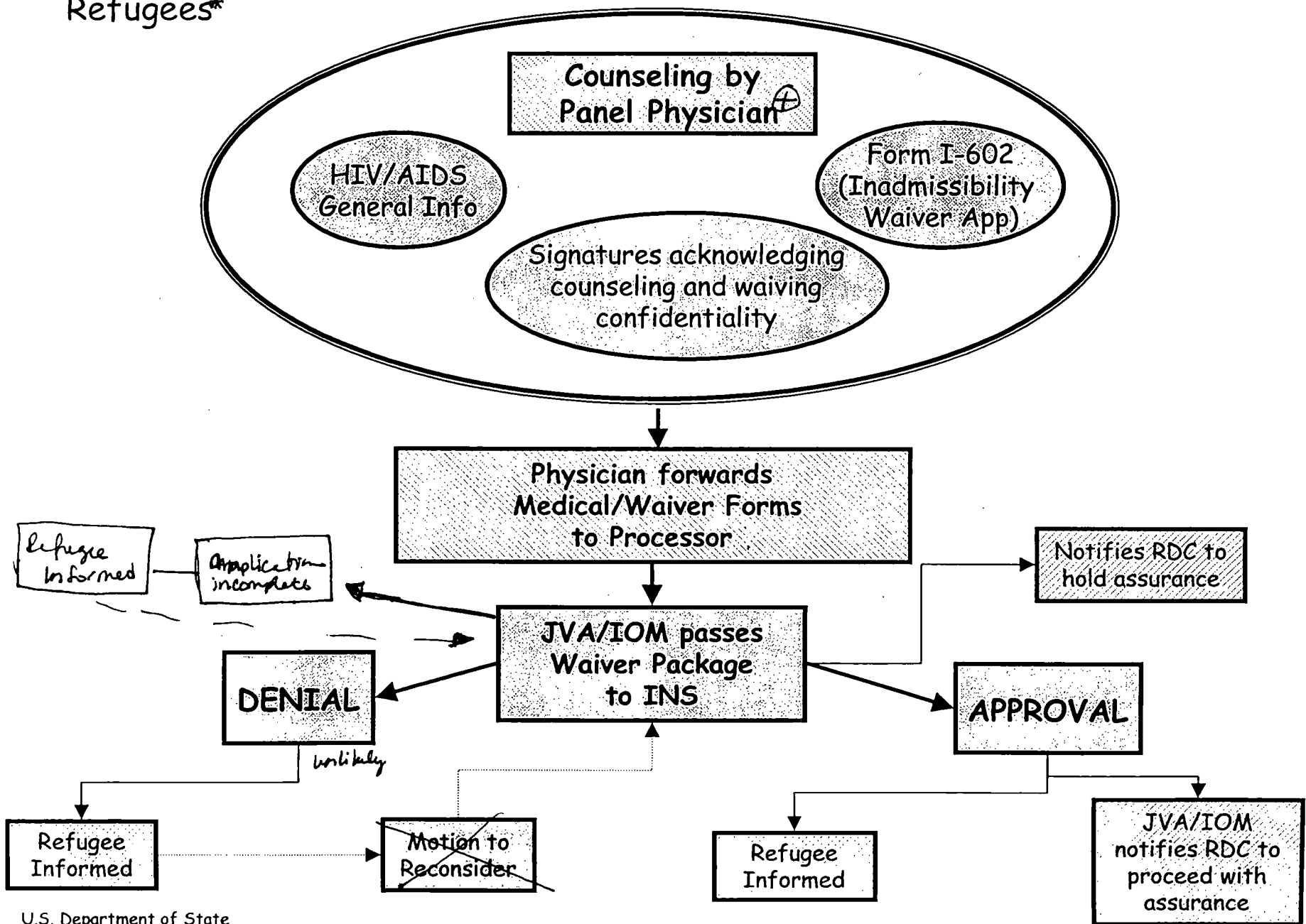
I. HIV-POSITIVE REFUGEE PROCESSING: OUTLINE

- **STEP 1**, COUNSELING BY PHYSICIAN
- **STEP 2**, COUNSELING INCLUDES INFORMATION ON RESETTLEMENT
- **STEP 3**, FILLING OUT THE WAIVER APPLICATION FORM (I-602)
- **STEP 4**, REQUIRED SIGNATURES ON THE BACK OF THE COUNSELING FORM: ALL THREE STATEMENTS ON THE BACK OF THE COUNSELING FORM, THE "STATEMENT BY PANEL PHYSICIAN," THE "STATEMENT BY WAIVER APPLICANT," AND THE "STATEMENT OF RELEASE OF CONFIDENTIAL INFORMATION" MUST/MUST BE SIGNED FOR THE WAIVER PROCESS TO CONTINUE.
- **STEP 5**, PHYSICIAN FORWARDS ALL THE ABOVE FORMS WITH THE OF-157
- **STEP 6**, THE REFUGEE PROCESSOR'S INITIAL ACTIONS: THE REFUGEE PROCESSOR PASSES ALL THESE FORMS TO THE INS. THE PROCESSOR ALSO INFORMS THE RDC (THE REFUGEE DATA CENTER) IN NEW YORK THAT THERE IS A HOLD ON THE CASE AND A WAIVER APPLICATION PENDING.
- **STEP 7**, INS PROCEDURES: INS HAS THE AUTHORITY TO REQUEST AN INTERVIEW OR ADDITIONAL INFORMATION IF ANYTHING IN THE FILE IS NOT CLEAR. INS MAY ALSO EITHER REFUSE OR APPROVE THE WAIVER BASED ON THE FILE CONTENTS. (IF THE WAIVER IS REFUSED, THE REFUGEE WILL BE INFORMED. AS IN ALL INS REFUSALS, THE REFUGEE MAY FILE A "MOTION TO RECONSIDER" WITH INS.) IF INS APPROVES, THE OFFICER WILL PASS A COPY OF THE WAIVER APPROVAL TO THE REFUGEE PROCESSOR.
- **STEP 8**, THE REFUGEE PROCESSOR INFORMS THE REFUGEE AND THE RDC.
- FROM THE POINT OF VIEW OF OVERSEAS PROCESSING, THE REFUGEE AND HIS OR HER APPLICATION ARE NOW TREATED LIKE ANY OTHER.

U.S. Resettlement Processing



Resettlement Processing for HIV+ Refugees*



U.S. Department of State
Bureau of Population, Refugees, & Migration

⊕ About 5 applications considered - certified doctors.
⊕ State Dept. contracts w/ P.P. CDC over RDC