



Chapter Four: Health Care and Financial-Aid Benefits for Military Family Members with Disabilities

Caring for a disabled person can be enormously expensive. Ongoing medical treatment, high-tech equipment, and skilled nursing care represent major expenses, but special diets, frequent trips to see specialists, and time off from work add up, too. Most Americans could not provide adequate care for their disabled family members without medical and financial assistance through federal and state programs. Disabled family members of uniformed personnel have the advantage of a comprehensive health care entitlement—TRICARE. Many of them also qualify for disability benefits and assistance for low-income families. This chapter details the principal health care and financial-aid benefits that military special needs families are or may be entitled to receive.

4.1 Military Health Care System (TRICARE)

TRICARE, the Department of Defense's health care system for active duty and retired uniformed service members, their families, and survivors, serves over nine-million beneficiaries worldwide. TRICARE combines military health care resources and civilian health care providers authorized by TRICARE to receive reimbursement. Authorized civilian providers include

- network providers: those who have negotiated discount agreements with TRICARE
- participating providers: those non-network providers who have agreed to accept TRICARE allowable charges as payment in full
- non-participating providers: those who do not accept TRICARE allowable charges as payment in full; they may charge patients up to 15% more than the allowed charges, as well as require patients to file their own claims and wait for reimbursement

In military hospitals, clinics, and health care facilities worldwide, active duty service members from any of the seven uniformed services – Army, Air Force, Navy, Marine Corps, Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration – have priority for care.

4.1.1 TRICARE Regions

Within the United States, TRICARE is organized into three geographic health care service regions – North, South, and West. Each region is administered by a TRICARE Regional Office, with support from civilian health care contractors who are selected through a competitive procurement process. Each TRICARE region offers the same

choices for health care plans and coverage. TRICARE beneficiaries living overseas have fewer options. The TRICARE website www.tricare.osd.mil has links to websites for North, South and West regions, plus contact information for TRICARE overseas regions – Pacific, Europe, Canada/Latin America, and Puerto Rico/Virgin Islands.

4.1.2 TRICARE Program Options for Active Duty Family Members

TRICARE offers three health care options to family members of active duty service members living in the US and certain overseas location. They vary according to cost, flexibility, and availability. Family members with special needs may receive care under one of these TRICARE options, and if eligible, from a TRICARE special program described in the next section. TRICARE beneficiary eligibility status is determined by the Services and maintained in the Defense Enrollment Eligibility Reporting System (DEERS).



TRICARE beneficiary eligibility status is determined by the Services and maintained in the Defense Enrollment Eligibility Reporting System (DEERS).

TRICARE Prime: TRICARE Prime is a managed care option similar to a civilian health maintenance organization. Beneficiaries receive their care from a military treatment facility (MTF), or through the regional contractor’s provider network. TRICARE Prime is the only option for active duty service members, and it is the only option that requires enrollment by its users. Active duty family members enrolled in TRICARE Prime pay no fees, deductibles, or co-payments for authorized medical services, emergency care, MTF care and other care authorized by their Managed Care Support contractor. Family members living with their active duty service members in locations that are at least 50 miles or one hour from the nearest MTF may enroll in TRICARE Prime Remote for Active Duty Family Members.

TRICARE Extra: TRICARE Extra is a preferred-provider option that allows active duty family members to receive care from the network of providers with whom TRICARE has negotiated discounted costs. Beneficiaries are responsible for paying cost-shares for services after annual deductibles have been met. There are no claims to file, but the choice of providers is limited to those in the network. Active duty service members cannot use TRICARE Extra, and it is not available overseas.

TRICARE Standard: Formerly known as CHAMPUS, TRICARE Standard is a fee-for-service option that allows active duty family members to receive care from any TRICARE-authorized provider. Beneficiaries are responsible for paying cost-shares after annual deductibles have been met. Cost shares are five percent higher than with TRICARE Extra. However, Standard can be used simultaneously with Extra, and beneficiaries who use a network provider will have their claims adjudicated under Extra. By visiting a non-network provider, they will incur greater out of pocket expenses and may have to file their own claims. TRICARE Standard provides the broadest choice of providers and may be the only option available to family members in some locations. Active duty service members cannot use TRICARE Standard.

4.1.3 TRICARE Program Options for Retirees and their Families

TRICARE has three health care options available to retired service members and their families. They may choose to enroll in TRICARE Prime, if available, or they can use TRICARE Extra or Standard. Retirees, however, pay an enrollment fee and co-pays for TRICARE Prime or deductibles and cost-shares for TRICARE Extra and Standard. Retirees living overseas have only the option of TRICARE Standard available to them. TRICARE Prime Remote is not available to retirees or their family members.

TRICARE and Medicare: TRICARE beneficiaries who become entitled to Medicare Part A due to age, disability, or end-stage renal disease, and who pay Medicare Part B premiums, receive coverage under TRICARE For Life. TRICARE For Life acts as a second payor for TRICARE and Medicare covered services in the same manner as a supplemental health care policy. For services covered under one program but not the other, beneficiaries are responsible for any deductibles and cost shares not covered.

4.1.4 Cost Comparison of TRICARE Options

Active duty and retiree families should compare the cost of each TRICARE option in relation to their unique needs and living situations before deciding which option to use. The TRICARE website has a chart that compares the costs of each option for different beneficiary groups at www.tricare.osd.mil/tricarecost.cfm.

4.2 TRICARE Benefits for Special Needs Care

In addition to the benefits of the Basic Program, TRICARE will introduce in 2005 a supplemental program of extended benefits for active duty family members with a qualifying condition. This program, known as the Extended Care Health Option (ECHO) replaces its predecessor, the Program for Persons with Disabilities (PPPWD). The purpose of ECHO is to provide eligible active duty family members with an additional financial resource for an integrated set of services, equipment, and supplies designed to assist in the reduction of the disabling effects of the beneficiary's qualifying condition. This section describes benefits and eligibility requirements for the ECHO program plus other basic TRICARE benefits for persons needing intensive or specialized care.

Notice: *At publication of this manual, TRICARE had not yet implemented ECHO but anticipates doing so prior to the end of 2005. Until it is implemented, PFPWD will be available.*

4.2.1 ECHO

The TRICARE ECHO offers most of the benefits of PFPWD plus a new respite care benefit, an expanded home health care benefit, and an increase in the maximum allowable cost share by the government from \$1,000 to \$2,500 per month. The sponsor's or beneficiary's cost share for each month an ECHO benefit is received is based on the sponsor's rank and ranges from \$25 for an E-4 to \$250 for an O-10. ECHO is not a stand-alone program; it may be used concurrently with other medical benefits of the TRICARE Basic Program.



The TRICARE ECHO offers most of the benefits of PFPWD plus a new respite care benefit, an expanded home health care benefit, and an increase in the maximum allowable cost share by the government from \$1,000 to \$2,500 per month.

ECHO eligibility: ECHO is available to active duty family members with a qualifying condition:

- moderate or severe retardation
- serious physical disability
- extraordinary physical or psychological conditions
- multiple disabilities involving different body systems

To receive ECHO benefits, sponsors must register the family member with the Managed Care Support contractor where the beneficiary lives and obtain TRICARE approval before receiving services. Registration also includes showing evidence of enrollment in the Exceptional Family Member Program (EFMP) of the sponsor's branch of service. EFMP enrollment is waived in cases where the sponsor belongs to a Service, such as the US Public Health Service, which does not have an EFMP.

If the qualifying condition existed prior to the beneficiary reaching age 21, he or she remains eligible for ECHO as long as the sponsor is on active duty. When the service member retires, adult children incapable of self support due to mental or physical incapacity will continue to be covered under the basic TRICARE options.

ECHO benefits: To the extent they are not available through the TRICARE Basic Program, ECHO benefits include

- medical and rehabilitative interventions, prostheses, orthopedic braces, and appliances
- special educational services
- residential care in public, private, or nonprofit settings when protective custody or training in a residential setting is necessary
- transportation to and from facilities to receive authorized ECHO care
- durable equipment and maintenance
- training when required for use of assistive technology devices
- training for parent/guardian or siblings to provide assistance with home-administered interventions
- assistive communication services (interpreters, translators, readers for the blind)
- equipment adaptation



To receive ECHO benefits, sponsors must register the family member with the Managed Care Support contractor where the beneficiary lives and obtain TRICARE approval before receiving services. Registration also includes showing evidence of enrollment in the Exceptional Family Member Program (EFMP) of the sponsor's branch of service.

Respite care: The ECHO program has a new respite care benefit. It provides short-term care for a patient in order to relieve those who have been caring for him/her at home, usually the family. A maximum of 16 hours of respite care may be provided per month for any month a family member is receiving ECHO benefits. However, unused hours may not be banked for future use.



A maximum of 16 hours of respite care may be provided per month for any month a family member is receiving ECHO benefits.

This benefit is not meant to be a relief for parents to be deployed, be employed, seek employment, or pursue education. ECHO respite care services are provided by TRICARE-authorized home health agencies.

Extended home health care (EHHC): The EHHC replaces the Custodial Care Transition Policy as a means of providing intensive home health care services to active duty family members. EHHC is available only to those who are otherwise eligible for ECHO and are homebound, require medically necessary skilled services, and reside within the 50 United States, District of Columbia, Puerto Rico, US Virgin Islands, or Guam. Beneficiaries must be case managed, including periodic assessment of needs, and receive services from a TRICARE-authorized home health agency. Although the hours of care are not limited to 28 per week as with home health care provided under the TRICARE Basic Program, the beneficiary's plan of care must validate the need for EHHC and define the services, the number of hours, and the type of providers needed to provide care. Finally, EHHC has its own respite care benefit of eight hours per day for five days per week. It is intended for beneficiaries who have medical conditions that require frequent interventions to give the primary caregiver time to sleep. The EHHC respite care benefit cannot be banked for future use nor used for deployment, employment, seeking employment or pursuing education.

ECHO limitations: Among the services not covered by ECHO are

- any benefits available through the TRICARE Basic Program
- structural alterations of residences
- dental care and orthodontic treatment
- deluxe accommodation
- computers
- services written into a beneficiary's IEP and required by a public education agency to be provided by others without charge

A contractor's case manager or the TRICARE Service Center can help active duty families determine if they qualify for ECHO, understand its benefits and limitations, and decide how to make the best use of TRICARE benefits for special needs.



A contractor's case manager or the TRICARE Service Center can help active duty families determine if they qualify for ECHO, understand its benefits and limitations, and decide how to make the best use of TRICARE benefits for special needs.

4.2.2 Home Health Care

When home health care is authorized for a TRICARE beneficiary, reimbursement is paid according to the Medicare Home Health Agency Prospective Payment System (HHA-PPS) for *up to* 28 hours per week (35 hours for short periods) and renewable for 60 days at a time. Services include skilled nursing and home health aide care. This option may be authorized for an active duty family instead of ECHO EHHC when the need is for only intermittent or part-time home health care. It is not available overseas. Providers must be Medicare and TRICARE authorized.

4.2.3 Skilled Nursing Facility Care

The TRICARE benefit for care in a skilled nursing facility (SNF) also mirrors the Medicare benefit except that care is not limited to 100 days as long as it is medically necessary. For skilled nursing care to be covered, the eligible beneficiary must have a qualifying hospital stay of three consecutive days or more and enter the skilled nursing facility within 30 days of being discharged from the hospital. A skilled nursing facility has the staff and equipment to provide skilled nursing, skilled rehabilitation, or other medically necessary health care services including prescription medications. Facilities authorized by TRICARE to provide skilled nursing care must also be Medicare certified. Care in a skilled nursing facility is not the same as nursing home care. TRICARE does not cover care in a nursing home or assisted-living facility for beneficiaries needing only help with activities of daily living.



TRICARE does not cover care in a nursing home or assisted-living facility for beneficiaries needing only help with activities of daily living.

4.2.4 Hospice Care

TRICARE covers the cost of hospice care for terminally ill patients who are not expected to live longer than six months if the illness runs its normal course. Hospice is a special concept of care designed to provide comfort, support, and pain relief to patients at the end of life. There are no limits on custodial care or personal comfort items under hospice rules. Beneficiaries must elect hospice in lieu of basic benefits.

4.2.5 Mental Health Care

Mental health care is not classified as a TRICARE special needs program, but benefits can be confusing for special needs families unless the beneficiary has a serious mental illness that qualifies for care under ECHO. Mental health care covered under the TRICARE Basic Program has the following restrictions.

- The TRICARE contractor must pre-authorize as medically necessary
 - inpatient care
 - care at residential treatment facilities
 - extensions to TRICARE annual limits on inpatient care
 - outpatient mental health care exceeding two outpatient visits per week or eight outpatient visits per year

- The annual limit on inpatient care is
 - 30 days for patients over age 19
 - 45 days for patients under age 19
 - 150 days for inpatient care in residential treatment centers (available only to those under age 21)
 - 7 days detox and 21 days rehabilitation for substance abuse

The disorders that qualify for TRICARE mental health care benefits involve clinically significant behavioral or psychological patterns and impaired ability to function appropriately. They are listed in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (DSM-IV) and include conditions such as depression, anxiety, obsessive-compulsive disorder, bi-polar disorder, schizophrenia, attention deficit disorders, and autism. TRICARE mental health benefits do not cover treatment for marital problems, weight loss, sexual dysfunction, certain personality disorders, or special learning disabilities. Beneficiaries who need counseling for behavioral or emotional difficulties that are not covered under TRICARE may be referred to Military OneSource (see Chapter Five).

4.2.6 Benefit Authorizations

TRICARE programs for special needs care, as well as mental health care that exceeds basic authorization, are managed to ensure they are medically necessary and appropriate for patients' needs. Beneficiaries of these programs should be advised to seek a new authorization if they move, need to change providers, or extend services beyond TRICARE authorized limits. Services will not be authorized by TRICARE if other public funds are available and sufficient to meet disability-related needs. Special needs families can incur expenses that are not covered by their TRICARE/Medicare benefits if they receive services that have not been authorized. A typical scenario is the beneficiary referred by their authorized provider to another provider for specialty care, and the family assumes that authorization for the second provider is automatic.



Special needs families can incur expenses that are not covered by their TRICARE/Medicare benefits if they receive services that have not been authorized.

4.2.7 Case Management

TRICARE beneficiaries receiving care for chronic and/or high-risk/high cost health issues, as well as catastrophic or terminal illnesses, may receive case management services as a no-cost benefit. Case managers are usually nurses or social workers assigned according to patients' needs and desires. Their role is to help patients who require extended resources and services, and their families, to successfully negotiate complex health care and support systems in order to maximize clinical and financial outcomes. Although participation in case management is voluntary, individuals receiving TRICARE special needs care benefits are likely to require a case manager for limited or extended periods of time, depending upon the nature of their disability and their unique needs.

4.3 TRICARE Information and Assistance

The TRICARE website www.tricare.osd.mil/ is a comprehensive source of information for TRICARE beneficiaries and those who assist them. In addition to information about all TRICARE benefits, programs, and services, it provides contact information for TRICARE regional contractors, TRICARE service centers, and military treatment facilities. TRICARE offers Beneficiary Counseling and Assistance Coordinator (BCAC) and Debt Collection Assistance Officer (DCAO) assistance to beneficiaries who cannot access specific TRICARE information through other means or cannot resolve specific concerns through normal channels.

4.3.1 Beneficiary Counseling and Assistance

All TRICARE Regional Offices and most MTFs are staffed with BCACs whose role is to serve as the beneficiary's advocate and trouble shooter. BCACs provide information, guidance and assistance on benefit options, TRICARE Prime enrollment, special authorizations, status of claims and eligibility, plus assistance with referrals and appointments. The BCAC will interface with the MTF staff, managed care support contractors, and claims processors to resolve beneficiary concerns and facilitate answers to questions for problems that cannot be resolved through normal channels. In the event that beneficiaries have been unable to resolve concerns or disagree with decisions related to their benefits, the BCAC can provide information on the TRICARE appeals process.

4.3.2 Debt Collection Assistance

TRICARE has a debt collection assistance officer (DCAO) assigned to TRICARE Regional Offices and MTFs worldwide to help beneficiaries understand and get assistance with debt collection problems related to TRICARE. Individuals who have received a notice from a collection agency or a negative credit report because of a medical or dental bill should be referred to the nearest DCAO. The DCAO will ask for documentation including debt collection letters, TRICARE explanation of benefits, and bills from providers. He/she will then research the claim, provide a written resolution to the collection problem, and notify collection agencies that action is being taken.

4.4 IDEA-Related Services

The Individuals with Disabilities Education Act (IDEA), reauthorized in 2004, is the legislation that gives children with disabilities the right to a free, appropriate public education including related services necessary to meet their educational goals (see Chapter Three). IDEA Part C requires that infants and toddlers who are or may become developmentally delayed due to cognitive, physical, communicative, social, emotional or adaptive impairment also receive early intervention services (EIS). EIS and special education related services are often medical, diagnostic, or therapeutic in nature and provided by health care providers. They must be identified in the individualized family service plan (IFSP) for EIS or in a student's individualized education program (IEP). IDEA legislation intends for these services to be provided at no cost to families (except where a state has established a system of payments by families, including a schedule of sliding fees).

4.4.1 TRICARE and IDEA

States may request and receive annual funding for IDEA Part C services, but they do not always fully cover direct services by health care providers.

Instead, states will share the cost of direct services such as medical treatment, physical therapy and speech therapy with TRICARE, Medicaid, private insurance and other sources. The most recent IDEA legislation stipulates that TRICARE will pay its share first, but only for services that are medically or psychologically necessary and otherwise a TRICARE benefit.

TRICARE cost-sharing determinations are on a case-by-case basis. Services included on the IEP for special education students from age 3 to 21 are paid for by state educational agencies through contracts or other arrangements, and TRICARE is involved only when it is determined that the necessary services are not available or adequate.



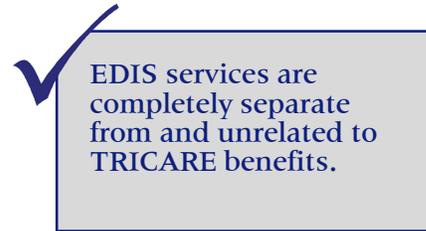
The most recent IDEA legislation stipulates that TRICARE will pay its share first, but only for services that are medically or psychologically necessary and otherwise a TRICARE benefit.

4.4.2 Educational Developmental and Intervention Services (EDIS)

In locations where DoD educates children of active duty service members (and DoD civilians overseas), it is also responsible for early intervention and related services. EDIS clinics were established by DoD to meet requirements of IDEA for early intervention and medically related services. They are organized under Army, Air

Force and Navy Medical Departments at CONUS installations with DoD schools and within assigned geographic areas of responsibility overseas. EDIS clinics overseas are staffed with comprehensive teams of professionals in

- early childhood special education
- occupational therapy
- physical therapy
- social work
- speech-language pathology
- audiology
- psychology
- child psychiatry
- developmental pediatrics



In CONUS, some EDIS services may be purchased by DoD from the local community. EDIS services are completely separate from and unrelated to TRICARE benefits.

4.5 Federal and State Programs with Benefits for Eligible Special Needs Families

The US government provides financial assistance and medical care to disabled children and adults through a number of different programs, each with its own purpose and eligibility criteria. If eligible, military families can use these benefits to augment TRICARE and secure the future care of the disabled family member. Special needs families should be encouraged to know their benefits and file for them as soon as possible. This section gives an overview of the government's benefits most often (after TRICARE) used by military personnel with disabled family members. States have additional programs and services for disabled citizens that may also be used by military families.

4.5.1 Supplemental Security Income (SSI)

SSI is a monthly payment to people with low incomes and few resources who are age 65 or older, blind, or disabled. Children as well as adults may qualify for SSI. The Social Security Administration manages the SSI program, although SSI is not paid by Social Security taxes. Payments come from US Treasury general funds. In many states, eligibility for SSI automatically qualifies the individual for Medicaid.

Income and resources: To qualify for SSI, applicants must not exceed the income limits set for their state. Some forms of income are not included in the limit. The local Social Security office can provide the state income limit and exclusions. Resources are the assets owned by the applicant, which may not exceed \$2000 for an individual or \$3000 for a couple. Assets usually not counted include the person's home, life insurance policies of \$1,500 or less, car, and burial funds. If the applicant is younger than 18, a part of the income and assets of the parents are counted.

Disability determination: The Social Security Administration defines disability as a physical or mental condition that prevents a person from being able to work and is expected to last at least a year or result in death. Childhood disability is further defined as an impairment that severely limits age-appropriate functioning. Applicants must prove their disability by providing documentation such as medical records, employment records, and contact information for doctors, hospitals, clinics, and therapists who have provided diagnosis and treatment. A doctor's statement saying a person is disabled will not automatically qualify him/her for SSI. It takes several months for the Social Security Administration to process a disability claim, and it will move more quickly if applicants provide as much documentation as they can when they apply. Disability claims are often denied on the first attempt and then appealed. It is not uncommon for applicants to hire an attorney to help with the appeal for a percentage of the lump sum payment, if they win.

Other SSI allowances or restrictions: Military families with a disabled child on SSI may continue to receive payments if they PCS overseas, provided he/she was eligible for SSI in the month before the sponsor reported for duty. However, military families cannot apply for SSI while overseas. SSI recipients overseas are required to report any moves, or changes in the number of people in the household. Sponsors who leave the military and remain overseas with their disabled family member will no longer be eligible for SSI. SSI rules vary for disabled persons living away from home.

✓ Military families with a disabled child on SSI may continue to receive payments if they PCS overseas, provided he/she was eligible for SSI in the month before the sponsor reported for duty.

- A person living in a city or county rest home, halfway house, or other public institution may not qualify for SSI.
- A person living in a publicly operated community residence that serves no more than 16 people may get SSI.
- A person living in a public institution mainly to attend approved educational or job training to help them get a job may get SSI.
- A person living in a public or private institution and Medicaid is paying more than half of the cost may get a small SSI benefit.

SSI application process: Military families with a disabled child or adult who may qualify for SSI should be encouraged to apply by calling or visiting the nearest Social Security Office or by calling the Social Security Administration’s toll free number 1-800-772-1213. Applicants may complete part of their application online by first visiting the Social Security Website www.socialsecurity.gov. At the appointment, applicants will be asked to provide proof of age, information about their home, their income, insurance, and assets, in addition to the disability-related documentation mentioned above. The Social Security website can help applicants identify all of the documents to support their claim. Parents or guardians, and in some cases third parties, can apply for children.

Note: SSI and Social Security Disability Insurance (SSDI) are often confused with each other. SSDI provides benefits to disabled or blind individuals who are “insured” by their contributions to the Social Security Trust Fund. Insured persons are the disabled worker and his or her aged or dependent family members (including adult disabled children) and survivors. The two programs are similar in that the Social Security Administration handles claims for both and applies the same criteria for determining disability. Some low-income individuals who have paid Social Security taxes will qualify for benefits under both programs at the same time. The SSI home page www.ssa.gov/notices/supplemental-security-income provides additional information and publications that may be downloaded.

4.5.2 Medicaid

Medicaid is an entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. It is jointly funded by federal and state governments, but states generally have broad discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. However, there are mandatory Medicaid eligibility categories for which federal matching funds are provided. One of these categories is SSI recipients. In most states, eligibility for SSI and Medicaid are the same, but a few states still use more restrictive Medicaid eligibility requirements that pre-date SSI. States also have the option of providing Medicaid coverage to additional categories including the “medically needy” who may not qualify for SSI. Military families with a disabled member who is qualified to receive SSI payments or struggling with the cost of care should apply for Medicaid. Medicaid may provide eligible military families with benefits over and above those offered by TRICARE, although it will be necessary for them to reapply upon each move to another state.



State Medicaid programs are usually administered by departments of social service or departments of medical assistance. In some states, Medicaid enrollment is automatic with SSI eligibility determination, while in other states a separate application is required for Medicaid. The Medicaid website www.cms.hhs.gov/medicaid has links to state Medicaid sites with information on application procedures, eligibility, and the scope of service provided.

4.5.3 Medicare

Medicare is the basic health insurance program for Americans age 65 and older and many people with disabilities. People qualify for Medicare based on the Medicare tax they paid through their work. Workers’ spouses, minor children, and adult disabled children may also be covered. Medicare coverage is automatic upon reaching age 65, but people who are on SSDI must wait two years before they can be covered. Medicare has two parts. Part A is hospital insurance, which does not cost the beneficiary anything if they have at least 40 quarters of Medicare-covered employment. Part B is medical insurance, which is optional and comes with a monthly premium (\$78.20 in 2005). Beneficiaries must pay the Part B premium in order to take advantage of the new prescription drug benefit and to be covered by TRICARE for Life. Some low-income Medicare recipients will qualify for Medicaid

assistance that pays the Medicare premium and other out-of-pocket expenses such as deductibles and co-insurance. The Medicare website www.medicare.gov has information for current and prospective Medicare recipients.

4.5.4 Food Stamps

Some military families in lower pay grades will qualify for food stamps. Eligibility for food stamps is based on income and resources, and recipients of SSI will usually qualify. Disability is not a specific eligibility criterion for food stamps, although the limit on resources is higher for households with an aged or disabled member. The Food Stamp Program is administered by the Food and Nutrition Service of the US Department of Agriculture (USDA) for the purpose of helping low-income households buy the food they need for a nutritionally adequate diet. Local food stamp programs are operated by state welfare or social services offices. The Food and Nutrition Service's Food Stamp Program website www.fns.usda.gov/fsp has information about food stamps and tools to help people find out if they qualify before visiting the Food Stamp Office.

4.5.5 WIC

WIC is the Special Supplemental Nutrition Program for Women, Infants, and Children. It also is administered by the USDA Food and Nutrition Service to help safeguard the health of low-income pregnant women, new mothers and their infants, and children up to age five who are at nutritional risk. It provides nutritious foods to supplement diets, information and counseling on healthy eating, and referrals to health care. WIC offices may be found in hospitals, agencies, and other locations that are frequented by young, low-income mothers, including many military installations. The WIC website www.fns.usda.gov/wic offers information about WIC services, eligibility requirements, and locations by state.

WIC overseas: WIC services are provided overseas by DoD to ensure services for families who would be eligible for WIC stateside. WIC overseas is managed by TRICARE and has the same services and eligibility criteria as the USDA WIC program. More information on WIC overseas, including locations, can be found on the website: www.tricare.osd.mil/wic.



WIC and early intervention: WIC can play a role in both prevention and early identification of developmental delay. According to USDA, WIC participation during pregnancy has been associated with reductions in the prevalence of very low birth-weight babies and with a significantly lower incidence of infant mortality. WIC children have improved dietary intake, reduced rates of iron deficiency anemia, improved cognitive development, and improved immunization rates. WIC staff working closely with young mothers on their nutrition and health often pick up early signs of developmental problems and make referrals for early intervention services. And WIC participation may be included in the IFSP for families evaluated as eligible for early intervention programs.

4.5.6 Title V of the Social Security Act

Many states have services for children with special health care needs that are funded by the Maternal and Child Health Services Block Grant, or Title V. States use Title V funding for a variety of maternal and child health-related programs. They include providing rehabilitation services for blind and disabled individuals under age 16 receiving SSI payments, to the extent medical assistance for such services is not provided under Medicaid. State departments of health websites and local health departments will be able to provide information on state health benefits for children with special health care needs.

