Health Impact Review of 5232-S.E. AMH ELHS H1986.1
Supporting economic security by updating provisions related to the home security fund and the essential needs and housing support program
(2025 Legislative Session)

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Full review

The full Health Impact Review report is available at:
https://sboh.wa.gov/sites/default/files/2025-04/HIR-2025-07-HouseCommitteeStriker1986.1.pdf

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Executive Summary
5232-S.E. AMH ELHS H1986.1, Supporting economic security by updating provisions related to the home security fund and the essential needs and housing support program (2025 Legislative Session)

Evidence indicates that 5232-S.E. AMH ELHS H1986.1 (House Committee Striker 1986.1) may result in some local service providers distributing Essential Needs and Housing Support (HEN) program funds for expanded eligible uses, which may increase financial and housing stability, improve health outcomes, and decrease inequities for some people who receive HEN services.

BILL INFORMATION

Sponsors: House Early Learning & Human Services Committee (originally sponsored by Senators C. Wilson, Frame, Harris, Hasegawa, Nobles, and Saldaña; by request of Department of Commerce)

Summary of Bill:

- Expands eligible uses of HEN funds, by:
  - Allowing Washington State Department of Commerce (Commerce) to distribute HEN funds to adults with low- or extremely low-incomes who are elderly or disabled and transitioning off HEN benefits, receiving federal social security benefits, and experiencing an immediate housing need, without referral from the Washington State Department of Social and Health Services (DSHS).
  - Requiring local service providers to verify HEN referrals from DSHS for rental assistance every 12 months.
  - Permitting direct cash assistance as an allowable expense only when it addresses a need identified in a person's housing stability plan.
    - Specifies that direct cash assistance may be provided through debit cash cards or other forms of flexible funding assistance, including vouchers for transportation, gift cards, direct payments to vendors, and other similar methods of assistance.
  - Expanding HEN eligibility for victims of human trafficking as defined in RCW 74.04.005.
  - Removing the eligibility requirement that a person must be a U.S. citizen, an alien lawfully admitted for permanent residence, or otherwise residing in the U.S. under color of the law[a].

[a] Key informants stated that "Permanently Residing Under Color of Law" (PRUCOL) is outdated terminology used within the context of public benefits eligibility, and it is not a formal immigration status (personal communications, DSHS, March 2025). It refers to non-citizens who are legally residing in the U.S. with the knowledge of the U.S. Citizenship and Immigration Services (USCIS) and whose departure is not being actively pursued (personal communication, DSHS, April 2025).

- Directs Commerce to align the administration rate for HEN with other home security funded programs.

HEALTH IMPACT REVIEW

Summary of Findings:
This Health Impact Review found the following evidence for House Committee Striker 1986.1:

- **Informed assumption** that expanding eligible uses of HEN funds by: 1) Allowing Commerce to distribute HEN funds, without referral from DSHS, to certain people transitioning off HEN; 2) Requiring local service providers to verify HEN eligibility every 12 months; 3) Permitting local service providers to provide direct cash assistance, in certain circumstances; and 4) Expanding HEN eligibility for victims of human trafficking would likely result in DSHS conducting rulemaking and Commerce issuing guidance to local service providers about expanded eligible uses of HEN funds. This assumption is based on information from key informants from Commerce and DSHS.
- **Informed assumption** that DSHS conducting rulemaking and Commerce issuing guidance to local service providers about expanded eligible uses of HEN funds may result in some local service providers distributing HEN funds for expanded eligible uses. This assumption is based on information from key informants.
- **Informed assumption** that local service providers distributing HEN funds for expanded eligible uses may increase financial and housing stability for some people who receive HEN services. This assumption is based on HEN program evaluations and information from key informants.
- **Very strong evidence** that improved financial and housing stability would likely improve health outcomes for some people who receive HEN services.
- **Very strong evidence** that improving health outcomes would likely decrease inequities for some people who receive HEN services.

Additional Considerations includes discussion of potential impacts due to immigration status.

Introduction and Methods

A Health Impact Review is an analysis of how a proposed legislative or budgetary change will likely impact health and health disparities in Washington State (RCW 43.20.285). For the purpose of this review "health disparities" have been defined as differences in disease, death, and other adverse health conditions that exist between populations (RCW 43.20.025). Differences in health conditions are not intrinsic to a population; rather, inequities are related to social determinants (access to healthcare, economic stability, racism, etc.). This document provides summaries of the evidence analyzed by State Board of Health's Health Impact Review staff during the Health Impact Review of the House Early Learning & Human Services Committee's striking amendment 5232-S.E. AMH ELHS H1986.1 (House Committee Striker 1986.1)

Health Impact Review staff analyzed the content of House Committee Striker 1986.1 and created a logic model visually depicting the pathway between bill provisions, social determinants, and health outcomes and equity. The logic model reflects the pathway with the greatest amount and strongest quality of evidence. The logic model is presented both in text and through a flowchart (Figure 1).

We conducted an objective review of published literature for each step in the logic model pathway using databases including PubMed, Google Scholar, and University of Washington Libraries. The annotated references are only a representation of the evidence and provide examples of current research. In some cases, only a few review articles or meta-analyses are referenced. One article may cite or provide analysis of dozens of other articles. Therefore, the number of references included in the bibliography does not necessarily reflect the strength-of-evidence. In addition, some articles provide evidence for more than one research question and are referenced multiple times.

We consulted with people who have content and context expertise about the provisions and potential impacts of the bill. The primary intent of key informant interviews is to ensure staff interpret the bill correctly, accurately portray the pathway to health and equity, and understand different viewpoints, challenges, and impacts of the bill. For this Health Impact Review, we spoke with 18 key informant interviewees, including: 13 state agency staff with expertise in administering HEN and determining HEN eligibility and 5 staff from community organizations or local service providers with expertise providing HEN services. More information about key informants and detailed methods is available upon request.

We evaluated evidence using set criteria and determined a strength-of-evidence for each step in the pathway. The logic model includes information on the strength-of-evidence. The strength-of-evidence ratings are summarized as:

- **Very strong evidence:** There is a very large body of robust, published evidence and some qualitative primary research with all or almost all evidence supporting the association. There is consensus between all data sources and types, indicating that the premise is well accepted by the scientific community.
- **Strong evidence:** There is a large body of published evidence and some qualitative primary research with the majority of evidence supporting the association, though some sources may

have less robust study design or execution. There is consensus between data sources and types.

- **A fair amount of evidence:** There is some published evidence and some qualitative primary research with the majority of evidence supporting the association. The body of evidence may include sources with less robust design and execution and there may be some level of disagreement between data sources and types.
- **Expert opinion:** There is limited or no published evidence; however, rigorous qualitative primary research is available supporting the association, with an attempt to include viewpoints from multiple types of informants. There is consensus among the majority of informants.
- **Informed assumption:** There is limited or no published evidence; however, some qualitative primary research is available. Rigorous qualitative primary research was not possible due to time or other constraints. There is consensus among the majority of informants.
- **No association:** There is some published evidence and some qualitative primary research with the majority of evidence supporting no association or no relationship. The body of evidence may include sources with less robust design and execution and there may be some level of disagreement between data sources and types.
- **Not well researched:** There is limited or no published evidence and limited or no qualitative primary research and the body of evidence was primarily descriptive in nature and unable to assess association or has inconsistent or mixed findings, with some supporting the association, some disagreeing, and some finding no connection. There is a lack of consensus between data sources and types.
- **Unclear:** There is a lack of consensus between data sources and types, and the directionality of the association is ambiguous due to potential unintended consequences or other variables.

This review was requested during legislative session and was therefore subject to the 10-day turnaround required by law. This review was subject to time constraints, which influenced the scope of work for this review.

Analysis of House Committee Striker 1986.1 and the Scientific Evidence

Summary of relevant background information

- Generally, households "are considered housing cost-burdened if they spend more than 30% of their income on housing costs, including rent and utilities" and are "severely housing cost-burdened if they spend more than 50% of their income on housing costs."[1,2]
- Housing instability includes a range of challenges, including difficulty paying rent, spending a large percentage of household income on housing, overcrowding, frequent moves, forced evictions, and houselessness.[3]
- Economic stability "accounts for a population's ability to maintain steady employment and afford items needed to remain healthy, such as housing, utilities, food, and medications."[4]

Essential Needs and Housing Support (HEN) Program

- HEN provides funding to local governments and community-based organizations (i.e., local service providers) to support people referred to HEN by DSHS with time-limited rental assistance, services connected to housing stability, and limited essential needs items, such as personal hygiene items and transportation.[5]
  - HEN was developed as 1 of 3 programs to replace the Disability Lifeline (DL) cash assistance program (formerly General Assistance)[6] that was discontinued during the Great Recession (personal communications, March 2025). It was meant to buffer vulnerable DSHS clients from the potential impact of losing cash assistance by providing support such as rent and utility assistance.[6]
  - In January 2013, following the first year of implementation, a program evaluation assessed the impact of HEN services on measures of well-being over a 6-month follow-up period.[6] Compared to 2 statistically well-matched comparison groups, people who received HEN services experienced greater housing stability, remained connected to Basic Food assistance at significantly higher rates, and were less likely to be incarcerated in a state Department of Corrections (DOC) facility.[6]
  - Results of a recent third-party HEN program evaluation are expected to be released in 2025 (personal communications, March 2025).
- The Washington State Department of Commerce (Commerce) administers HEN and distributes funds in the form of grants to designated agencies in each county (RCW 43.185C.220). Funding for HEN is designated by the Washington State Legislature in the biennial operating budget. HEN services are subject to funding availability.[7]
  - Local service providers must prioritize housing support: first, for people experiencing houselessness and, second, for people who are at substantial risk of losing stable housing without housing support within the next 30 days.
    - Rapid Rehousing assistance serves people who are experiencing homelessness; and

        - Homelessness Prevention assistance offers rental assistance to people who may be at risk of homelessness (personal communication, Commerce, March 2025).
    - Funds should be used "as flexibly as is practicable to provide essential needs items and housing support" to people who receive HEN services.
- Under RCW 74.04.805, the Washington State Department of Social and Health Services (DSHS) is responsible for determining a person's eligibility for a HEN referral. DSHS must review a person's eligibility every 12 months. Specifically, people may be eligible for a HEN referral when they:
    - Have been deemed eligible for the Aged, Blind, or Disabled (ABD) Assistance Program or the Pregnant Women Assistance (PWA) Program (RCW 74.62.030), or
    - Are unable to work for at least 90 days due to a physical incapacity, mental incapacity, or substance use disorder (SUD) (WAC 388-447-0001);[8,9] and
    - Are a U.S. citizen, an alien lawfully admitted for permanent residence, or otherwise residing in the U.S. under color of the law[b], or are a victim of human trafficking as defined in RCW 74.04.005;
    - Have provided their Social Security Number (SSN) to DSHS, with some exceptions;
    - Have countable monthly income at or below 100% of the federal poverty level (FPL) or meet income eligibility for PWA;
    - Do not have resources in excess of those described in RCW 74.04.005; and
    - Are not eligible for federal aid assistance other than basic food benefits and medical assistance.
- People may receive a HEN referral from DSHS in 3 ways: by receiving the ABD cash assistance program, by receiving the PWA cash assistance program, or by being determined eligible based on an incapacity (personal communications, DSHS, April 2025). People must meet specified eligibility criteria for each program. Generally:
    - ABD provides cash assistance and a HEN referral primarily for adults with low-income who have no dependents, are age 65 years or older, are blind, or are determined likely to meet federal Supplemental Security Income (SSI) disability criteria.[10] The average monthly cash assistance payment per person was $399 in State Fiscal Year (SFY) 2024.[10] ABD is the priority program for adults without dependents who are unable to work due to a health condition (personal communication, DSHS, April 2025). If the severity or duration of a person's physical or mental health condition does not meet ABD eligibility criteria, the person is then considered for HEN eligibility based on an incapacity (personal communication, DSHS, April 2025).

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[b] Key informants stated that "Permanently Residing Under Color of Law" (PRUCOL) is outdated terminology used within the context of public benefits eligibility, and it is not a formal immigration status (personal communications, DSHS, March 2025). It refers to non-citizens who are legally residing in the U.S. with the knowledge of the U.S. Citizenship and Immigration Services (USCIS) and whose departure is not being actively pursued (personal communication, DSHS, April 2025).

- PWA provides cash assistance and a HEN referral for people with low-income who are pregnant and not eligible for Temporary Assistance for Needy Families (TANF) or State Family Assistance (SFA).[11] The average monthly cash assistance payment per person was $395 in SFY 2024.[12]
- The HEN incapacity program[c] provides a HEN referral for adults with low-income who are unable to work for at least 90 days due to a physical or mental incapacity. [WAC 388-400-0070] outlines eligibility for the HEN incapacity program.[9]

- Once a person goes through the process and is deemed eligible for ABD, PWA, or the HEN incapacity program, they receive a HEN referral and a letter from DSHS providing the name and contact information for the HEN local service provider in their county (personal communication, DSHS, March 2025). A person may then choose to connect with local service providers to determine whether they may receive HEN services (personal communications, March 2025).
- Local service providers may provide the following services:
  - Personal health and hygiene items,
  - Cleaning products,
  - Transportation assistance,
  - Rent and utility assistance if someone is homeless or at risk of becoming homeless, and/or
  - Case management and support.[7]

Additional Washington State law and policies

- In 2018, the Washington State Legislature passed Substitute House Bill 2667 ([Chapter 48, Laws of 2018]), which amended HEN eligibility and required Commerce to provide a secure and current list of people with a HEN referral from DSHS to Consolidated Homeless Grant (CHG) grantees.[13]
  - The HEN Referral List (List) is held on a secure file site and contains personally identifying information and contact information for everyone in Washington State who has a HEN referral from DSHS.[13] It is updated monthly, and HEN local service providers with approved access can sort the list by county and review names of people in their service area.[13]
  - The List is meant to assist local service providers in conducting outreach to people with a HEN referral who are experiencing houselessness.[13] However, the CHG grant terms do not require local service providers to take any action with the information on the List.[13] Key informants from Commerce stated that the List was created by DSHS at a time when local service providers had capacity to assist

[c] The formal name of DSHS's program is the "HEN Referral program". However, the term "HEN referral" is also used more broadly as there are 3 ways a person may receive a referral from DSHS. Therefore, to distinguish between the formal DSHS program and a HEN referral more broadly, this Health Impact Review uses: "HEN incapacity program" to specifically discuss the DSHS program that provides a HEN referral for adults with low-income who are unable to work for at least 90 days due to a physical or mental incapacity; and, "a HEN referral" to discuss when a person receives a referral by receiving the ABD cash assistance program, by receiving the PWA cash assistance program, or by being determined eligible based on an incapacity.

additional people, but that is not the case currently as many local jurisdictions have waiting lists or pools due to limited funding and, therefore, inability to add more clients to their caseloads (personal communication, Commerce, March 2025).

- In 2020, through the state operating budget (ESSB 6168; Chapter 357, Laws of 2020), the Washington State Legislature provided Commerce $5 million to conduct a pilot program to address housing needs of adults with low- or extremely low-incomes who are elderly or disabled and who are receiving federal SSI, Social Security Disability Insurance (SSDI), or Social Security Retirement Income benefits and living in Clark, King, Kitsap, Pierce, Snohomish, or Thurston counties (SSI Bridge Pilot Program).
  - In 2021, the state operating budget (ESSB 5092; Chapter 334, Laws of 2021) provided Commerce $5 million to continue the SSI Bridge Pilot Program through the 2021-2023 biennium.
  - In 2023, the state operating budget (ESSB 5187; Chapter 475, Laws of 2023) did not provide Commerce dedicated funding for the SSI Bridge Pilot Program. However, the operating budget specified that Commerce may use appropriated HEN funds to continue the pilot program.
- Washington State law (Chapter 49.60 RCW) prohibits discrimination in real property transactions, including rental of real property, due to race, creed, color, national origin, citizenship or immigration status, families with children, sex (or gender),[d] marital status, sexual orientation, age, honorably discharged Veteran or military status, or the presence of any sensory, mental, or physical disability or the use of a trained dog guide or service animal by a person with a disability.[14]
- RCW 59.18.255 prohibits landlords subject to the Residential Landlord-Tenant Act (RLTA) from discriminating against an otherwise eligible tenant or prospective tenant based on the source of income.[15]
  - The "source of income" includes benefits or subsidy programs administered by any federal, state, local, or nonprofit entity.[15]
  - Discrimination can take one of many forms including refusal to lease or rent a property; expelling a prospective or current tenant from the property; making any distinction, discrimination, or restriction in the price, terms, conditions, fees, or privileges relating to the rental, lease, or occupancy; etc.[15]

Other jurisdictions

- Federal social security benefits:
  - The federal SSI program guarantees a minimum level of income for people who are aged, blind, or disabled.[16] The intent of the SSI program is to act as a safety net for people who have limited resources and little or no Social Security income or other income.[16] In 2025, an SSI eligible individual may receive a monthly maximum benefit amount of $967.[17]

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[d] We recognize that sex and gender are distinct and separate, where gender is a social construct used to classify a person as a man, woman, or some other identity. It is fundamentally different from the sex one is assigned at birth. However, RCW 49.60.040 defines sex to mean "gender."

  - SSDI may provide monthly payments to people who have a disability that stops or limits their ability to work.[18] People may be eligible for SSDI if they have a disability or blindness and sufficient work history.[18] People may be able to receive SSDI and SSI at the same time.[18]
  - Social Security Retirement benefit eligibility is based on work history.[19] Most employers take Social Security taxes out of a person's paycheck, and the person may receive a monthly check that replaces part of their income if they reduce work hours or stop working altogether.[19]
- On March 24, 2025, the U.S. Departments of Housing and Urban Development (HUD) and Homeland Security (DHS) signed the "American Housing Programs for American Citizens" Memorandum of Understanding (MOU).

Summary of House Committee Striker 1986.1

- Expands eligible uses of HEN funds by:
  - Allowing Commerce to distribute HEN funds to adults with low- or extremely low-incomes who are elderly or disabled and transitioning off HEN benefits, receiving federal social security benefits, and experiencing an immediate housing need, without referral from DSHS.
  - Requiring local service providers to verify HEN referrals from DSHS for rental assistance every 12 months.
  - Permitting direct cash assistance as an allowable expense only when it addresses a need identified in a person's housing stability plan.
    - Specifies that direct cash assistance may be provided through debit cash cards or other forms of flexible funding assistance, including vouchers for transportation, gift cards, direct payments to vendors, and other similar methods of assistance.
  - Expanding HEN eligibility for victims of human trafficking as defined in RCW 74.04.005.
  - Removing the eligibility requirement that a person must be a U.S. citizen, an alien lawfully admitted for permanent residence, or otherwise residing in the U.S. under color of the law.
- Directs Commerce to align the administration rate for HEN with other home security funded programs.

Health impact of House Committee Striker 1986.1

Evidence indicates that House Committee Striker 1986.1 may result in some local service providers distributing HEN funds for expanded eligible uses, which may increase financial and housing stability, improve health outcomes, and decrease inequities for some people who receive HEN services.

Pathway to health impacts
The potential pathway leading from provisions of House Committee Striker 1986.1 to health and equity are depicted in Figure 1. We have made the informed assumption that expanding eligible uses of HEN funds by: 1) Allowing Commerce to distribute HEN funds, without referral from DSHS, to certain people transitioning off HEN; 2) Requiring local service providers to verify HEN eligibility every 12 months; 3) Permitting local service providers to provide direct cash assistance, in certain circumstances; and 4) Expanding HEN eligibility for victims of human trafficking would likely result in DSHS conducting rulemaking and Commerce issuing guidance to local service providers about expanded eligible uses of HEN funds. We have made the informed assumption that DSHS conducting rulemaking and Commerce issuing guidance to local service providers about expanded eligible uses of HEN funds may result in some local service providers distributing HEN funds for expanded eligible uses. We have also made the informed assumption that local service providers distributing HEN funds for expanded eligible uses may increase financial and housing stability for some people who receive HEN services. These assumptions are based on information from key informants. There is very strong evidence that increasing financial and housing stability would likely improve health outcomes[1,3,20-30] and decrease inequities for some people who receive HEN services.[1,3,8,10,12,31-53]

Scope
Due to time limitations, we only researched the most linear connections between provisions of the proposal and health and equity and did not explore the evidence for all possible pathways. For example, we did not evaluate potential impacts related to:

- HEN administration rate. House Committee Striker 1986.1 directs Commerce to align the administration rate for HEN with other home security funded programs. This change would raise the administration rate for HEN local service providers from 7% to 15% to align with the administration rate for programs funded through the Home Security Fund.[5] This Health Impact Review did not evaluate how changes to the HEN administration rate may impact local service providers or HEN funding allocations.

- DSHS technology systems. Key informants from DSHS stated that the agency uses an Automated Client Eligibility System (DSHS ACES) to determine eligibility and issue benefits for cash, food, and medical assistance (personal communication, DSHS, March 2025). DSHS ACES is programmed to support staff in eligibility determinations and allows for managing a household's eligibility for multiple assistance programs, as applicable (personal communication, DSHS, March 2025). If House Committee Striker 1986.1 were to pass, DSHS anticipates DSHS ACES would need to be updated to accommodate expanded HEN eligibility criteria (personal communication, DSHS, March 2025). Specifically, DSHS noted that provisions related to citizenship and immigration status requirements and victims of human trafficking could require changes to DSHS ACES (personal communication, DSHS, March 2025). See Additional Considerations on page 34 for further discussion about potential impacts due to immigration status. In the fiscal note for House Committee Striker 1986.1, DSHS stated that "[s]ystems and training would be need to be updated to support the implementation of this [proposal] even if the number of [people] eligible for a HEN referral under the expansion would be small."[54] For example, DSHS may need to modify eligibility processing rules, data elements,

databases, interfaces, and various client letters.[54] Key informants stated that DSHS is currently updating DSHS ACES to comply with multiple changes from the federal administration and would be unable to make potential changes, if House Committee Striker 1986.1 were to pass, until December 2027 (which exceeds the 90-day implementation date for the proposal) (personal communication, DSHS, March 2025). This Health Impact Review did not assess potential impacts of House Committee Striker 1986.1 on DSHS technology systems or DSHS's ability to meet the proposal's implementation date.

- Medical Care Services (MCS) Program. The MCS Program is administered by DSHS; the Washington State Health Care Authority (HCA) provides health coverage through Apple Health (Medicaid) (personal communication, DSHS, March 2025). The MCS Program provides healthcare coverage to adults who receive ABD cash assistance, adults eligible for the HEN incapacity program, or victims of human trafficking who receive SFA; who are unable to access other Apple Health programs due to their citizenship and immigration status; and who are not residing in a public institution (WAC 182-508-0005).[55] If HEN eligibility is expanded, eligibility for the MCS Program would also expand and more people may move onto the MCS Program (personal communication, DSHS, March 2025). Enrollment in the MCS Program is capped. Therefore, depending on the potential increase in enrollment, people may be disenrolled from or not receive coverage if the cap is reached (personal communication, DSHS, March 2025). This Health Impact Review did not evaluate potential impacts or access to health coverage under the MCS Program.

Magnitude of impact
House Committee Striker 1986.1 relates to the Essential Needs and Housing Support (HEN) program and would impact people who may be eligible for a HEN referral as well as people who receive a HEN referral and people who receive HEN services.

HEN provides funding to local service providers to support people referred to HEN by DSHS with time-limited rental assistance, services connected to housing stability, and limited essential needs items, such as personal hygiene items and transportation.[5] DSHS determines a person's eligibility for HEN. People may receive a HEN referral from DSHS in 3 ways: by receiving the ABD cash assistance program, by receiving the PWA cash assistance program, or by being determined eligible based on an incapacity (personal communications, DSHS, April 2025). People must meet specified eligibility criteria for each program. Once a person receives a HEN referral from DSHS, they may choose to connect with local service providers to determine whether they may receive HEN services (e.g., housing assistance, essential needs).

To apply for ABD or PWA, a person may submit an application for cash assistance (in person, online, or by fax, mail, or phone) and complete a financial interview in person or by phone (personal communication, DSHS, March 2025). DSHS's Economic Security Administration's (ESA) Community Services Division provides direct client services to the public through a network of 52 local Community Services Offices (CSOs), including 38 full-service offices and 14 branch offices.[56] Nearly all (i.e., close to 100%) of referrals for ABD, PWA, and the HEN

incapacity program are issued through ESA's CSOs.[8,10,12] Referrals may also be issued by Customer Service Contact Centers (CSCC), DSHS's Aging and Long-Term Support Administration's (ALTSA) Home and Community Service Offices (HCS), DSHS's Developmental Disability Administration (DDA), or Port Gamble S'Klallam Tribe.[8,10,12]

People who are aged, blind, or disabled will first be considered for ABD as a priority program (personal communication, DSHS, April 2025). If a person does not meet the eligibility criteria for ABD, or the severity or duration of a person's physical or mental health condition does not meet ABD eligibility criteria, and they claim an incapacity, the person will be considered for the HEN incapacity program (personal communication, DSHS, April 2025). Similarly, for people who are pregnant, they will first be considered for TANF as a priority program; if the person does not meet TANF eligibility criteria, they will be considered for PWA (personal communication, DSHS, April 2025).

If a person meets financial eligibility for ABD cash assistance and the HEN incapacity program, they will be referred to a social worker to begin the process to determine if they meet disability or incapacity eligibility based on program requirements (personal communication, DSHS, April 2025). DSHS conducts a review of a person's financial eligibility every 12 months (personal communication, DSHS, March 2025). DSHS conducts a review of a person's disability status for ABD every 24 months or their incapacity status for the HEN incapacity program every 12 months (personal communication, DSHS, April 2025). Depending on DSHS's review, people may transition from the HEN incapacity program to ABD (personal communication, DSHS, April 2025).

Once a person goes through the process and is deemed eligible for ABD, PWA, or the HEN incapacity program, they receive a HEN referral and a letter from DSHS providing the name and contact information for the HEN local service provider in their county (personal communication, DSHS, March 2025). If the person chooses to connect with the local service provider, the local service provider will verify whether a person has an active HEN referral from DSHS and will conduct an intake process to determine if a person is eligible for locally provided essential needs or housing assistance (personal communications, March 2025). This process is unique to each county (personal communications, March 2025). For example, due to high volume, King County currently adds people to a rental interest list and prioritizes new HEN enrollments by date added to the list (personal communication, Catholic Community Services [CCS], March 2025). Kitsap and Thurston Counties use a vulnerability assessment tool to determine a score to place people on a waitlist for HEN services (personal communication, CCS, March 2025).

People who receive a HEN referral

DSHS ESA maintains data related to HEN referrals but does not have data related to which referrals may result in a connection with local service providers (personal communication, DSHS, April 2025). People may receive a HEN referral from DSHS in 3 ways: by receiving the ABD cash assistance program, by receiving the PWA cash assistance program, or by being determined eligible based on an incapacity (personal communications, DSHS, April 2025). People must meet specified eligibility criteria for each program. People who are deemed eligible for ABD and PWA receive cash assistance and a HEN referral. People deemed eligible for the HEN incapacity program receive a HEN referral. Combining the total number of people deemed

eligible for each program provides a full picture of the total number of people who receive a HEN referral and, therefore, the total pool of people who might receive HEN services (personal communication, DSHS, April 2025).

ABD

In SFY 2024, 47,496 people received ABD assistance[10] and, therefore, a HEN referral. A monthly average of 30,870 people received ABD, including: 23,567 people who were likely to meet SSI disability criteria; 6,182 people who were aged; 1,120 people who were disabled; and 2 people who were blind.[10] The monthly average of ABD recipients increased 12.8% from SFY 2023.[10]

Based on data from June 2024, the majority of people receiving ABD assistance were male (52.5%), non-Hispanic white (54.1%), never married (48.0%), and an average age of 49.9 years.[10] About 55.5% of ABD recipients had a mental disability and 24.2% had a physical disability.[10] About 28.4% of ABD recipients self-reported experiencing homelessness[e].[10] On average, people remain on ABD for 27.3 months.[10]

PWA

In SFY 2024, 52 people received PWA[12] and, therefore, a HEN referral. A monthly average of 17 people received PWA, an increase from 0 people in SFY 2023.[12] In June 2024, all PWA recipients were female and the majority were non-Hispanic white (38.5%), never married (73.1%), and an average age of 34.5 years.[12] About 19.2% of PWA recipients self-reported experiencing homelessness.[12] On average, people remain on PWA for 6.3 months.[12]

Incapacity

In SFY 2024, 6,673 people received HEN incapacity program[f] assistance[8] and, therefore, a HEN referral. An average of 2,710 people received HEN incapacity program assistance each month, a 6.6% decrease from SFY 2023.[8]

In June 2024, the majority of people receiving HEN incapacity program assistance were male (64.5%), non-Hispanic white (64.4%), never married (61.6%), and an average age of 41.5 years.[8] About 76.7% of people who received HEN incapacity program assistance had a mental disability and 23.2% had a physical disability.[8] About 48.8% of people self-reported experiencing homelessness.[8] On average, people receive HEN incapacity program assistance for 7.9 months.[8]

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[e] DSHS defines homeless (based on the self-reported living arrangement code in DSHS ACES) as "homeless without housing, homeless with housing (staying temporarily with family or friends—commonly referred to as 'couch surfing'), emergency shelter, or domestic violence shelter". This Health Impact Review retains the term "homeless" as needed for program accuracy and uses the term "houselessness" where possible to reflect preferred language.

[f] The formal name of DSHS's program is the "HEN Referral program". However, the term "HEN referral" is also used more broadly as there are 3 ways a person may receive a referral from DSHS. Therefore, to distinguish between the formal DSHS program and a HEN referral more broadly, this Health Impact Review uses: "HEN incapacity program" to specifically discuss the DSHS program that provides a HEN referral for adults with low-income who are unable to work for at least 90 days due to a physical or mental incapacity; and "a HEN referral" to discuss when a person receives a referral by receiving the ABD cash assistance program, by receiving the PWA cash assistance program, or by being determined eligible based on an incapacity.

DSHS also reported data from February 2025 (the most recent full month of data available) related to housing instability for people who receive HEN incapacity program assistance. In February 2025, there were 2,714 people who received HEN incapacity program assistance, of which 1,270 people (46.8%) were experiencing homelessness and 1,444 people (53.2%) were not experiencing homelessness.[31] Among people experiencing homelessness, 704 people (55.4%) were homeless without housing (i.e., lacked a fixed, regular, and adequate nighttime residence and indicated that they did not have a place to stay at the time of report); 552 (43.5%) were homeless with housing (i.e., did not have a fixed regular nighttime residence, but indicated they had a place to stay at the time of report [e.g., "couch surfing"]); and 13 (1.0%) were staying at an emergency shelter (i.e., resided at a publicly or privately operated temporary shelter).[31]

Based on collective ABD, PWA, and HEN incapacity program data, 54,221 people received a HEN referral in SFY 2024. About 87.6% of HEN referrals were people who received ABD; 12.3% were people eligible due to an incapacity; and less than 1% were people who received PWA.

People who receive HEN services

Once a person receives a HEN referral from DSHS, they may choose to connect with local service providers to determine whether they may receive HEN services (e.g., housing assistance, essential needs). Due to current HEN funding limitations, local service providers can only serve about 3,500 people per year (personal communications, March 2025). In SFY 2024, 3,975 people (7.33% of people who received a HEN referral) received HEN services: 2,199 people received Homelessness Prevention assistance and 1,776 people received Rapid Rehousing assistance (personal communication, Commerce, April 2025). Demographic information for people who receive HEN services is not readily available.

Key informants stated that the majority of people who receive HEN services are ABD recipients, as ABD is the way most people receive a HEN referral from DSHS (personal communications, March 2025). For example, in King County, 95% of people who receive HEN services also receive ABD assistance (personal communication, CCS, March 2025). Very few victims of human trafficking apply for a HEN referral and, therefore, receive HEN services (personal communications, March 2025).

Overall, House Committee Striker 1986.1 has the potential to affect people who may be eligible for a HEN referral as well as people who receive a HEN referral and people who receive HEN services.

Logic Model

Expands eligible uses of HEN funds by:

- **Allowing Commerce to distribute HEN funds, without referral from DSHS, to certain people transitioning off HEN**
- **Requiring local service providers to verify HEN eligibility every 12 months**
- **Permitting local service providers to provide direct cash assistance, in certain circumstances**
- **Expanding HEN eligibility for victims of human trafficking**

DSHS conducts rulemaking and Commerce issues guidance to local service providers about expanded eligible uses of HEN funds

Some local service providers distribute HEN funds for expanded eligible uses

Increased financial and housing stability for some people who receive HEN services

Improved health outcomes for some people who receive HEN services

Decreased inequities for some people who receive HEN services

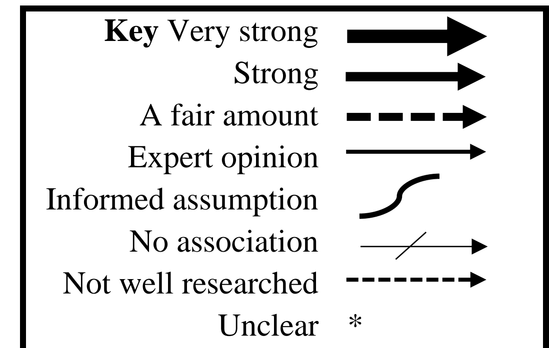

Figure 1:

Supporting economic security by updating provisions related to the home security fund and the essential needs and housing support program

House Committee Striker 1986.1

Summaries of Findings

Would expanding eligible uses of Essential Needs and Housing Support (HEN) program funds by: 1) Allowing Washington State Department of Commerce (Commerce) to distribute HEN funds, without referral from Department of Social and Health Services (DSHS), to certain people transitioning off HEN; 2) Requiring local service providers to verify HEN eligibility every 12 months; 3) Permitting local service providers to provide direct cash assistance, in certain circumstances; and 4) Expanding HEN eligibility for victims of human trafficking result in DSHS conducting rulemaking and Commerce issuing guidance to local service providers about expanded eligible uses of HEN funds?
We have made the informed assumption that expanding eligible uses of HEN funds by: 1) Allowing Commerce to distribute HEN funds, without referral from DSHS, to certain people transitioning off HEN; 2) Requiring local service providers to verify HEN eligibility every 12 months; 3) Permitting local service providers to provide direct cash assistance, in certain circumstances; and 4) Expanding HEN eligibility for victims of human trafficking would likely result in DSHS conducting rulemaking and Commerce issuing guidance to local service providers about expanded eligible uses of HEN funds. This assumption is based on information from key informants from Commerce and DSHS.

Commerce administers HEN and distributes funds in the form of grants to designated agencies in each county (RCW 43.185C.220). Key informants stated that, generally, grants are distributed to county governments, which fund community-based organizations (i.e., local service providers) to support people referred to HEN by DSHS with time-limited rental assistance, services connected to housing stability, and limited essential needs items (personal communications, March 2025).[5] Commerce issues guidance about eligible uses of HEN funds to local service providers, which specifies that HEN funds can be used for rent, utilities, case management, essential needs items, and operations and administrative costs (personal communication, Commerce, March 2025). Key informants from local service providers stated that Commerce provides general guidance about eligible uses of HEN funds, which allows counties to prioritize use of HEN funds to meet community needs (personal communications, March 2025).

Under RCW 74.04.805, DSHS is responsible for determining a person's eligibility for a HEN referral. Specifically, people may be eligible for a HEN referral when they:

- Have been deemed eligible for the Aged, Blind, or Disabled (ABD) Assistance Program or the Pregnant Women Assistance (PWA) Program (RCW 74.62.030), or
- Are unable to work for at least 90 days due to a physical incapacity, mental incapacity, or substance use disorder (SUD) (WAC 388-447-0001);[8,9] and
- Are a U.S. citizen, an alien lawfully admitted for permanent residence, or otherwise residing in the U.S. under color of the law[g], or are a victim of human trafficking as defined in RCW 74.04.005;

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[g] Key informants stated that "Permanently Residing Under Color of Law" (PRUCOL) is outdated terminology used within the context of public benefits eligibility, and it is not a formal immigration status (personal communications, DSHS, March 2025). It refers to non-citizens who are legally residing in the U.S. with the knowledge of the U.S. Citizenship and Immigration Services (USCIS) and whose departure is not being actively pursued (personal communication, DSHS, April 2025).

- Have provided their Social Security Number (SSN) to DSHS, with some exceptions;
- Have countable monthly income at or below 100% of the federal poverty level (FPL) or meet income eligibility for the PWA Program;
- Do not have resources in excess of those described in RCW 74.04.005; and
- Are not eligible for federal aid assistance other than basic food benefits and medical assistance.

House Committee Striker 1986.1 would expand eligible uses of HEN funds. In 2020, through the state operating budget (ESSB 6168; Chapter 357, Laws of 2020), the Washington State Legislature provided Commerce $5 million to conduct a pilot program to address housing needs of adults with low- or extremely low-incomes who are elderly or disabled and who are receiving federal Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), or Social Security Retirement Income benefits and living in Clark, King, Kitsap, Pierce, Snohomish, or Thurston counties (SSI Bridge Pilot Program). Prior to the SSI Bridge Pilot Program beginning in 2020, based on HEN eligibility criteria, a person receiving HEN services would no longer qualify for assistance once they received federal social security benefits (i.e., federal aid assistance other than basic food benefits and medical assistance) (personal communications, March 2025). The SSI Bridge Pilot Program was intended to create a "bridge" using HEN funds to pay rent so that people who receive federal social security benefits can remain housed until they find another stable housing opportunity that is affordable on their federal benefit amount (personal communications, March 2025). In 2023, the Legislature specified that Commerce may use appropriated HEN funds to continue the pilot program (ESSB 5187; Chapter 475, Laws of 2023). House Committee Striker 1986.1 would allow Commerce to distribute HEN funds, without referral from DSHS, to certain people transitioning off HEN. Key informants stated that this change would expand the SSI Bridge Pilot Program statewide, allowing counties not part of the pilot program to use HEN funds to support people who receive HEN services once they begin receiving federal social security benefits (personal communications, March 2025).

Second, Commerce requires HEN lead/subgrantees (i.e., local governments or local service providers) to document recertification of the household's HEN referral from DSHS as documented in the Benefits Verification System (BVS) at least every 3 months.[57] House Committee Striker 1986.1 would extend the verification requirement to every 12 months.

Third, RCW 43.185C.220 prohibits the use of HEN funds to provide direct cash assistance. House Committee Striker 1986.1 would permit direct cash assistance as an allowable expense only when it addresses a need identified in a person's housing stability plan. Specifically, direct cash assistance would be allowed through the provision of debit cash cards or other forms of flexible funding assistance, including vouchers for transportation, gift cards, direct payments to vendors, and other similar methods of assistance.

Fourth, victims of human trafficking are currently eligible for a HEN referral if they receive ABD, PWA, or experience a physical or mental incapacity. House Committee Striker 1986.1 would expand HEN eligibility for victims of human trafficking by expanding the primary categories of HEN eligibility to include victims of human trafficking (in addition to the 3 ways people may currently receive a HEN referral from DSHS).[54] By removing the requirement that

victims of human trafficking receive ABD, PWA, or experience a physical or mental incapacity to be eligible for a HEN referral, key informants stated all victims of human trafficking may be eligible for a HEN referral if they also met additional eligibility criteria (income and resource eligibility, etc.) (personal communications, March 2025).

Lastly, House Committee Striker 1986.1 would remove the HEN eligibility requirement that a person must be a U.S. citizen, an alien lawfully admitted for permanent residence, or otherwise residing in the U.S. under color of the law. However, key informants stated that eliminating the citizenship and immigration status eligibility requirement under House Committee Striker 1986.1 would have no impact on HEN eligibility because the proposal retains the requirement that a person provide their SSN to DSHS (personal communications, March 2025). See Additional Considerations on page 34 for further discussion about potential impacts due to immigration status.

Since House Committee Striker 1986.1 impacts HEN eligibility requirements, key informants from DSHS stated they would need to conduct rulemaking to update WAC 388-400-0070 and other related rules, as required (personal communication, DSHS, March 2025). Additionally, key informants from Commerce stated that, if the proposal were to pass, Commerce would update existing guidance to reflect expanded eligible uses of HEN funds to guide local service providers in delivering HEN services (personal communication, Commerce, March 2025).

Therefore, we have made the informed assumption that, if House Committee Striker 1986.1 were to pass, DSHS would likely conduct rulemaking and Commerce would likely issue guidance to local service providers about expanded eligible uses of HEN funds.

Would DSHS conducting rulemaking and Commerce issuing guidance to local service providers about expanded eligible uses of HEN funds result in some local service providers distributing HEN funds for expanded eligible uses?

We have made the informed assumption that DSHS conducting rulemaking and Commerce issuing guidance to local service providers about expanded eligible uses of HEN funds may result in some local service providers distributing HEN funds for expanded eligible uses. This assumption is based on information from key informants.

RCW 43.185C.220 specifies that HEN local service providers must prioritize housing support: first, for people experiencing houselessness and, second, for people who are at substantial risk of losing stable housing without housing support within the next 30 days. Specifically, Rapid Rehousing assistance serves people who are experiencing homelessness, and Homelessness Prevention assistance offers rental assistance to people who may be at risk of homelessness (personal communication, Commerce, March 2025). RCW 43.185C.220 further states that funds should be used "as flexibly as is practicable to provide essential needs items and housing support" to people who receive HEN services.

Key informants stated that the funding appropriation for HEN is limited and insufficient to meet the potential need for the program (personal communications, March 2025). For example, statewide, the total HEN-eligible population is approximately 49,400 people (unpublished data, Commerce, April 2025). Within this group, an estimated 17,500 people experience housing

instability and may qualify for HEN rental assistance (unpublished data, Commerce, April 2025). However, due to current funding limitations, local service providers can only serve about 3,500 people per year (personal communications, March 2025). In SFY 2024, 3,975 people (7.33% of people who received a HEN referral) received HEN services (personal communication, Commerce, April 2025). Counties may operate a waitlist, wait pool, or use a first-come, first-served system to provide HEN services (personal communication, Commerce, March 2025). Key informants stated that prioritization of how to use HEN funds and who to assist is localized so that local service providers can connect people with needed services (personal communication, Commerce, March 2025).

House Committee Striker 1986.1 would provide local service providers flexibility and the option to use funding for expanded eligible uses (personal communications, March 2025). All key informants stated flexibility and options are beneficial to meet the needs of their communities and that, if House Committee Striker 1986.1 were to pass, some local service providers would distribute HEN funds for expanded eligible uses (personal communications, March 2025).

Specifically, key informants from local service providers stated that counties would likely distribute funds to implement the SSI Bridge Pilot Program if it were expanded statewide (personal communications, March 2025). Key informants shared that local service providers in counties not included in the pilot program have stated, if allowed, they would offer SSI Bridge assistance because they have invested so much into housing a person and do not want to see the person experience houselessness (personal communications, March 2025).

Therefore, we have made the informed assumption that allowing local service providers flexibility and the option to use HEN funds for expanded eligible uses would result in some local service providers distributing HEN funds for expanded eligible uses.

Would some local service providers distributing HEN funds for expanded eligible uses increase financial and housing stability for some people who receive HEN services?

We have made the informed assumption that local service providers distributing HEN funds for expanded eligible uses may increase financial and housing stability for some people who receive HEN services. This assumption is based on HEN program evaluations and information from key informants.

All key informants stated that expanded eligible uses outlined in House Committee Striker 1986.1 would increase financial and housing stability for some people who currently receive HEN services (personal communications, March 2025). However, key informants stated that provisions would also limit the number of new, additional people with a HEN referral from DSHS that may receive HEN services (personal communications, March 2025). Key informants stated that, with the current funding appropriation for HEN, there is insufficient funding for people who currently receive a HEN referral or for people who may be eligible for a HEN referral based on provisions of House Committee Striker 1986.1 (personal communications, March 2025). Moreover, key informants stated that some expanded eligible uses may “lock up” HEN funds by allowing people who receive HEN services to receive assistance for longer periods of time (personal communication, Commerce, March 2025). For example, if a local service provider uses HEN funds to continue to support people who receive HEN services once

they begin receiving federal social security benefits, the person currently receiving HEN services may experience increased housing stability, but funding will remain with that person rather than freeing up to provide HEN services to new, additional people with a HEN referral from DSHS (personal communication, Commerce, March 2025). Key informants from local service providers stated that expanded eligible uses may result in lengthier waitlists in more counties (personal communication, CCS, March 2025).

There have been 2 program evaluations of HEN. In January 2013, following the first year of implementation, a program evaluation assessed the impact of HEN services on measures of well-being over a 6-month follow-up period.[6] Compared to 2 statistically well-matched comparison groups, people who received HEN services experienced greater housing stability, remained connected to Basic Food assistance at significantly higher rates, and were less likely to be incarcerated in a state Department of Corrections (DOC) facility.[6] Compared to cash assistance programs, HEN reduced participant housing instability by 18% and reduced participant prison incarceration by 86%.[58]

Results of a recent third-party HEN program evaluation are expected to be released in 2025 (personal communications, March 2025). Preliminary results suggest that people receiving HEN rental assistance have improved housing outcomes (unpublished data, Commerce, March 2025). For example, the Homelessness Prevention assistance group (i.e., assistance for people at risk of homelessness) had a higher percentage of people who were no longer unstably housed compared to a matched comparison group (unpublished data, Commerce, March 2025). Similarly, people receiving Rapid Rehousing assistance (i.e., assistance for people who are experiencing homelessness) and who had a move-in date were less likely to be homeless 12 months after the month of HEN enrollment compared to the comparison group (unpublished data, Commerce, March 2025). More than a third of people who receive HEN services stated that the largest benefit of HEN services was rental assistance and resulting housing stability (unpublished data, Commerce, March 2025). About 25% of people who receive HEN services stated that the largest benefit was preventing homelessness or eviction (unpublished data, Commerce, March 2025).

Key informants also suggested that provisions of House Committee Striker 1986.1 may increase housing stability for some people who receive HEN services (personal communications, March 2025). For example, key informants specifically stated that the proposal would improve housing stability for people who begin receiving federal social security benefits and would otherwise transition off HEN (personal communications, March 2025). Prior to the SSI Bridge Pilot Program beginning in 2020, a person receiving HEN services would no longer qualify for assistance once they received federal social security benefits (personal communications, March 2025). However, for example, SSI is not sufficient to pay rent, and people cannot rely on SSI to cover housing expenses (personal communications, March 2025). In 2025, an SSI eligible individual receives a monthly maximum benefit amount of $967,[17] regardless of where in the U.S. they live (personal communications, March 2025). In 2023 (the most recent data available), the median gross rent in Washington State was $1,682, which was $198 higher than in 2021 and above the national median gross rent of $1,348.[33,59] Therefore, people who may rely on SSI may be unable to afford rents in Washington State.

The intent of the SSI Bridge Pilot Program was to create a "bridge" by using HEN funds to pay rent so that people who receive federal social security benefits can remain housed until they are able to find another opportunity for stable housing that they can afford on their federal benefit amount (personal communications, March 2025). Key informants from local service providers participating in the SSI Bridge Pilot Program noted that, with the pilot program, most people do not transition off HEN (personal communications, CCS, March 2025). A recent HEN program evaluation found that the SSI Bridge Pilot Program helped keep people housed who would have otherwise lost their housing after they started receiving federal social security benefits (unpublished data, Commerce, March 2025).

Counties participating in the SSI Bridge Pilot Program have implemented the program differently based on the needs of people in their communities. In King, Kitsap, and Thurston Counties, people participating in the SSI Bridge Pilot Program must pay 30% of their income toward housing (personal communication, CCS, March 2025). Counties also pay different amounts toward rent. For example, King County pays up to 50% of Fair Market Rent (FMR) for a studio apartment ($1,119 per month for 2025), which allows local service providers to provide housing assistance to more people (personal communication, CCS, March 2025). Local service providers noted that, even with this additional rent assistance, it is challenging to find affordable units in safe and supportive areas and some people may continue to struggle to pay the balance of their rent (personal communication, CCS, April 2025). Some counties pay FMR, which may limit the number of people they can assist due to higher costs. Additionally, some counties have set time limitations for participation in the SSI Bridge Pilot Program. In Kitsap and Thurston Counties, people may participate in the SSI Bridge Pilot Program for 12 months (personal communication, CCS, March 2025). During this 12 month "bridge" period, local service providers work with the person to help find stable housing based on their federal benefit amount (personal communication, CCS, March 2025). In the past, some local service providers in smaller communities had a Memorandum of Understanding (MOU) with public housing authorities and were able to transition people to affordable housing (personal communication, CCS, March 2025). However, these types of MOUs were rare across the state and are not possible under recent actions by the U.S. Department of Housing and Urban Development (HUD) (personal communication, CCS, March 202 5).

Currently, Commerce requires local service providers to verify HEN eligibility every 3 months.[57] Key informants stated that this requirement presents multiple challenges (personal communications, Commerce, March 2025). HEN referrals from DSHS are for 12 months, and people who receive HEN services must recertify their HEN referral with DSHS every 12 months (personal communication, Commerce, March 2025). However, once a person receives a HEN referral, it may take multiple months to find housing (personal communication, Commerce, March 2025). Key informants stated that, with these overlapping timelines, people may only be able to receive housing assistance for a few months (e.g., 3-6 months) before they would need to submit materials for recertification (personal communication, Commerce, March 2025). In these cases, people may lose their existing housing (personal communication, Commerce, March 2025). Key informants also stated that it is challenging to find landlords willing to provide month-to-month or short-term rental agreements (personal communications, Commerce, March 2025). House Committee Striker 1986.1 would extend the requirement for local service providers to verify HEN eligibility from every 3 months to every 12 months, which could make it easier to

find housing (i.e., with standard 12-month rental agreements) and extend housing stability for people who receive HEN services (personal communication, Commerce, March 2025).

Some local service providers stated that they would continue to check HEN eligibility every month to ensure people they serve receive advance notice of the need to recertify with HEN referral with DSHS (personal communication, CCS, March 2025). One local service provider stated that changing the verification requirement from every 3 months to every 12 months would substantially reduce the paperwork burden on staff (personal communication, CCS, March 2025). Generally, key informants agreed that allowing flexibility for local service providers to determine what verification timeline works best for their program would be beneficial (personal communication, CCS, March 2025).

Key informants offered different perspectives on how permitting direct cash assistance may impact people who receive HEN services. Some key informants stated that direct cash assistance, if regular or ongoing, could count as income or resources, which could impact a person's income eligibility for ABD, PWA, HEN incapacity program[h], and other assistance programs (e.g., food benefits, Apple Health, additional programs administered by DSHS) (personal communication, DSHS, March 2025). In the fiscal note for House Committee Striker 1986.1, DSHS noted that "direct cash assistance is intended to provide clients with one-time or limited assistance for housing stability and support. Therefore, [DSHS's ESA] does not anticipate material impacts to client benefits."[54] Since bill provisions specify that direct cash assistance may only be provided when it addresses a need identified in a person's housing stability plan, some key informants stated that they anticipate direct cash assistance would be limited or infrequent and would likely not impact benefit program eligibility (personal communication, DSHS, March 2025).

Other key informants suggested that local service providers may provide direct cash assistance when they cannot meet the needs of client directly (personal communication, Commerce, March 2025). For example, there may be personal care items or culturally responsive items that a local service provider may not have access to or that a client may obtain more easily (personal communication, Commerce, 2025). However, key informants stated that Commerce currently permits flexible funding that local service providers may use to purchase essential needs items to provide to people who receive HEN services (personal communication, CCS, March 2025). They stated that counties may set different limits for how much funding may be used per person (personal communication, CCS, April 2025). While Commerce allows local service providers to spend up to $5,000 per person, key informants from local service providers noted that most programs do not have budgets to provide that level of support (personal communications, CCS, April 2025). Without additional HEN funding, local service providers might not use HEN funds to provide direct cash assistance, especially as purchasing debit cash cards could require additional program spending (activation fee, etc.) (personal communication, CCS, March 2025). However, key informants noted that additional flexibility to provide direct cash assistance may

[h] The formal name of DSHS's program is the "HEN Referral program". However, the term "HEN referral" is also used more broadly as there are 3 ways a person may receive a referral from DSHS. Therefore, to distinguish between the formal DSHS program and a HEN referral more broadly, this Health Impact Review uses: "HEN incapacity program" to specifically discuss the DSHS program that provides a HEN referral for adults with low-income who are unable to work for at least 90 days due to a physical or mental incapacity; and, "a HEN referral" to discuss when a person receives a referral by receiving the ABD cash assistance program, by receiving the PWA cash assistance program, or by being determined eligible based on an incapacity.

be helpful for some counties to meet the needs of community (personal communication, CCS, March 2025).

Lastly, key informants stated that very few victims of human trafficking apply for a HEN referral and, therefore, receive HEN services (personal communications, March 2025). Key informants from local service providers stated that victims of human trafficking may need other supports and assistance to remain stably housed (personal communication, CCS, March 2025). Generally, key informants stated that House Committee Striker 1986.1 would expand HEN eligibility for victims of human trafficking, but they anticipated the change may have limited impact for victims of human trafficking, especially since there are already large waitlists in many jurisdictions (personal communications, March 2025).

While House Committee Striker 1986.1 would likely increase financial and housing stability for some people who receive HEN services, key informants stated that it may also limit the number of potential new, additional people with a HEN referral from DSHS that may receive HEN services as funding may be tied up for longer periods of time for people already receiving HEN services (personal communications, March 2025). Overall, we have made the informed assumption that House Committee Striker 1986.1 may increase financial and housing stability for some people who receive HEN services.

Would increasing financial and housing stability for some people who receive HEN services improve health outcomes?

There is very strong evidence that improved financial and housing stability would likely improve health outcomes for some people who receive HEN services. Healthy People 2030 states that housing instability includes a range of challenges, including difficulty paying rent, spending a large percentage of household income on housing, overcrowding, frequent moves, forced evictions, and houselessness.[3] It is well-documented that housing instability, across the range of challenges, is associated with worse health outcomes.[1,3,20-30]

Generally, housing instability has been linked to mental health outcomes (i.e., depression, anxiety, stress, psychological health, mental health strain, suicide ideation, and death by suicide); substance use (i.e., alcohol use, drug use, high-risk behaviors like syringe sharing); general and physical health outcomes (i.e., poor self-reported health, high blood pressure, weight gain, chronic health concerns [e.g., hypertension, diabetes]); and death (i.e., cardiovascular disease [CVD]-related mortality, all-cause mortality).[23,26] Housing instability may also make it more difficult for people to access healthcare.[3] People experiencing housing instability who also have diabetes and CVD have been found to have higher acute healthcare use than those who do not experience housing instability.[23] Housing instability has also been associated with negative health outcomes in children, including chronic health conditions, poor physical health, physical abuse, hospitalization, poor diet, and high cortisol (a hormone indicating stress) levels.[3,26] Children who experience housing instability are also more likely to lack access to health insurance.[3] In addition, interventions to improve housing stability have shown decreases in negative health outcomes.[21] For example, results of a recent third-party HEN program evaluation found that people who received HEN services reported reduced stress and improved physical, mental, and spiritual health (unpublished data, Commerce, 2025).

Housing costs
Research shows that housing stability, cost of living, and healthcare needs are connected. Evidence indicates that people who are housing cost-burdened have limited finances available to spend on other needs such as healthcare, resulting in negative health outcomes.[23,24] Studies have also shown that severely housing cost-burdened renters spend "70% less on healthcare than the lowest-income renters who are not cost burdened."[1] A 2019 survey of 500 medical professionals found that "100% reported having patients express concerns about the cost of housing, and 92% of patients advised to reduce stress reported that personal finances were their biggest stressor."[24] Data also show that when housing needs are met, healthcare costs decrease.[24] One study found that "when previously cost-burdened renters gained access to affordable housing, outpatient care increased, and emergency care decreased – leading to an overall 12% decrease in Medicaid costs."[24]

Moving and relocation
Moving frequently has been shown to affect health outcomes. Research shows that "people who moved in the past [3] years for any reason were slightly more likely to be in poor or fair health, report anxiety attacks, and have depression than those with no [housing] instability."[25] Among people who moved, those who moved for financial reasons were "2.6 times more likely to report fair or poor health, 2.5 times more likely to experience an anxiety attack, and nearly twice as likely to experience depression than those with no [housing] instability."[25] In contrast, social connectedness is associated with better health,[4] and moving frequently can affect social connectedness. Some studies have shown that students who change schools several times are more likely to be behind their peers in reading and math and are more likely to repeat a grade.[25] Research also shows that policies that benefit tenants who stay in rent-stabilized units may lead to those tenants remaining in their unit for longer periods of time, which could lead to improved neighborhood stability, community continuity, aging in place, retention of a workforce in high-cost cities, and associated health and social benefits.[24,25]

Eviction
Researchers have noted, "of all scenarios that can be described as housing insecurity, risk of losing one's dwelling or being evicted is one of the most important."[27] While eviction is typically included as a measure of housing instability, evidence "generally support[s] the idea of forced housing loss as a unique stressor that affects physical and physiological functioning."[26] Researchers have noted 3 main pathways between eviction and health outcomes: 1) psychosocial stress; 2) environmental exposures related to substandard housing; and 3) exposure to disease.[26]

<u>Psychosocial stress</u>
Eviction is linked to numerous health outcomes.[26-28] A systematic review of 47 articles published through March 2016 evaluating the impact of eviction on health found a "general consensus that [people] under threat of eviction present negative health outcomes, both mental (e.g., depression, anxiety, psychological distress, and [death by suicide]) and physical (poor self-reported health, high blood pressure, and child maltreatment)."[27] The review found that being evicted is related to higher risk of depression and anxiety, psychological distress, and death by suicide.[27] People who experienced eviction were also at greater risk for substance misuse (e.g., alcohol, tobacco, other drugs) and food insecurity.[27] Additionally, "some qualitative studies reported that [threats of eviction] are experienced by [people] as a personal failure and as a concealable stigma, leading

to feelings of insecurity, embarrassment, isolation, and having a lack of control of key aspects of daily living."[27] Authors noted that these feelings can further contribute to anxiety, depression, and suicide ideation.[27] Other research has found that threat or loss of housing due to eviction can "lead to increased rumination, hopelessness, anxiety, depression, and risk of suicide. This stress can be compounded by the experience of social stigma associated with eviction and housing loss."[26] Stigma can increase mental health impacts as well as result in disrupted sleep quality, hormonal changes, and reduced immune function.[26]

A longitudinal study of tenants older than 18 years of age who appeared in eviction court from March 2017 to October 2018 in New Haven, Connecticut, and had been issued an eviction notice due to non-payment of rent or a lease violation, found that "one-third of participants screened positive for major depressive disorder and over one-third screened positive for [posttraumatic stress disorder (PTSD)] and/or generalized anxiety disorder at baseline; while these rates did decrease over time, many participants continued to report problems (15-19% screened positive for at least [1] of these disorders at 9 months)".[29] In addition, 17% of participants reported suicide ideation at baseline, and "evictions have [been] found to be a precipitating factor for [death by suicide]."[29] Mental health symptoms were similar between people that had to move and people that did not have to move, suggesting "participants are already very distressed with high rates of mental health problems during presentation to eviction court."[29] While people with severe mental illness are often evicted for their disability status,[29] these findings could also suggest that people may experience mental health impacts from involvement in the eviction process regardless of the outcome of court proceedings.

Additionally, a nationally-representative longitudinal study of young adults found a positive association between eviction history and depressive risk, such that young adults who experienced eviction had statistically significantly more depressive symptoms than young adults who were not evicted.[26] This relationship persisted over time, and:

> the longitudinal associations between changes in eviction and changes in depressive risk persisted after adjusting for other markers of household and neighborhood socioeconomic conditions as well as measures of housing and financial insecurity, which would suggest that eviction serves as a particular salient health risk among young adults.[26]

The authors also found a strong positive association between eviction history and self-reported health.[26] For example, people experiencing eviction were more likely to report poor or fair health compared to those who did not experience eviction.[26]

Environmental exposures related to substandard housing

Increased environmental exposures (e.g., lead, asthma irritants, asbestos) result from increased risk of exposure to substandard housing or becoming houseless as a result of eviction.[26] Eviction also increases the risk of experiencing houselessness,[30] particularly for families with children.[28] A study in Seattle found that most people who were evicted became houseless, with 37.5% of people completely unsheltered, 25% living in a shelter or transitional housing, and 25% staying with family or friends.[30] Only 12.5% of respondents who were evicted moved into another apartment or home.[30]

Exposure to disease

Lastly, eviction can directly increase a person's exposure to infectious disease risks.[26] For example:

> Upon experiencing eviction, individuals and families may seek shelter in crowded, unsafe situations. This can include homeless shelters, doubling up (moving in with friends or family), or seeking alternative accommodations in one's vehicle or on the street. Any of these options can lead to increased exposure to those infectious diseases that continue to disproportionately affect [people experiencing houselessness] such as HIV, Hepatitis B, Hepatitis C, and tuberculosis.[26]

Houselessness

Healthy People 2030 states that houselessness "is housing deprivation in its most severe form."[3] It is well-documented that people who experience houselessness have worse health outcomes than their housed peers, including higher rates of chronic disease, mental health concerns, and premature death.[3] A 2022 review of systematic reviews and meta-analyses evaluating the association between houselessness and health found that houselessness is significantly associated with hospitalization for people living with HIV; falls; mortality due to any cause; mortality due to intentional and unintentional injury; HIV infection among people who inject drugs; and limitations of daily activities (e.g., dressing, eating, using the bathroom, using the phone, using transportation, taking medications).[22] Overall, researchers found that people experiencing houselessness "had a mortality rate [6] times [people not experiencing houselessness or the general public] and they were about 15 times more likely to die from either accidents or intentional self-harm."[22] The authors also noted that people experiencing houselessness "may face social and economic challenges that may lead to poor health, such as poverty, poor nutrition, and social exclusion" and may experience lower access to healthcare compared to the general public.[22]

Moreover, housing instability affects whole community health. Research shows that:

> stress [due to housing instability] can increase not only in response to one's own experience of financial strain or a forced move, but also at the population level through observing neighbors' experiences of residential displacement in areas with high foreclosure and eviction rates, which can contribute to decreased social cohesion and neighborhood disinvestment.[23]

Overall, there is very strong evidence that improved financial and housing stability would likely improve health outcomes for some people who receive HEN services.

Would improving health outcomes for some people who receive HEN services decrease inequities?

There is very strong evidence that improving health outcomes would likely decrease inequities for some people who receive HEN services. Since many people who receive a HEN referral and HEN services experience housing inequities and inequities related to mental, physical, and behavioral health outcomes, House Committee Striker 1986.1 has the potential to reduce inequities for some people who receive HEN services.

The population eligible for and receiving a HEN referral from DSHS is constantly shifting, dependent on people's changing circumstances. However, since people must meet specified eligibility criteria (eligibility for ABD and PWA; incapacity; income; etc.) to receive a HEN referral, some groups are more likely than others to receive a HEN referral.

In addition, since available HEN funding is limited, local service providers must prioritize how to use HEN funds and who to provide HEN services (personal communications, March 2025).

While key informants stated that local prioritization allows local service providers to meet the needs of their community, it may also introduce differences in HEN services across the state (personal communication, Commerce, March 2025). Key informants confirmed that there are large variances in how HEN is implemented by county (personal communications, March 2025). For example, in smaller communities, a person may receive HEN services more quickly (personal communications, March 2025). However, in larger communities, there may be a larger eligible population requiring a waitlist or pool for HEN services, and people may be less likely to receive HEN services (personal communications, March 2025). Regardless, local service providers must prioritize housing support: first, for people experiencing houselessness and, second, for people who are at substantial risk of losing stable housing without housing support within the next 30 days.

Many people who receive a HEN referral experience houselessness or are at risk of experiencing houselessness. In SFY 2024, 48.8% of people who received HEN incapacity program assistance self-reported experiencing homelessness,[8] 28.4% of ABD recipients self-reported experiencing homelessness,[10] and 19.2% of PWA recipients self-reported experiencing homelessness.[12] In February 2025, there were 2,714 people who received HEN incapacity program assistance (and, therefore, a HEN referral), of which 1,270 people (46.8%) were experiencing homelessness and 1,444 people (53.2%) were not experiencing homelessness.[31] Among people experiencing homelessness, 704 people (55.4%) were homeless without housing (i.e., lacked a fixed, regular, and adequate nighttime residence and indicated that they did not have a place to stay at the time of report); 552 (43.5%) were homeless with housing (i.e., did not have a fixed regular nighttime residence, but indicated they had a place to stay at the time of report [e.g., "couch surfing"]); and 13 (1.0%) were staying at an emergency shelter (i.e., resided at a publicly or privately operated temporary shelter).[31]

In SFY 2024, 3,975 people received HEN services: 2,199 people received Homelessness Prevention assistance and 1,776 people received Rapid Rehousing assistance (personal communication, Commerce, April 2025), suggesting that everyone who received HEN services in SFY 2024 were either experiencing houselessness or at risk of houselessness.

Systemic factors impact housing stability in the U.S., including rising inflation, stagnating wages, a national affordable housing crisis, systemic racism, and housing discrimination.[32] Nationally, the U.S. has experienced a "long-term loss and systemic shortage of affordable rental housing."[1] The National Low Income Housing Coalition (NLIHC) stated that the "private market cannot provide a sufficient supply of affordable housing for the lowest-income renters, because what renters with extremely low-income can afford to pay in rent often does not cover the costs of maintaining older rental properties."[1] While state and federal subsidized housing options are available, data have suggested that, "[3] out of every [4] eligible households do not receive federal housing assistance due to severe underfunding" by the federal government.[1] Similarly, in SFY 2024, only 7.33% of people who received a HEN referral received HEN services (personal communication, Commerce, April 2025).

People with low-incomes, people with a disability, older adults, and people who are Black are disproportionately more likely to experience homelessness.[32] In 2024, HUD completed a point-

in-time estimate of the U.S. population experiencing homelessness.[32] HUD reported the highest ever number of people experiencing chronic patterns of homelessness, defined as a person:

> with a disability [i.e., a mental, physical, or emotional impairment or SUD] who has been continuously experiencing homelessness for [1] year or more or has experienced at least [4] episodes of homelessness in the last [3] years where the combined length of time experiencing homelessness on those occasions is at least 12 months.[32]

The point-in-time estimate found that 31,554 people experienced homelessness in Washington State in 2024, an increase of 12.5% from 2023.[32] Washington State had the highest rate of people experiencing chronic patterns of homelessness in the U.S.[32] HUD estimated there were 11,986 people experiencing chronic patterns of homelessness in Washington State in 2024, an increase of 4,295 people (56%) between 2023 and 2024 (the highest numeric increase in the U.S.).[32] Washington State communities participating in the point-in-time estimate attributed the increase to a lack of affordable housing as "housing costs continue to rise in Washington, leading to higher rates of homelessness overall."[32]

It is well-documented that people who experience houselessness have worse health outcomes than their housed peers, including higher rates of chronic disease, mental health concerns, and premature death.[3] Therefore, since many people who receive a HEN referral and HEN services experience houselessness or are at risk of houselessness, and since people experiencing houselessness experience health inequities, House Committee Strike 1986.1 would likely decrease inequities by housing status for some people who receive HEN services.

Moreover, based on HEN eligibility requirements and eligible uses of HEN funds, House Committee Striker 1986.1 may also decrease inequities for some adults with low- and extremely low-income, people with disabilities, older adults, and victims of human trafficking.

Inequities by socioeconomic status, income, and wealth

To be eligible for ABD cash assistance, PWA cash assistance, and HEN incapacity program assistance, people must meet income eligibility requirements. To be eligible for a HEN referral, a person must have a countable monthly income at or below 100% of the FPL or meet income eligibility for the PWA Program. In 2025, the FPL for 1 person is $15,650 per year (approximately $1,304 per month).[60]

In 2021, 62.6% of Washington renters' household income was less than $15,000 and nearly half (49%) of renters in Washington State paid 30% or more of their income on rent.[33] Low-wage workers and renters with low-income pay a larger portion of their income towards rent, which may limit money to pay for other necessities like food, childcare, transportation, and healthcare.[1] For example, severely housing cost-burdened renters spend "70% less on healthcare than the lowest-income renters who are not [housing] cost burdened."[1] Renters with extremely low-income are more likely than other renters to be older adults or people with disabilities.[34]

Low-wage workers, families with children, and people on fixed incomes (e.g., people who are disabled, older adults) may be more likely to be housing cost-burdened than the general public.[1] People who rent tend to earn less and have less wealth than homeowners.[35] Based on data from the Federal Reserve's 2022 Survey of Consumer Finances, about 40% of people in the lowest income quartile (i.e., family income less than $25,000) rent their homes, compared to 11% of

people in the top income quartile who rent (family income $100,000 or more).[36] In 2022, the median rent amount in the West Census region was $1,200.[36] Survey results also showed that many renters faced challenges paying rent in 2022.[36] Seventeen percent of renters reported that they had been behind on their rent in the past year.[36]

For people on fixed incomes, including people who are disabled and older adults, federal social security benefits may not be sufficient to pay rent, and people cannot rely on federal benefit amounts to cover housing expenses (personal communications, March 2025). For example, in 2025, an SSI eligible individual receives a monthly maximum benefit amount of $967,[17] regardless of where in the U.S. they live (personal communications, March 2025). In 2023 (the most recent data available), the median gross rent in Washington State was $1,682, which was $198 higher than in 2021 and above the national median gross rent of $1,348.[33,59] Therefore, people who may rely on SSI may be unable to afford rents in Washington State.

For people who may be working, the Housing Wage is a calculation of the hourly wage a full-time worker must earn to afford FMR for a one-bedroom or a two-bedroom rental home without paying more than 30% of their income on housing.[1] In 2023, the national one-bedroom Housing Wage was $23.67 and the national two-bedroom Housing Wage was $28.58.[1] The NLIHC stated that the Housing Wage is:

> higher than federal [$7.25] or state minimum wages, and higher than median wages for workers in some of the country's most common occupations, like home health and personal care aides, food service workers, and administrative assistants […] nearly 50% of workers earn an hourly wage that is less than the one-bedroom Housing Wage.[1]

NLIHC reported, "modest rental housing is out of reach for nearly every worker in the bottom half of the wage distribution."[1] Moreover, even after accounting for state and county minimum wages that are higher than the federal minimum wage, "the average minimum-wage worker must work 104 hours per week (2.6 full-time jobs) to afford a two-bedroom rental home, or 86 hours per week (just over [2] full-time jobs) to afford a one-bedroom rental home at the [FMR]."[1]

There is a large body of robust evidence that supports the association between income, or socioeconomic status, and health. A report by the U.S. Agency for Healthcare Research and Quality stated, "more than half of measures show that [households with low-income] have worse [health]care than [households with high-income]" and that "significant [inequities] continue for people [with low-incomes] compared with [people with high-incomes] who report they were unable to get or were delayed in getting needed medical care due to financial or insurance reasons."[37] Significant correlations exist between having a lower-income and a number of health indicators including worse overall self-reported health, depression, asthma, arthritis, stroke, oral health, tobacco use, women's health indicators, health screening rates, physical activity, and diabetes.[38] Further, 2021 Washington State Behavioral Risk Surveillance System (BRFSS) data indicate that general health status as well as chronic health indicators including asthma, depression, diabetes, and cancer were significantly worse among Washingtonians with low-income.[39] In 2016, household income was the strongest predictor of self-reported health status in Washington State, even after accounting for age, education, and race/ethnicity.[40] Among children, evidence indicates that low socioeconomic status in the first 5 years of life has negative health outcomes in later childhood and adolescence, including activity-limiting illness, parent-reported poor health status, acute and recurrent infections, increasing body mass index (BMI), dental caries, and higher rates of hospitalization.[41] Further, research also shows that among

people experiencing housing instability, those living in lower-income neighborhoods experience longer-lasting and worse adverse health outcomes compared to people living in higher-income neighborhoods.[42]

Since people with low-wages and on fixed incomes are more likely to rent, more likely to experience housing instability, and more likely to experience adverse health outcomes than people with financial stability and wealth, House Committee Striker 1986.1 would likely reduce inequities due to socioeconomic status, income, and wealth for some people who receive HEN services.

Inequities due to ableism

Renters with extremely low-income are more likely than other renters to be people with disabilities.[34] Key informants stated that the majority of people who receive HEN services are also Aged, Blind, or Disabled (ABD) Assistance Program recipients (personal communications, March 2025). For example, in King County, 95% of people who receive HEN services are also ABD recipients (personal communication, CCS, March 2025). In SFY 2024, 47,496 people received ABD assistance (and therefore a HEN referral), including: 23,567 people who were likely to meet SSI disability criteria; 6,182 people who were aged; 1,120 people who were disabled; and 2 people who were blind.[10] In addition, 76.7% of people who received HEN incapacity program assistance had a mental disability and 23.2% had a physical disability.[8]

Households with people with disabilities have significantly lower household income and are more likely to receive public assistance and disability income than households without people with disabilities.[43] Washingtonians with disabilities experience very high rates of financial poverty relative to people without disabilities. Approximately "19.5% of people with disabilities have incomes below 100% of [FPL] and 43% below 200% of [FPL], [compared to] 10% and 23% of people without disabilities."[44]

Moreover, disabilities and chronic disease can lead to decreased financial earnings and increased medical expenses.[45] Adults in Washington State with disabilities are more likely to experience adverse health outcomes, including depression, obesity, diabetes, and heart disease, and to use tobacco products than Washingtonians without disabilities.[46]

People with disabilities also experience disparate outcomes in housing insecurity and housing quality. One report estimated that more than 37,000 adults with intellectual and developmental disabilities in Washington State face housing insecurity.[47] Another study found that "households with people with disabilities are significantly disadvantaged on all dimensions of neighborhood and housing quality relative to households without people with disabilities."[43]

Since people with disabilities are more likely to experience financial poverty and housing instability, which negatively affects health outcomes, House Committee Striker 1986.1 would likely reduce inequities due to ableism for some people who receive HEN services.

Inequities by age

Older adults are disproportionally affected by housing instability.[45] Cost burden is higher among older adult households that are headed by renters, a person of color, or by a person with low-

income.[45] Data from the Joint Center for Housing Studies found that "as of 2019, over 10 million households headed by [a person] age 65 [years] or older spent more than a third of their income on housing."[45] Data show that renters with extremely low-income are more likely than other renters to be older adults.[34] Older adults are often on fixed incomes, meaning they are particularly impacted by rising rental costs.[45] Data also show that the median older renter had a net wealth of less than $6,000.[45] Further, inequities in housing quality exist. One report found that, "131,000 [households with renters with low-income] headed by someone age 62 [years] or over lived in severely inadequate housing."[45]

Older adults are more at risk for severe illness and hospitalization (e.g., for pneumonia[49]), and many cannot afford the housing services they need to age in place.[45] For example, 1 in 4 older adults fall each year, and falls are a leading cause of injury for this age group.[49] Older adults are also at higher risk for chronic health problems like diabetes, osteoporosis, and Alzheimer's disease.[3]

Since older adults are more likely to experience financial poverty and housing instability, which negatively affects health outcomes, House Committee Striker 1986.1 would likely reduce inequities by age for some people who receive HEN services.

Inequities due to human trafficking

Human trafficking (or trafficking in persons) is a crime that "involves compelling or coercing a person to provide labor or services, or to engage in commercial sex acts. The coercion can be subtle or overt, physical or psychological."[50] In a 2016 report, the U.S. Department of State noted, "[g]iven the complex nature of human trafficking, it is difficult to amass reliable data to document local, regional, and global prevalence."[61] Victims and survivors of human trafficking can be anyone—regardless of race, color, national origin, disability, religion, age, gender, sexual orientation, gender identity, socioeconomic status, education level, or citizenship status.[50] In the U.S., trafficking victims can be American or foreign citizens.[50] The U.S. Department of Justice has stated:

> human traffickers often prey upon members of marginalized communities and other vulnerable [people], including children in the child welfare system or children who have been involved in the juvenile [criminal legal] system; runaway and homeless youth; unaccompanied children; [people] who do not have lawful immigration status in the [U.S.]; Black people and other people of color; American Indians, Alaska Natives, Native Hawaiians, Pacific Islanders, and other [I]ndigenous peoples of North America; Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex (LGBTQI+) individuals; migrant laborers; persons with disabilities; and [people] with [SUD].[50]

Additionally, "traffickers frequently prey on people whose vulnerabilities […] are exacerbated by lack of stable, safe housing, and limited economic and educational opportunities."[50]

Studies have found that providers working with victims of human trafficking consistently cite access to safe transitional or general housing among the top-ranked needs for survivors of human trafficking.[51] Key informants from local service providers stated that victims of human trafficking may need additional supports and assistance to remain stably housed (personal communication, CCS, March 2025).

A growing body of evidence demonstrates that victims and survivors of human trafficking experience disproportionately high rates of violence and abuse.[52,53] Evidence indicates such

exposure to violence is associated with physical and mental health issues, both acute and chronic, and substance use.[52,53] In addition to physical trauma, evidence indicates high rates of mental and behavioral health concerns among victims and survivors of human trafficking.[52,53] Commonly reported mental health outcomes/symptoms included depression,[51-53] anxiety,[51-53], dissociation,[51] hypervigilance,[51] nightmares,[52] flashbacks,[52] low self-esteem,[52] feelings of shame or guilt,[52] suicide ideation and attempts,[51,52] and other symptoms interrelated with PTSD.[51,52] Moreover:

> The psychological trauma experienced by [survivors of human trafficking] affects well-being, development, trust, and impulse control, resulting in strained social and interpersonal relationships. Furthermore, poly-victimization involves a trajectory of trauma over time, potentially compounding already complex traumatization.[51]

Evidence also suggests elevated use of drugs or alcohol.[52,53] Substance use was particularly high among victims of trafficking "either because the substances were forced on them as a control mechanism by […] traffickers or because substance use was a means of coping with the immense abuse […] suffered."[52]

Since victims and survivors of human trafficking experience housing instability and health inequities, and since House Committee Striker 1986.1 would expand HEN eligibility for victims of human trafficking, the proposal would likely reduce inequities for some victims of human trafficking who receive HEN services.

Overall, since House Committee Striker 1986.1 would expand eligible uses of HEN funds, and since many people who receive a HEN referral and HEN services experience housing inequities and inequities related to mental, physical, and behavioral health outcomes, there is very strong evidence that House Committee Striker 1986.1 would likely decrease inequities by housing status, by socioeconomic status, due to ableism, by age, and for victims of human trafficking.

Additional considerations

This Health Impact Review focused on the most linear pathway between provisions in the bill and health outcomes and equity. Evidence related to potential impacts due to immigration status is discussed below.

Among current HEN eligibility requirements (RCW 74.04.805), people must be a U.S. citizen, an alien lawfully admitted for permanent residence, or otherwise residing in the U.S. under color of the law, and must provide their Social Security Number (SSN) to DSHS.

House Committee Striker 1986.1 removes the eligibility requirement that a person must be a U.S. citizen, an alien lawfully admitted for permanent residence, or otherwise residing in the U.S. under color of the law. Key informants stated that removing the citizenship and immigration status requirement may increase access to housing assistance, regardless of immigration status (personal communications, March 2025). Housing stability may also be impacted by current restrictions under HUD (personal communications, March 2025). For example, on March 24, 2025, HUD and the Department of Homeland Security (DHS) signed the "American Housing Programs for American Citizens" MOU. Previous federal administrations have sought to prohibit immigrant households with low-incomes from accessing affordable housing, which has impacted people's housing stability and impacted whether people access and receive public services, including medical and food benefits and housing assistance.[62] It is unknown how the recent MOU may impact housing stability and assistance by immigration status.

However, key informants stated that, while House Committee Striker 1986.1 removes citizenship and immigration status requirements, the proposal retains the eligibility requirement that people must provide their SSN to DSHS to be eligible for a HEN referral (personal communications, DSHS, March 2025). To be eligible for a SSN, a person must be a U.S. citizen, a lawful permanent resident, or meet specific work or school requirements.[63,64] For example, generally only people authorized to work in the U.S. by DHS can get a SSN.[64] Therefore, key informants stated that eliminating the citizenship and immigration status eligibility requirement under House Committee Striker 1986.1 would have no impact on HEN eligibility because the proposal retains the requirement that a person provide their SSN to DSHS (personal communication, DSHS, March 2025).

Additionally, key informants stated that eligibility for ABD (RCW 74.62.030) and HEN incapacity program also require people to provide their SSN to DSHS (personal communication, DSHS, March 2025). Key informants stated that removing citizenship and immigration status requirements would complicate policy intersections between eligibility for the ABD cash assistance program and the HEN incapacity program and introduce differences in how eligibility criteria are currently administered (i.e., considering ABD as a priority program before considering eligibility for the HEN incapacity program) (personal communication, DSHS, March 2025).

Therefore, since it is unclear how House Committee Striker 1986.1 may impact eligibility based on immigration status as people would still be required to provide their SSN to DSHS to receive a HEN referral, this pathway was not included in the logic model.

Annotated References

1. **Coalition National Low Income Housing. Out of Reach: The High Cost of Housing.2023.**

In this annual report, the National Low Income Housing Coalition (NLIHC) summarizes data and information demonstrating the "gap between incomes and housing costs and what it means for renters nationwide." The report includes state-level data, including data specific to Washington State. NLIHC reported that the affordable housing crisis was exacerbated due to the COVID-19 pandemic, low housing vacancy rates, increasing rental prices, and inflation. They reported that "[n]ationwide, median rents increased by 18% during 2021 and by 25% between January 2021 and June 2022". Rent growth returned to and stabilized at pre-pandemic levels by February 2023. However, "[e]ven amid slowing rent growth, renters are facing the effects of a long-standing trend in which rents have risen faster than wages." NLIHC uses the Housing Wage to demonstrate the gap between income and housing costs. The Housing Wage is the hourly wage a full-time worker must earn to afford Fair Market Rent for a one-bedroom or a two-bedroom rental home without paying more than 30% of their income on housing. Households "are considered housing cost-burdened if they spend more than 30% of their income on housing costs, including rent and utilities" and are "severely housing cost-burdened if they spend more than 50% of their income on housing costs." In 2023, the national one-bedroom Housing Wage was $23.67, which "is more than three times the federal minimum wage [$7.25] and more than what most of country's low-income seniors, people with disabilities, families with children, and low-wage workers can comfortably afford." The national two-bedroom housing wage is $28.58. Moreover, the Housing Wage is "higher than federal or state minimum wages, and higher than median wages for workers in some the country's most common occupations, like home health and personal care aides, food service workers, and administrative assistants […] nearly 50% of workers earn an hourly wage that is less than the one-bedroom Housing Wage." NLIHC reported "modest rental housing is out of reach for nearly every worker in the bottom half of the wage distribution." Moreover, even after accounting for state and county minimum wages that are higher than the federal minimum wage, "the average minimum-wage worker must work 104 hours per week (2.6 full-time jobs) to afford a two-bedroom rental home, or 86 hours per week (just over two full-time jobs) to afford a one-bedroom rental home at the fair market rent." Low-wage workers and low-income renters pay a larger portion of their income towards rent, which limits money to pay for other necessities like food, childcare, transportation, and healthcare. For example, severely housing cost-burdened renters spend "70% less on healthcare than the lowest-income renters who are not cost-burdened." NLIHC stated, "[p]eople of color are disproportionately impacted by the gap between low wages and high rents because they disproportionately work in low-wage jobs and rent their homes" due to "[h]istorical barriers to wealth accumulation and ongoing housing discrimination [that] restrict homeownership for many people of color, particularly Black households, while racial [inequities] in income are the result of discrimination in hiring and wage setting and unequal opportunities." NLIHC reported that 19% of Black households, 17% of American Indian or Alaska Native households, and 14% of Latino households are extremely low-income renters, compared to 6% of white households. Regardless of race/ethnicity, women also earn less than their male counterparts and experience greater difficulty affording rental housing compared to men. In addition, there is a "long-term loss and systemic shortage of affordable rental housing" in the U.S. NLIHC explained that the "private market cannot provide a sufficient supply of affordable housing for the lowest-income

renters, because what extremely low-income renters can afford to pay in rent often does not cover the costs of maintaining older rental properties." However, "three out of every four eligible households do not receive federal housing assistance due to severe underfunding" by the federal government. Based on data from the U.S. Census Bureau and HUD, Washington State ranks 5th for states with the most expensive two-bedroom Housing Wage. The state-wide two-bedroom Housing Wage is $36.33 for Washington State, which is higher than the national level ($28.58). The Seattle-Bellevue HUD Metro Fair Market Rent Area is the 9th most expensive metropolitan area in the U.S., with a two-bedroom Housing Wage of $47.21 (more than New York City). Washington State is also the 9th most expensive for non-metropolitan areas, with a two-bedroom Housing Wage of $21.80. In Washington State, the Fair Market Rent for a two-bedroom apartment in 2023 is $1,889. NLIHC stated that, "to afford this level of rent and utilities—without paying more than 30% of income on housing—a household must earn $6,296 monthly or $75,556 annually." From 2017 through 2021, there were 1,066,944 renter households in Washington State, representing 36% of all households. In 2023, the estimated average renter wage in Washington State was $30.32 per hour. If a full-time worker earned the mean renter wage (calculated as the compensation a typical renter is likely to receive), a monthly rent of $1,577 or less would be affordable. However, based on data from HUD, the Fair Market Rent for a two-bedroom apartment in Washington State is $1,889.

2. **Development U.S. Department of Housing and Urban. Rental Burdens: Rethinking Affordability Measures.PD&R Edge: An online magazine2014.**
This featured article from the U.S. Department of Housing and Urban Development (HUD) provides a summary of housing affordability measures in the U.S. The article included background about the "30-percent rule" for measuring housing affordability and a critique of the measure as an indicator of housing affordability.

3. **U.S. Department of Health and Human Services Healthy People 2030: Social Determinants of Health Literature Summaries - Economic Stability, Housing Instability. Available at: https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/housing-instability. Accessed July 26, 2023.**
This summary of literature from Healthy People 2030 focuses on housing instability, a component of the Economic Stability health domain. Healthy People 2030 organizes the social determinants of health into 5 health domains. Housing instability relates to three Healthy People 2030 Objectives, including: Reduce the proportion of people living in poverty (SDOH-01) and reduce the proportion of families that spend more than 30% of income on housing (SDOH-04). Housing instability, which is linked to cost of housing, substandard housing, and forced evictions "may negatively affect physical health and make it harder to access health care." This summary states, housing instability "encompasses a number of challenges, such as having trouble paying rent, overcrowding, moving frequently, staying with relatives, or spending the bulk of household income on housing." Specifically, "households are considered to be cost burdened if they spend more than 30% of their income on housing and severely cost burdened if they spend than 50% of their income on housing." Households with low-incomes and households of color are at higher risk of being cost burdened. Approximately 84% of households with an annual income less than $15,000 were cost burdened. It cites evidence that Black and Hispanic households were twice as likely to be cost burdened compared to white households. Cost burdened households are also more likely to experience eviction and forced moves. Healthy People 2030 noted that, "research

has shown that renters who are forced to move are more likely to relocate to poorer and higher-crime neighborhoods compared to those who move voluntarily. Evictions may be especially traumatizing to residents due to short relocation notices." Children who experience housing instability are more likely to have chronic health conditions, poor physical health, and lack of access to health insurance. Healthy People 2030 also acknowledges that "homelessness is housing deprivation in its most severe form." It is well-documented that individuals who experience homelessness have worse health outcomes than their housed peers, including higher rates of chronic disease, mental health concerns, and premature death.

4. **Quality Agency for Healthcare Research and. Services USDoHaH.National Healthcare Quality and Disparities Report.2022.**
The Agency for Healthcare Research and Quality's National Healthcare Quality and Disparities Report (NHQDR) has provided an annual summary of the status of health and healthcare delivery in the United States since 2003. The NHQDR team prioritizes reporting data and measures that are broadly representative of the performance of the nation's healthcare system over time.

5. **Research Office of Program. House Bill Report, ESSB 5232, As reported by House Committee on Early Learning & Human Services. 2025.**
This Bill Report provides background information and summarizes provisions for ESSB 5232 as reported by the House Early Learning & Human Services Committee. This bill report includes summary of the striking amendment as discussed in Committee.

6. **Mancuso D., Ford Shah M. , Black C., et al. Washington State's Housing and Essential Needs Program: Impacts on Housing Status, Use of Food Assistance, Arrests, Incarcerations, and Health Outcomes. In: Services WSDoSaH, ed. Olympia, WA2013.**
This January 2013 Evaluation of Washington's Housing and Essential Needs (HEN) Program was completed by DSHS's Research and Data Analysis (RDA) Division. Implemented in 2011, the HEN program was 1 of 3 programs to replace the Disability Lifeline (DL) cash assistance p (formerly General Assistance). Authors cited evidence that termination of General Assistance (GA) cash assistance in other states was associated with an increase in housing instability. Various evaluations found increases in utility shut-offs and evictions (doubled), the number of former GA recipients living with relatives or friends (nearly five-fold increase), and homelessness (from 2% to 25% in 7-months following program termination). The HEN program was developed to buffer vulnerable DSHS clients from the potential impact of losing cash assistance by providing support such as rent and utility assistance. The Washington State Department of Commerce requested DSHS's RDA evaluate the impact of HEN services on measures of well-being over a 6-month follow-up period. The initial population of people who had Medical Care Services (MCS)/DL-U medical coverage and received HEN services at some point between November 2011 and January 2012 consisted of 2,107 people. After imposing restrictions, a total of 661 HEN recipients were included in the evaluation. The analysis compared participants to 2 statistically well-matched comparisons groups drawn from the DSHS Integrated Client Database: the "Concurrent Group" reflected the same period during which the HEN program operated and the "Retrospective Group" from the year before the HEN program was created. RDA compared outcomes for people who received HEN services to the statistically matched comparison groups (i.e., with similar baseline characteristics but who did not receive

HEN services). Over the 6-month follow-up period, HEN recipients experienced greater housing stability, remained connected to Basic Food assistance at significantly higher rates, and were less likely to be incarcerated in a state Department of Corrections (DOC) facility. The baseline characteristics that were associated with greater likelihood of engagement in HEN services included: “being in poorer physical health; being recently engaged in alcohol/drug treatment; being diagnosed with depression or anxiety; being African American; living in counties with low-to-moderate urban density (as opposed to rural or densely urban counties); and not having been recently arrested.” Baseline differences remained after the initial study population selection criteria were imposed. Therefore, RDA used statistical processes to create comparison groups that were well-matched at baseline. The analysis found that by 6 months, “65[%] of the HEN group experienced housing instability compared to 79% of both the concurrent and retrospective comparison groups (p<.0001 for both comparisons).” Additionally at the end of 6 months, “96% of the HEN group was receiving Basic Food, compared to 82% of the concurrent comparison group (p<.0001) and 88[%] of the retrospective comparison group (p<.0001).” Related to criminal justice involvement, “Rates of arrest for felonies and gross misdemeanors, as recorded in Washington State Patrol data, were slightly lower for HEN recipients [14%] compared to both the concurrent comparison group [15 percent] and retrospective comparison group [17%].” However, these results were not statistically significant. Meanwhile, differences in incarceration were statistically significantly different. In the follow-up period, 0.3% of HEN recipients (n=2) were incarcerated in a DOC facility, compared to 2.1% of the concurrent comparison group (n=14; p=.003) and 2.3% of the retrospective comparison group (n=15; p=.002). RDA staff also “examined the percent of each group under DOC jurisdiction, which includes both incarcerations and community supervision, and observed a similar pattern (18 individuals from the HEN group compared to 28 in the concurrent group and 40 in the retrospective group).” Additionally, HEN recipients spent significantly more time (i.e., average number of coverage months) than the concurrent comparison group on disability-related medical coverage (1.1 months compared to 0.9 months; p=0.05) and on Medical Care Services (MCS) medical coverage (4.2 months compared to 3.3 months; p<.0001). Similarly, HEN recipients spent more time on disability-related medical coverage when compared to the retrospective comparison group (1.1 months compared to 0.4 months; p<.0001). Authors stated, “[t]he higher likelihood of retaining MCS medical coverage is an encouraging result in the context of the anticipated expansion of Medicaid under Health Care Reform.” Authors concluded, “the findings to date suggest that providing housing and other essential items may protect clients from some of the impact they might otherwise have experienced due to the loss of cash assistance.”

7. **Housing and Essential Needs Referral Program. Available at: https://www.dshs.wa.gov/esa/community-services-offices/housing-and-essential-needs-referral-program. Accessed 3/27/2025, 2025.**
This Washington State Department of Social and Health Services' (DSHS) Economic Services Administration webpage provides an overview of the Housing and Essential Needs (HEN) Referral program, eligibility for referral, and application process.

8. **Services Washington State Department of Social and Health. Housing and Essential Needs (HEN) Referral | SFY 2024 ESA Briefing Book. In: Administration ES, ed2024.**
This DSHS Economic Security Administration's (ESA) Briefing Book provides HEN eligiblity data based on incapacity for State Fiscal Year 2024. It includes an overview of the HEN program

and presents eligibility data based on incapacity for SFY 2015-2024 with specific details based on a June 2024 program snapshot.

9. **Washington State Department of Social and Health Services. Housing and Essential Needs (HEN) Referral. Available at: https://www.dshs.wa.gov/esa/program-summary/housing-and-essential-needs-hen-referral. Accessed 3/27/2025.**
This DSHS ESA webpage provides an overview of the Housing and Essential Needs (HEN) Referral program's purpose and clarifying information for eligibility.

10. **Services Washington State Department of Social and Health. Aged, Blind, or Disabled (ABD) | SFY 2024 ESA Briefing Book. In: Administration ES, ed2024.**
This DSHS Economic Security Administration's (ESA) Briefing Book provides Aged, Blind, and Disabled (ABD) eligiblity data for State Fiscal Year 2024. ABD provides cash assistance and a referral to HEN for low-income adults who are age 65 or older, blind, or likely to meet federal SSI disability criteria.

11. **Pregant Women Assistance (PWA) Program. no date; Available at: https://www.dshs.wa.gov/esa/community-services-offices/pregnant-women-assistance-pwa-program. Accessed 4/1/2025.**
This DSHS webpage provides an overview, including information about eligibility, for the Pregant Women Assistance (PWA) Program.

12. **Services Washington State Department of Social and Health. Other Programs | SFY 2024 ESA Briefing Book. In: Administration ES, ed2024.**
This DSHS Economic Security Administration's (ESA) Briefing Book provides data for other programs, including Pregnant Women Assistance (PWA) for State Fiscal Year 2024.

13. **Commerce Washington State Department of. HEN Referral List.**
This Q&A sheet from the Washington State Department of Commerce describes DSHS' HEN Referral List available to Consolidated Homeless Grant grantees as well as who has access to the list, why it is available, and how to access if approved.

14. **Discrimination - Human Rights Commission, Chapter 49.60 RCW(1995).**
Washington State law Chapter 49.60 RCW prohibits discrimination due to race, creed, color, national origin, citizenship or immigration status, families with children, sex, marital status, sexual orientation, age, honorably discharged veteran or military status, or the presence of any sensory, mental, or physical disability or the use of a trained dog guide or service animal by a person with a disability.

15. **RCW 59.18.255 Source of Income—Landlords prohibited from certain acts—Violation—Penalties., RCW 59.18.255 Revised Code of Washington(2018).**
This Washington State statute prohibits landlords subject to the Residential Landlord Tenant Act (RLTA) from discriminating against an otherwise eligible prospective or current tenant based on the source of their income. However, it allows a landlord to refuse to rent to the tenant if all three of the following criteria are true: 1) the property must pass inspection for the tenant to keep their rental assistance; 2) it will cost more than $1,500 to make sure the property will pass the

inspection; and 3) the landlord has not received money to make the improvements. The law allows a tenant or prospective tenant to bring a civil action if they believe a landlord has discriminated against them due to their source of income. If a landlord violates this statute, they may be required to pay up to 4.5 times the amount of the monthly rent, plus costs and reasonable attorney's fees. The law specifies that "source of income" includes "benefits or subsidy programs" and "does not include income derived in an illegal manner."

16. **Administration U.S. Social Security. Annual Report of the Supplemental Security Income Program. 2024.**
The Annual Report of the Supplemental Security Income (SSI) Program provides a comprehensive overview of SSI.

17. **SSI Federal Payment Amounts for 2025. 2025; Available at: https://www.ssa.gov/oact/cola/SSI.html. Accessed 3/28/2025.**
This U.S. Social Security Administration webpage provides information about the maximum federal Social Security Income (SSI) payment amounts effective January 1, 2025.

18. **Disability. Available at: https://www.ssa.gov/disability. Accessed 4/2/2025.**
This Department of Social Security Administration webpage provides information about federal Social Security Disability Insurance (SSDI) .

19. **Social Security in retirement. Available at: https://www.ssa.gov/retirement. Accessed 4/2/2025.**
This Department of Social Security Administration webpage provides information about federal Social Security Retirement income.

20. **Taylor L.A. Housing and Health: An Overview of the Literature. *Health Affairs.* 2018.**
In this Health Policy Brief, Taylor states that, “there is strong evidence characterizing housing’s relationship to health” and “housing is one of the best-researched social determinants of health.” There are four primary pathways from housing to health, including housing stability, safety and quality of housing, housing affordability, and neighborhoods. Overall, individuals who experience housing instability are more likely to experience worse health outcomes compared to their stably housed peers.

21. **Chen K. L., Miake-Lye I. M., Begashaw M. M., et al. Association of Promoting Housing Affordability and Stability With Improved Health Outcomes: A Systematic Review. *JAMA Network Open.* 2022;5(11):e2239860.**
Chen et. al. conducted a systematic review of literature to characterize associations of primary prevention strategies for housing insecurity with adult physical health, mental health, health-related behaviors, health care use, and health care access. The authors define housing insecurity as difficulty with housing affordability and stability. Prior evidence indicates that housing insecurity is associated with less access to health care, worse mental and physical health, and mortality. The researchers systematically reviewed 26 quantitative studies published between 2005 to 2021 that studied interventions aimed at improving housing affordability or stability. The studies either supported at-risk households (targeted primary prevention) or enhanced

community-level housing supply and affordability in partnership with the health sector (structural primary prevention). The research also examined ways studies of primary prevention interventions for housing insecurity addressed concepts associated with race and racism. The researchers followed the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) reporting guideline and used the Grading of Recommendations Assessment, Development, and Evaluation criteria to evaluate risk of bias. The review included 3 randomized trials and 20 observational studies. The authors frame their research with the following logic: "[housing] affordability and stability are associated with both structural, population-level factors (including housing supply and demand factors, which may influence market prices and may shape—and may be shaped by—broader societal conditions) and individual-level factors (including household income and expenses)." The interventions were sorted into short- and long-term strategies. Rent stabilization was categorized as a targeted primary prevention and long-term strategy. The results show that most interventions work to mitigate housing insecurity for the most vulnerable groups of people, rather than work to prevent housing insecurity overall. The results also show with moderate certainty that eviction moratoriums were associated with reduced COVID-19 cases and death. The results show with low or very low certainty that other targeted primary prevention interventions (emergency rent assistance, legal assistance with waiting list priority for public housing, long-term rent subsidies, and homeownership assistance) are associated with health outcomes. No studies examined structural primary prevention strategies. "One observational study involved provision of temporary financial assistance for housing-related expenses, such as rent, utilities, and security deposits, to veterans at imminent risk of homelessness. It was associated with $219 per quarter in total health care cost savings." None of the studies in this review evaluated the health associations of rent stabilization. Among the studies reviewed, "racism in housing and health outcomes was largely limited to controlling for race and ethnicity without conceptual justification". The authors state that while "long-term rent subsidies are highly effective at promoting housing affordability and preventing displacement and homelessness, alone they have little to no association with poverty, and they should likely be combined with other social interventions plus case management to connect people with resources". The authors conclude with recommendations for program and policy intervention strategies that focus on a systems-based, population level approach, rather than on household-level interventions.

22. **Fornaro M., Dragioti El., De Prisco M., et al. Homelessness and health-related outcomes: An umbrella review of observational studies and randomized controlled trials. *BMC Medicine.* 2022;20:224-.**

Fornaro et al. conducted a review of 1,549 systematic reviews and meta-analyses published through April 28, 2021 that evaluated the association between homelessness and health. Using strict inclusion criteria, the authors included findings from 2 systematic reviews and 8 meta-analyses in this report. The authors then ranked the credibility of evidence using 5 categories of evidence: Convincing (Class I); Highly suggestive (Class II); Suggestive (Class III); Weak (Class IV); or Non-significant. Across these studies, the authors identified 23 unique associations between homelessness and housing, including 12 associations that were statistically significant. Overall, the authors found 2 associations with Convincing evidence; 5 associations with Highly suggestive evidence; 5 associations with Suggestive evidence; 4 associations with weak evidence; and 7 associations with non-significant evidence. The two associations with "Convincing evidence" were: 1) Hospitalization among people experiencing homelessness and

living with HIV and 2) Falls in the past year among people experiencing homelessness. The 5 associations with Highly suggestive evidence were: 1) Mortality due to any cause; 2) Mortality due to intentional and unintentional injury among people experiencing homelessness compared to the general population; 3) HIV infection among people experiencing homelessness who used injection drugs compared to those who did not; 4) Limitations in "activities of daily living" (e.g., dressing, eating, using the bathroom); and 5) Limitations in "instrumental activities" (e.g., using the phone, using transportation, taking medications) among people experiencing homelessness compared to people not experiencing homelessness. The authors found that people experiencing homelessness "had a mortality rate [6] times [people not experiencing homelessness or the general population] and they were about 15 times more likely to die from either accidents or intentional self-harm." The authors also noted that people experiencing homelessness "may face social and economic challenges that may lead to poor health, such as poverty, poor nutrition, and social exclusion" and may experience less access to healthcare compared to the general population. Moreover, "people who lack stable and appropriate housing appear to be at relatively high risk for a broad range of acute and chronic illnesses, especially infectious diseases, heart diseases, substance use disorders, and severe mental disorders." Researchers also noted that it is unclear whether poor health outcomes contribute to homelessness or whether homelessness contributes to worse health outcomes.

23. **Gu K. D., Faulkner K. C., Thorndike A. N. Housing instability and cardiometabolic health in the United States: a narrative review of the literature. *BMC Public Health.* 2023;23(1):931.**

Gu, Fulkner, and Thorndike conducted a systematic review of literature to examine the association of housing instability and cardiometabolic health conditions of overweight/obesity, hypertension, diabetes, and cardiovascular disease. "Housing instability is variably defined but generally encompasses difficulty paying rent, living in poor or overcrowded conditions, moving frequently, or spending the majority of household income on housing costs." The review included 42 studies where exposure variables were related to housing cost burden, frequency of moves, living in poor or overcrowded conditions, or experiencing eviction or foreclosure. The variables were measured at either the individual household level or at a population level. The researchers also examined the effects of receiving government rental assistance. Most studies included in the review were cross-sectional. The results indicate some "mixed, but generally adverse associations between housing instability and cardiometabolic health, including higher prevalence of overweight/obesity, hypertension, diabetes, and cardiovascular disease; worse hypertension and diabetes control; and higher acute health care utilization among those with diabetes and cardiovascular disease." Evidence shows that housing-related cost burden "is associated with cost-related nonadherence, both to prescription medications and health care visits". The researchers also write that "stress can increase not only in response to one's own experience of financial strain or a forced move, but also at the population level through observing neighbors' experiences of residential displacement in areas with high foreclosure and eviction rates, which can contribute to decreased social cohesion and neighborhood disinvestment". The authors conclude with recommendations for future research to better formulate effective housing policies or programs.

24. **Law The Network for Public Health. Rent Control and Stabilization. 2021. https://www.networkforphl.org/resources/housing-availability-and-affordability-toolkit/rent-control-and-stabilization/. Accessed July 14, 2023.**
The Network for Public Health Law published a fact sheet about rent control and stabilization. The authors summarize previously published literature. The fact sheet clarifies that while rent control and rent stabilization are often used interchangeably, rent "control" freezes the price of rent between lease terms for continuous tenants, and rent "stabilization" sets a cap on allowable price increases between lease terms, whether a tenant is continuously occupying the premises or a new tenant. Rent control often allows price increases only between tenants. The authors cite other studies and state that "nearly half of renters in the U.S. are 'cost burdened,' spending more than 30% of their incomes on housing, and about one in four renters (almost 11 million people) spend more than 50% of their incomes on housing ('severe' cost burden)." The authors connect housing affordability to health by describing that whenever tenants are cost burdened, they do not have finances available to spend on other needs such as healthcare, resulting in negative health outcomes. The authors cite additional prior research, stating that "when previously cost-burdened renters gained access to affordable housing, outpatient care increased, and emergency care decreased – leading to an overall 12% decrease in Medicaid costs". Additionally, "[i]n a 2019 survey of 500 medical professionals, 100% reported having patients express concerns about the cost of housing, and 92% of patients advised to reduce stress reported that personal finances were their biggest stressor." Further, the national median rent has been increasing each year, and increasing more after the COVID-19 pandemic. From January-September 2021, national median rent increased 16.4%, compared to an average of 3.4% in that same period from 2017 through 2019. One study by Diamond et al. shows that rent price restrictions can provide benefits to the tenants living in those units. Benefits are magnified in rent-stabilized units where "allowable rent increases are lower between lease terms with continuous tenants than between tenants". Policies that benefit tenants who stay in price-restricted units may lead to those tenants remaining in their unit for longer periods of time, which could lead to improved neighborhood stability and associated health and social benefits. However, rent control and stabilization policies only benefit tenants while they occupy those units. When viewing these policies at a systems-level, they tend to decrease housing stock and affordability of other rentals. For example, landlords may choose to convert rentals to condominiums or new builds to avoid the policy. A 2019 study of San Francisco rent control policies found that "rent controlled buildings were 8 percentage points more likely to convert to a condo [or other exempt dwelling]" compared to buildings not covered by the policy. Since 1994, when the policy was first implemented, "the supply of small multi-family rental housing decreased by 15 percentage points". Further, rent price restrictions can harm young low-income families, since tenants benefitting from rent-controlled housing may not be motivated to move out even after shifting employment or needs. Lastly, research indicates that rent price restriction policies may lead to a lack of maintenance and conditions of rentals, as landlords may not be motivated to make home improvements without additional rental income. The authors call for intervention in housing policy to make housing more affordable and to protect public health.

25. **Pastor M., Carter V., Abood M. Rent Matters: What are the Impacts of Rent Stabilization Measures?: USC Dornsife;2018.**
Researchers from USC Dornsife wrote a review of literature on rent stabilization policies. The discussion of the policy context is from the perspective of applicability in California. A

background is provided on how the field of economics approaches rent. Changes in cost of rent "may arise for reasons having to do nothing with whether a landlord has improved his or her actual housing product but instead may arise due to external factors such as the overall set of market conditions, nearby public investments (such as new transit lines), or other sorts of public policies". Further, "most literature on rent regulations comes from the discipline of economics. While this perspective is critical, economic literature typically treats housing as an exchangeable commodity and focuses on the monetary value of homes by comparing rents and home prices. However, the value of housing in most people's lives and the importance of housing in society cannot be captured solely through a market analysis. Housing fulfills important social needs—it provides stability, safety, and security to individuals and families, outcomes that are valued but not always tagged with a market price. For that reason, our analysis integrates economic literature with an analysis of housing and tenant mobility drawn from the fields of public health, education, urban planning, and sociology." The authors describe ways that rent stabilization policies have affected housing market factors. The reviewers cite study findings from 1973 to 2018 to highlight that tenants in rent-regulated apartments benefit from rent stabilization and stay in their units longer, and that these benefits outweigh the unclear potentially negative impacts that rent stabilization policies may have on the housing market overall. The health benefits associated with housing stability are described. The researchers state that rent stabilization efforts are most effective at mitigating housing crises when paired with additional policies such as "promoting housing supply, particularly of affordable units, and job training and economic development programs that can lift incomes and promote mobility".

26. **Hoke M. K., Boen C. E. The health impacts of eviction: Evidence from the national longitudinal study of adolescent to adult health.** ***Soc Sci Med.*** **2021;273:113742.**
Hoke and Boen conducted a longitudinal study of the health impacts of eviction for young adults. Using nationally representative data from the 1994-2008 National Longitudinal Study of Adolescent to Adult Health, the authors evaluated the impacts of eviction on depression and self-rated health over time. Approximately 1.6% of young adults reported experiencing eviction. Overall, the authors found a positive association between eviction history and depressive risk, such that young adults who experienced eviction had statistically significantly more depressive symptoms than young adults who were not evicted. This relationship persisted over time and "the longitudinal associations between changes in eviction and changes in depressive risk persisted after adjusting for other markers of household and neighborhood socioeconomic conditions as well as measures of housing and financial insecurity, which would suggest that eviction serves as a particular salient health risk among young adults." The authors also found a strong positive association between eviction history and self-reported health, and individuals experiencing eviction were more likely to report poor or fair health compared to those that did not experience eviction. In addition, individuals with low-incomes and people of color are more likely to experience eviction and resulting depressive symptoms. Black young adults were disproportionately more likely to have experienced eviction and "while Black young people comprised approximately 12 percent of the full sample, they represented approximately 23 percent of those who reported being evicted." The study also found that "evictions may serve as both a cause and consequence of economic insecurity and a source of population-level socioeconomic health inequality." The authors found that psychosocial stress may mediate the relationship between eviction and depressive symptoms and self-reported health. The authors summarize literature identifying three primary pathways between eviction and health, including

1) psychosocial stress; 2) environmental exposures related to substandard housing; and 3) increased disease exposure. The authors state that the threat or loss of housing due to eviction can "lead to increased rumination, hopelessness, anxiety, depression, and risk of suicide. This stress can be compounded by the experience of social stigma associated with eviction and housing loss." Stigma can increase mental health impacts, as well as result in disrupted sleep quality, hormonal changes, and reduced immune function. Increased environmental exposures results from increased "likelihood of being exposed to substandard housing or becoming homeless" as a result of eviction. In the third pathway, "eviction can directly increase one's exposure to infectious disease risks. Upon experiencing eviction, individuals and families may seek shelter in crowded, unsafe situations. This can include homeless shelters, doubling up (moving in with friends or family), or seeking alternative accommodations in one's vehicle or on the street. Any of these options can lead to increased exposure to those infectious diseases that continue to disproportionately affect homeless populations such as HIV, Hepatitis B, Hepatitis C, and tuberculosis" as well as COVID-19. The authors also cited background research showing that housing instability has been linked to mental health outcomes (i.e. depression, anxiety, stress, psychological health, mental health strain, suicide ideation, and death by suicide), substance use (i.e. alcohol use, drug use, high-risk behaviors like syringe sharing) and general and physical health outcomes (i.e., poor self-reported health, high blood pressure, weight gain, chronic health concerns [e.g. diabetes]), and death (i.e. cardiovascular disease-related mortality, all-cause mortality). Housing instability has also been associated with negative health outcomes in children (i.e. physical abuse, hospitalization, poor diet, high cortisol levels). While eviction is included in the definition of housing instability, studies "generally support the idea of forced housing loss as a unique stressor that affects physical and physiological functioning." Eviction has been associated with increased rates of sexually transmitted infections, increased viral load in individuals with HIV, low birthweight, infant mortality, food insecurity, medication use, sleep disturbances, and worse chronic disease outcomes.

27. **Vasquez-Vera H., Palencia L., Magna I., et al. The threat of home eviction and its effects on health through the equity lens: A systematic review. *Soc Sci Med.* 2017;175:199-208.**

Vasquez-Vera et. al. conducted a systematic review of 47 articles published through March 2016 to determine the impacts of threat of eviction on health outcomes. The majority of studies (77%) occurred in the U.S. Specifically, they evaluated the threat of eviction (i.e., mortgage or rent arrears, foreclosure, eviction) on mental health, physical health, and health-related behaviors. The study authors noted, "of all scenarios that can be described as housing insecurity, risk of losing one's dwelling or being evicted is one of the most important." Overall, they found a "general consensus that individuals under threat of eviction present negative health outcomes, both mental (e.g., depression, anxiety, psychological distress, and suicides) and physical (poor self-reported health, high blood pressure and child maltreatment)." One study stated that, "threat of eviction can directly affect health in two ways: through psychological changes resulting in poor mental health, and by adopting unhealthy habits that constitute risk factors for several diseases." They found that being evicted is related to higher risk of depression and anxiety, psychological distress, and death by suicide. Individuals who experienced eviction were also at greater risk for substance use (e.g., alcohol, tobacco, other drugs) and food insecurity. Additionally, "some qualitative studies reported that [threats of eviction] are experienced by individuals as a personal failure and as a concealable stigma, leading to feelings of insecurity,

embarrassment, isolation, and having a lack of control of key aspects of daily living." They noted that these feelings can lead to anxiety, depression, and suicide ideation. The studies also revealed inequities by sex, age, race/ethnicity, geography, level of education, employment status, and socioeconomic status. The review notes that these populations experience worse health outcomes and "one of [the] mediating factors is housing." Eviction had a strong impact on mental and physical health for women compared to men. However, men who experienced eviction were at greater risk of alcohol dependence and drinking compared to women. Risk of death by suicide "among people nearing retirement was twice that among those aged 3-45 years." Studies also showed that Black individuals experience significantly worse mental health outcomes than white individuals experiencing eviction. Five studies evaluating whether living in areas with higher rates of evictions and foreclosures impacted health outcomes found, "significant associations with health outcomes such as high blood pressure, depressive symptoms, and higher frequencies of mentally unhealthy days. This is relevant because the threat of eviction is not only an individual-level risk factor, but also a contextual-level determinant of health" impacting "the wider community through various mechanisms, including declining local property values, degradation of the [neighborhood] environment, changes in safety levels, changes in retail and built environments, and other factors yet to be explored (spillover effects)."

28. **Desmond M. Unaffordable America: Poverty, housing, and eviction. *Fast Focus.* Vol 22. Madison, WI: Institute for Research on Poverty, University of Wisconsin-Madison; 2015.**

Desmond provides an overview of the crisis faced by low-income families "in finding and maintaining affordable housing." He describes trends that have contributed to the current situation: "rising housing costs, stagnant or falling incomes among the poor, and a shortfall of federal housing assistance." Single mothers with children who have low incomes, particularly Black mothers, are at greatest risk of eviction. Desmond cites evidence that "From 2001 to 2010, median rents increased by roughly 21[%] in Midwestern and Western regions" in 2015 U.S. dollars. In 2013, 67% of low-income renters did not benefit from federal housing programs. At the same time, 1 in 8 low-income renting families in the U.S. could not pay all their rent, and a similar number thought it was likely they would be evicted soon. A study of Milwaukee area renters (2009-2011) found "neighborhoods with a greater proportion of children have more evictions," even after controlling for financial poverty, racial composition, percentage of female-headed households, and several other factors. Eviction is the leading cause of homelessness, particularly among families with children. "Residential instability often brings about other forms of instability—in families, schools, communities—compromising the life chances of adults and children." Furthermore, involuntary displacement is linked to substandard housing conditions, which can negatively affect children's health. Evidence also indicates that "experiencing an eviction is associated with over a third of a standard deviation increase in neighborhood poverty and crime rates, relative to voluntary moves." Another consequence of eviction can be job loss due to time required and stress induced by an eviction (e.g., missed work, mistakes on the job). Eviction can also result in a longer commute that can increase the likeliness of tardiness and absenteeism. The Milwaukee Area Renters study found that "workers who involuntarily lost their housing were roughly 20 percent more likely to subsequently lose their jobs, compared to similar workers who did not." The author also cites evidence that eviction can negatively impact health (e.g., maternal depression).

29. **Tsai J., Jones N., Szymkowiak D., et al. Longitudinal study of the housing and mental health outcomes of tenants appearing in eviction court. *Social Psychiatry and Psychiatric Epidemiology.* 2020.**

Tsai et al. conducted a longitudinal study of tenants over 18 years of age who appeared in eviction court from March 2017 to October 2018 in New Haven, Connecticut and had been issued a "notice to quit" due to non-payment of rent or a lease violation. The purpose of the study was to determine the impact of eviction on mental health outcomes. They recruited 121 tenants and collected information about their housing status, mental health, and psychosocial status at baseline (appearance in eviction court) and at 1, 3, 6, and 9 months following their appearance in court. Housing status and previous history of evictions were assessed. Mental health status and psychosocial status was assessed using validated survey instruments. The authors cited previous research that "mental health and psychosocial problems can be both causes and consequences of eviction" and noted that individuals with severe mental illness are often evicted for their disability status. The authors stated, "the course and long-term outcomes of people who face eviction are unclear and so research is needed." At baseline, the majority of individuals appearing in eviction court were female (74%), Black (59%), aged 18-49 years (69%), never married (59%), with high school or some education (76%), and with an annual income less than $15,000 (55%). Additionally, about 28% were unemployed, 19% were disabled, 23% had ever been incarcerated, and 4% were military Veterans. About 42% of individuals had ever appeared in eviction court, with about 28% having experienced a previous eviction. Forty-four percent had ever experienced homelessness. At 1 month after eviction court, only 4.4% had lost their case and were evicted and only 3% had won their case and did not have to move. The majority of cases were referred to some type of mediation/stipulation process, with 48% of cases having to move. Overall, 54% of individuals who appeared in eviction court were forced to relocate and "these participants experienced significantly greater housing instability over time than those who did not have to move, underscoring the influence of the housing eviction process on housing stability for at least 9 months afterwards for those who had to move." The authors stated that, "participants experienced significantly fewer days housed in their own place and more days homeless or unstably housed over time, from baseline to 3, 6, and 9 months." Further, "after eviction court, many participants experienced increased homelessness and housing instability over time. In fact, participants reported that they were either homeless or unstably housed over one-fifth of the time after eviction court." The study also found that "one-third of participants screened positive for major depressive disorder and over one-third screened positive for PTSD and/or generalized anxiety disorder at baseline; while these rates did decrease over time, many participants continued to report problems (15–19% screened positive for at least one of these disorders at 9 months)." Seventeen percent of participants reported suicide ideation at baseline and "evictions have [been] found to be a precipitating factor for suicide." Individuals reported ongoing mental health problems over time, but only 17-22% sought mental health treatment and only 1-11% sought substance use treatment over time. They found that, "compared to participants who did not have to move, participants who did have to move experienced significantly greater increases in days unstably housed from baseline to 1 and 3 months, and decrease in number of days they spent in their own place during those time periods. There were no significant changes in mental health symptoms or utilization of mental health or substance [use] treatment services between groups over time." The authors state that this suggests, "participants are already very distressed with high rates of mental health problems during presentation to eviction court." Lastly, approximately 67% of participants had an eviction

recorded in their public record and "an eviction record is public and can negatively affect future applications for rental housing as many landlords are reluctant to rent to applicants with eviction records." The authors noted that study findings may not be generalizable to individuals who are evicted, but do not appear in eviction court.

30. **Cookson T. , Diddams M. , Maykovich X., et al. Losing Home: The Human Cost of Eviction in Seattle.Seattle, WA: Seattle Women's Commission; King County Bar Association's Housing Justice Project; September 2018 2018.**
This report authored by the Seattle Women's Commission (SWC) and the King County Bar Association's Housing Justice Project (HJP) analyzes eviction causes, process, and outcomes in Seattle to determine how eviction contributes to the homelessness crisis, which has disproportionately impacted marginalized communities (e.g., women, people of color, and people with low incomes). It "investigates how current policies and the practices of courts, landlords, attorneys, and other private actors facilitate the mass eviction of low-income tenants in Seattle." Additionally, "it assesses eviction factors like the amount of unpaid rent that trigger evictions, how much debt tenants accumulate as a result of eviction rulings, how evictions affect tenant and family health, and where tenants go after eviction." Authors identified 1,218 unlawful detainer cases filed against residential households, affecting a total of 1,473 tenants, within Seattle city limits in 2017 and gathered data related to demographics, reasons for eviction, financial costs, and tenant experiences. Results of the analysis showed: women were more likely to be evicted over small amounts of money (e.g., of single-tenant household cases where a tenant owed $100.00 or less, 81.0% were women); "51.7% of tenants in eviction filings were people of color; 31.2% were Black tenants, experiencing eviction at a rate 4.5 times what would be expected based on their demographics in Seattle"; "86.5% of eviction filings were for nonpayment of rent and of these, 52.3% were for one month or less in rent"; "Tenants face steep financial costs resulting from eviction: the median court judgment was $3,129.73, including rent owed, nonrent charges, and legal costs"; "Tenants were required to pay attorney's fees (90.6% of cases with a median charge of $416.19) and court costs (92.2% of cases with a median charge of $358.98) in the majority of cases"; and From the court records, 23.4% of tenants with legal counsel remained housed, compared to 14.6% without counsel", among others.

31. **M4552 Commerce HEN Homeless February 2025. In: DSHS/ESA-EMAPS, ed2025.**
This dataset presents HEN referrals from DSHS based on incapacity for February 2025, which is the most recent full month of data available.

32. **Development The U.S. Department of Housing and Urban. The 2024 Annual Homelessness Assessment Report (AHAR) to Congress.2024.**
In December 2024, HUD completed the Annual Homelessness Assessment Report (AHAR) to Congress. The report includes findings from a Point-In-Time estimate of people in the U.S. experiencing homelessness on a single night. This report provides a summary of Point-in-Time estimates, including information specific to Washington State.

33. **American Community Survey, DPO4, Selected Housing Characteristics: Washington State. In: Bureau USC, ed2021.**
As of the 2020 Decennial Census, there were 3,202,241 housing units in Washington State. The 2021 American Community Survey showed that 64% of housing units were owner-occupied and

36% were renter-occupied. The median gross rent in Washington State was $1,484, which was slightly above the national median gross rent of $1,191. Forty-nine percent of renters in Washington State pay 30% or more of their income on rent. Approximately 31% of householders had moved in 2019 or later.

34. **Coalition National Low Income Housing. The Gap A Shortage of Affordable Homes.Washington, DC2020.**
The National Low Income Housing Coalition (NLIHC) is an advocacy organization "dedicated to achieving socially just public policy that ensure people with the lowest incomes in the United States have affordable and decent housing." It conducts an annual report examining the American Community Survey to determine the availability of rental homes affordable to households with extremely low-income (i.e., those with incomes at or below the federal poverty line or 30% of the area median income, whichever is greater). This March 2020 report found that renters with extremely low incomes comprise 25% of all renter households and 8% of all U.S. households. Nationally, they estimate there are 36 affordable and available homes for every 100 extremely low-income renter households. Seventy-one percent of the country's extremely low-income renter households spend more than half of their income on rent and utilities. "Extremely low-income renters are more likely than other renters to be seniors or people with disabilities. Forty-six percent of extremely low-income renter households are seniors or disabled, and another 44% are in the labor force, in school, or single-adult caregivers." Additionally, evidence shows people of color are more likely than white people to be extremely low-income renters. Where 6% of white non-Hispanic households have extremely low-income, 22% of Black households, 17% of American Indian or Alaska Native households, 15% of Hispanic households, and 10% of Asian households have extremely low-income. The report provides additional context as to the historical and current policies that have led to the current gap in affordable housing.

35. **DeSilver D. As national eviction ban expires, a look at who rents and who owns in the U.S.: Pew Research Center;2021.**
The Pew Research Center summarized data from various sources related to renters and landlords in the U.S. Based on data from the U.S. Census Bureau, 36% of U.S. households were in renter-occupied units. Renters are more likely to be young people, people of color, and people with lower incomes. PEW reported that 58% of households headed by Black adults rent their homes, 52% of household headed by Hispanic or Latino adults rented, and 40% of households headed by Asian adults rented, compared to 28% of households headed by Non-Hispanic white adults who rented. Seventy-five percent of all owner-occupied housing units in the U.S. are owned by non-Hispanic, white householders. By age, 66% of people under 35 years old rent compared to 42% of people aged 35 to 44 years and 32% of people aged 45 to 54 years. Based on data from the Federal Reserve's 2019 Survey of Consumer Finances (the most recent report available), people who rent tend to earn less and have less wealth than homeowners. About 61% of people in the lowest income quartile rent their homes, compared to 10.5% of people in the top income quartile who rent. PEW reported that the majority of rental properties (7 out of 10) are owned by individuals, rather than for-profit business of any kind. In 2018, "only about half of individual landlords reported net income […] with the rest losing money on their properties." Moreover, "[r]egardless of whether the landlord is making money, rent makes up a big chunk of many tenants' expenses. Of the nearly 44.1 million renter households in 2019, more than 45% paid rent

equal to 30% or more of their gross household income (30% being a common [understanding] for how much of a person's gross income should be spent on housing)."

36. **Report on the Economic Well-Being of U.S. Households in 2022 - May 2023. 2023; Available at: https://www.federalreserve.gov/publications/2023-economic-well-being-of-us-households-in-2022-housing.htm. Accessed 4/1/2025.**
This Board of Governors of the Federal Reserve System provides a report on the economic well-being of U.S. households in 2022. Information presented includes data on housing including living arrangements, homeownership and mortgages, renters, and renter experiences. In 2022, 2% of current renters reported moving in the prior year because of an eviction or the threat of an eviction. This represents 13% of current renters who moved during 2022.

37. **Quality Agency for Healthcare Research and. 2016 National Healthcare Quality and Disparities Report.Rockville, MD: U.S. Department of Health and Human Services;2017.**
The National Healthcare Quality and Disparities Report is mandated by Congress and has been published every year since 2003. The intent of the report is to summarize the quality of healthcare received by people in the United States, and to identify disparities in care and access to care by priority populations. It evaluates quality of healthcare in six core areas: person-centered care, patient safety, healthy living, effective treatment, care coordination, and care affordability. The report uses four main measures for access to care: having health insurance, having a usual source of care, encountering difficulties when seeking care, and receiving care as soon as wanted. Over time, the report has found disparities in access to care based on race and ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location. The 2016 report concluded that, while disparities in health insurance status decreased since 2014, about 70% of care affordability measures have not changed since 2010 and disparities in care persisted for poor and uninsured populations in all priority areas. The report stated, "poor people experienced worse access to care compared with high income people for all access measures except one" and "more than half of measures show that poor and low-income households have worse care than high-income households." Further, the report concluded that "significant disparities continue for poor people compared with high-income people who report they were unable to get or were delayed in getting need medical care due to financial or insurance reasons."

38. **Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System Prevalence And Trends Data: Washington-2014. 2014; Available at: http://apps.nccd.cdc.gov/brfss/page.asp?cat=XX&yr=2014&state=WA#XX. Accessed August 16, 2016.**
Behavioral Risk Factor Surveillance System (BRFSS) 2014 data from Washington state show significant correlations between lower income and a number of health indicators including: worse overall self-reported health, depression, asthma, arthritis, stroke, oral health, tobacco use, women's health indicators, health screening rates, physical activity, and diabetes.

39. **Prevention Centers for Disease Control and. Behavioral Risk Factor Surveillance System. 2021.**
The Behavioral Risk Factor Surveillance System (BRFSS) is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their

health-related risk behaviors, chronic health conditions, and use of preventive services. Established in 1984 with 15 states, BRFSS now collects data in all 50 states as well as the District of Columbia and three U.S. territories. BRFSS completes more than 400,000 adult interviews each year, making it the largest continuously conducted health survey system in the world. Prevalence and trends data are available for individual states of the nation by health topic.

40. **Serafin M. Health of Washington State Report: Self-reported Health Status. Data Update 2016. Washington State Department of Health;2016.**
Data from Washington State on self-reported health status. The data show that after accounting for age, education, race and ethnicity, household income was a strong predictor of self-reported health status. Health status varied by race and ethnicity, with close to 20% of Native Hawaiian/Other Pacific Islander reporting fair or poor health.

41. **Spencer N., Thanh T. M., Louise S. Low income/socio-economic status in early childhood and physical health in later childhood/adolescence: a systematic review. *Maternal and child health journal.* 2013;17(3):424-431.**
Spencer et al. conducted a meta-analysis of studies examining the relationship between low socioeconomic status in the first five years of life and physical health outcomes in later childhood and adolescence. Nine studies met the researchers' strict inclusion criteria. The studies indicated significant associations between early childhood low-income status and a number of adverse health outcomes including activity-limiting illness, parent-reported poor health status, acute and recurrent infections, increasing body mass index (BMI), dental caries, and higher rates of hospitalization.

42. **Wang K. Housing Instability and Socioeconomic Disparities in Health: Evidence from the U.S. Economic Recession. *Journal of Racial and Ethnic Health Disparities.* 2022;9(6):2451-2467.**
Wang conducted a study to examine the association between neighborhood housing insecurity and health outcomes. The research focuses on income levels and racial groups. The researcher used national Census data to examine about 200 U.S. metropolitan areas after the 2008 housing crisis. The results indicate that "high levels of foreclosed properties in certain neighborhoods were strongly associated with more health problems among residents, but the results varied according to the income level and the dominant racial group in these neighborhoods". Worse health problems were present in lower income minority groups of people.

43. **Friedman S., Hamer-Small K., Choudary W. Disability Status, Housing Tenure, and Residential Attainment in Metropolitan America. *Social Sciences* 2018;7(144).**
Friedman, Hamer-Small and Choudary examined inequities in residential disadvantage among households with people with disabilities. The study found that disadvantage was worse in the sales market, compared to the rental market. Household income among households with people with disabilities is significantly lower than households without people with disabilities. Households with people with disabilities are more likely to receive public assistance and disability income. The authors call for support for people with disabilities and greater enforcement of the Fair Housing Amendments Act.

44. **Washington State Division of Vocational Rehabilitation. Disability & DVR Statistics Report.2017.**
The Disability & Division of Vocational Rehabilitation Statistics Report studies demographic, economic, and vocational rehabilitation service data to assess the complex factors affecting employment for Washingtonians with disabilities. Washington State DVR service data are compared to extant data from the US Census Bureau's American Community Survey and Current Population Survey and the Social Security Administration. These comparisons provide insight on a range of topics including, but not limited to, the extent of disability in Washington State, demographic and economic characteristics of people living with disabilities, differences between the populations of Washingtonians with and without disabilities, and potential service gaps for communities of individuals with disabilities.

45. **Molinsky J., Berlinger N. Advancing Housing and Health Equity for Older Adults: Pandemic Innovations and Policy Ideas. Harvard University Joint Center for Housing Studies, The Hastings Center 2022.**
The Harvard Joint Center for Housing Studies advances understanding of housing issues and informs policy. The Hastings Center is an independent, nonpartisan, interdisciplinary research institute that explores fundamental ethical and social issues in population health, health care, science, and technology. This report focuses on practices and policies that emerged during COVID-19 to respond to the needs of community-dwelling moderate- and low-income older adults. Recommendation 5 focused on flexibility in regulations and funding to increase effectiveness.

46. **Disabilities National Center on Birth Defects and Developmental. Disability Impacts Washington. Centers for Disease Control and Prevention;2021.**
The Centers for Disease Control and Prevention share data from the 2021 Behavioral Risk Factor Surveillance System (BRFSS). Data are specific to Washington State.

47. **ECONorthwest. Housing Needs for Individuals with Intellectual and Developmental Disabilities in Washington State. Washington State Department of Social and Health Services 2022.**
The Washington State Department of Social and Health Services, Developmental Disabilities Administration and ECONorthwest prepared this report to describe housing-related challenges among the Washington population of adults with intellectual and developmental disabilities. Key findings include that is likely that more than 37,000 adults with intellectual developmental disabilities in Washington State are facing housing insecurity. Demographics of people with disabilities, housing options, challenges, and development are included in the report. Appendices are available with additional data.

48. **Diamond R. , McQuade T., Qian F. The Effects of Rent Control Expansion on Tenants, Landlords, and Inequality: Evidence from San Francisco. *American Economic Review.* 2019;109(9):3365-3394.**
Diamond et al. leveraged data following a change to San Francisco law to study the effects of rent control on the city's tenants and landlords. After a 1994 ballot initiative, tenants who lived in small multi-family buildings (i.e., with 4 units or fewer) built before 1980 were suddenly protected by statute against rent increases. However, tenants who lived in small multi-family

housing built in 1980 or later did not benefit from rent control protections under the new law. Authors used this quasi-experimental variation in the assignment of rent control and newly available data tracking individuals' migration to assess the policy's impacts on tenants and landlords. To their knowledge, this paper was the first to study how rent control affected the behavior of actual tenant beneficiaries. Overall, evidence indicated rent control limited renters' mobility by 20% and lowered displacement from San Francisco. Authors found "[e]stimated effects [were] significantly stronger among older households and among households that [had] already spent a number of years at their address prior to [rent control]." Authors noted, these populations are less likely to experience personal shocks that require a change of residence. Therefore, these households are better positioned to benefit from potential savings offered by rent control. Results also indicated that rent control had an "especially large impact on preventing the displacement of racial minorities from San Francisco [...] at least among the initial cohort of renters covered by the law." Meanwhile, "landlords treated by rent control reduced rental housing supplies by [15%] by selling to owner-occupants and redeveloping buildings." Authors concluded that the implementation of rent control "ultimately led to a housing stock which [catered] to higher income individuals." New high-end housing attracted residents with at least 18% higher income compared to control group buildings in the same zip code. Evidence also indicated "the average tenant treated by rent control [lived] in a census tract with worse observable amenities, as measured by the census tract's median household income, share of the population with a college degree, median house value, and share unemployed." Authors concluded, "while rent control prevents displacement of incumbent renters in the short run, the lost rental housing supply likely drove up market rents in the long run, ultimately undermining the goals of the law."

49. **Healthy People 2030: Older Adults. Available at: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/older-adults. Accessed 4/1/2025.**
This HHS Healthy People 2030 webpage discusses health risks for older adults.

50. **What is Human Trafficking? Available at: https://www.justice.gov/humantrafficking/what-is-human-trafficking. Accessed 4/1/2025.**
This U.S. DOJ webpage provides an overview of human trafficking, or trafficking in persons, victims-survivors, vulnerabilities, locations, and traffickers.

51. **Preble K.M. , Nichols A. , Cox A. . Working With Survivors of Human Trafficking: Results From a Needs Assessment in a Midwestern State, 2019. *Public Health Reports.* 2022;137:111S-118S.**
Preble et al. surveyed health care, social service, law enforcement, public health, and other service providers involved in anti-human trafficking service delivery to assess the needs of survivors of human trafficking. In 2019, researchers collected responses from 107 service providers working with 422 survivors of human trafficking in the perious 12 montsh in a Midwestern state (Missouri). Respondents indicated on a Likert scale (1-5) the level of need for 37 social, health care, and legal services in their communities. Responding service providers reported "working primarily with survivors of sex trafficking (57.9%, n = 62), both sex and labor trafficking (12.1%, n = 13), and labor trafficking (2.8%, n = 3); the remaining 29 participants did not report working with a specific type of trafficking." Researchers noted that "Of the 422

identified survivors with whom respondents indicated they were working within the previous 12 months, 20 (4.7%) experienced labor trafficking only, 53 (12.6%) experienced both sex and labor trafficking, and 349 (82.7%) experienced sex trafficking only." Results showed that "the top-indicated needs statewide were mental health care, shelter/housing, peer mentorship programs, legal services, transportation, and provider training in juvenile courts, schools, law enforcement, and health care settings on human trafficking." Authors noted that identified housing and shelter needs are consistent with previous research (i.e., Virginia, multistate study). More specifically, providers surveyed indicated culturally competent shelter for lesbian, gay, bisexual, transgender, and queer/questioning populations and sex trafficking prevention programming as high-level needs. Authors noted that housing needs were relatively consistent across rural and urban regions included in the study.

52. **Lederer L. J., Wetzel C. A. . The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities. *Annals of Health Law.* 2014;23:61-91.**

Lederer et al. used a mixed-methods approach to collect data from female survivors of sex trafficking. Authors combined qualitative data collection from focus groups and structured interviews with quantitative analysis. Following a feasibility study (one focus group in November of 2011), researchers conducted a series of 11 similar focus groups in U.S. cities from January 2012 to December 2012. Focus groups included 107 participants, all survivors of domestic sex trafficking, ranging in age from 14 to 60 years of age. Following focus group sessions that discussed a range of topics (early childhood trauma, age at which trafficked, etc.) survivors completed an extensive health survey. The survey included three components. First, survivors reported on more than 100 discrete health conditions (e.g., general health, communicable and non-communicable diseases, dental health, psychological symptoms and disorders, and reproductive health) and violence experienced during trafficking—physical abuse (i.e. beaten, punched, kicked, raped, penetrated with foreign objects, threatened with a weapon, burned with cigarettes, strangled, stabbed, slashed, or forced to have unprotected sex) and other ways they were violated (e.g., participate in pornography, recreate scene from pornographic material, or submit to abuse by a person in authority). Second, they completed a series of open-ended questions about health care (e.g., access to and use of birth control, types of medical treatment sought and whether providers asked or knew about their situations, and reproductive history). Third, they answered questions regarding symptoms experienced after escaping trafficking (i.e., physical and psychological symptoms). Authors analyzed "the frequency with which individual symptoms and experiences were reported by the survivors in this study as well as the percentages of victims who reported at least one symptom or experience in a given category." Out of 106 survivors (one participant did not complete the first survey component), 105 (99.1%) reported at least one physical health problem during trafficking. "The most frequently reported physical problems were neurological—91.5% of respondents reported at least one neurological symptom and 82.1% specifically reporting memory problems, insomnia, or poor concentration." Survivors reported headaches or migraines (53.8%), dizziness (34.0%), severe weight loss (42.9%), malnutrition (35.2%), loss of appetite (46.7%), eating disorders (36.2%). Overall, 71.4% of respondents reported at least one diet-related symptoms. Moreover, nearly 70% reported physical injuries, most commonly to the head or face. Respondents also experienced symptoms not conventionally associated with sexual abuse including, cardiovascular or respirator difficulty (67.9%), gastrointestinal symptoms (61.3%), and dental problems

(54.3%). In addition to physical trauma, 98.1% of survivors (104/106) surveyed reported at least one psychological issue while being trafficked, and survivors noted an average of more than a dozen symptoms (12.11). "The most frequently reported problems included depression (88.7%), anxiety (76.4%), nightmares (73.6%), flashbacks (68.0%), low self-esteem (81.1%), and feelings of shame or guilt (82.1%) [...] 41.5% had attempted suicide (one victim reported 9 such attempts) and 54.7% suffered from Post Traumatic Stress Disorder." Overall, the psychological consequences that the victims of trafficking in these focus groups reported were "wide-ranging, severe, and in some cases nearly universal." When reporting on their health experiences after trafficking, "96.4% of survivors reported at least one psychological symptom and an average of 10.5." More than two-thirds of women (67.3%) contracted some form of sexually-transmitted disease or infection (STD/STI). "Survivors reported significantly higher rates of chlamydia (39.4%) and gonorrhea (26.9%) than the next most common disease (Hepatitis C, 15.4%)." Furthermore, 63.8% reported at least one gynecological symptom other than STDs/STIs, with pain during sex (46.2%), urinary tract infections (43.8%), and vaginal discharge (33.3%) among the most common symptoms. Authors note, "[o]n average, respondents reported being used for sex by approximately 13 buyers per day, with a median of 10. Some respondents reported typical days of as many as a thirty to fifty buyers." Despite reporting complications related to pregnancies and their results, authors conclude with confidence that pregnancy, miscarriage, and abortion were all common experiences for survivors in the study. Specifically, more than half of survivors who underwent one or more abortions while being trafficked reported that one or more of their abortions was at least partially forced upon them. One victim noted that "in most of [my six abortions,] I was under serious pressure from my pimps to abort the babies." When asked about experiences of violence or abuse, respondents reported an average of 6.25 of the 12 forms of violence. Eight of the 12 were reported by half or more of the respondents, including strangulation. Authors note that, "many survivors were dependent on drugs or alcohol while they were trafficked either because the substances were forced on them as a control mechanism by their traffickers or because substance use was a means of coping with the immense abuse they suffered." Results show that 84.3% used alcohol, drugs, or both during their captivity and more than a quarter (27.9%) said that their forced substance use was a part of their trafficking experience. Most survivors reported receiving medical treatment at some point during their trafficking. "Of those who answered the questions about their contact with healthcare (N=98), 87.8% had contact with a healthcare provider while they were being trafficked. By far the most frequently reported treatment site was a hospital/emergency room, with 63.3% being treated at such a facility." Authors noted 29.6% of survivors visited clinical treatment facilities (most commonly Planned Parenthood clinics), and "more than half (57.1%) of respondents had received treatment at some type of clinic (urgent care, women's health, neighborhood, or Planned Parenthood)." Nearly fifty-two percent of respondents who answered (N=81) said that "at least some of the time the doctor knew they were 'on the street,' while the remaining respondents did not believe doctors were aware of their situations." Meanwhile, "almost half of survivors (43.1%) (N=58) said the doctor asked them something about their lives, but only 19.5% of those who answered (N=41) reported that the doctor knew they had a pimp." Results indicate that some victims may seek health care services alone. If trust level and other considerations allow, providers may have the opportunity to ask questions about the victim's situation and provide her with resources like contact information for rescue and other services. Authors reference legal aid strategies as a guidance to "gradually working with the victim's identifiable health problems to elicit important facts about their over-arching situation is likely to be most effective and least

intrusive." Authors also recommend extending the Violence Against Women Reauthorization Act to cover adult trafficking victims and adult survivors, as their physical and mental health needs are just as great as those of minor sex trafficking victims.

53. **Farley M, Deer S., Golding J.M., et al. The prostitution and trafficking of American Indian/Alaska Native women in Minnesota.** ***American Indian Alaska Native Mental Health Res.*** **2016;23(1):65-104.**
Researchers interviewed 105 American Indian and Alaska Native (AI/AN) women in prostitution who were in contact with supportive agencies in Minnesota. The women volunteered for the study after seeing announcements posted at agencies or via snowball or chain referral sampling. Research interviews consisted of six questionnaires (i.e., The Prostitution Questionnaire, elements from the Dissociation subscale of the Briere's Trauma Symptoms Checklist, the Post-traumatic Stress Disorder Checklist, self-rating general health scale, the Native American Prostitution Questionnaire) that included both quantitative items and structured open-ended questions. The mean age of respondents was 35 years (range = 18 to 60 years, SD = 11 years). Ninety-eight percent of the women were currently or previously homeless. Of the AI/AN women interviewed, 9% had attended boarding school, and 69% had family members who had attended boarding school. Of the relatives who had attended boarding school, more than two-thirds (69%) were known by the women to have been abused there. Abuse perpetrated by teachers, church officials, and government officials included verbal or mental abuse (100%): spiritual, cultural, or physical abuse (94%); and sexual abuses (27%). Forty-six percent of the women interviewed had been in foster care, in an average of 5 foster homes (range = 1-20, mean = 3, SD = 4.8); and almost half of those who had been in foster care had been abused by their foster families. Overall, 52% of the women had been arrested during childhood and 88% had been arrested as adults; 12% reported being arrested for prostitution as an adult; 39% reported being younger than 18 years when they entered prostitution; 75% had engaged in prostitution in exchange for food, shelter, or drugs; and 45% had been trafficked for the purpose of prostitution. Researcher cited evidence that "prostitution often meets the legal definition of human trafficking, in that pimping or third-party control of a prostituted person cannot be distinguished from trafficking." More than half (53%, n=56) had been raped five to ten times, and 15% had been raped more than 20 times in prostitution. Women reported assault by the man who bought sex (44%, n=46), pimps (15%), or someone who was neither a sex buyer or pimp (27%). More than half (52%) had been physically threatened in the month prior to the interview. Of those, 87% had been threatened with a gun, knife, or other weapon. "Almost three fourths of the women (72%) had suffered traumatic brain injury. Assaults to the head included the following symptoms and sequelae: broken jaws, fractured cheekbones, missing teeth, punched lips, black eyes, blood clots in the head, hearing loss, memory loss, headaches, and neck problems." Other violent injuries suffered included flesh wounds; broken bones; arm/shoulder injuries; scars or bruises; knee/ankle injuries; and being raped, kicked, strangled, burned, or shot. More than half (51%) of the women interviewed had been diagnosed with physical health problems; 65% of respondents had been diagnosed with a mental health problem, most commonly depression (78%) and anxiety disorders (71%). Furthermore, 40% of the women had been psychiatrically hospitalized. Based on responses, 52% of the women met all criteria for a diagnosis of PTSD; their mean PTSD severity score was 51 (SD=19). This rate compares to an 8% prevalence rate in the general U.S. population. Analysis found that more severe the interviewees' symptoms of PTSD, the poorer their health ratings, r = .22, p = .024, N = 101. Moreover, researchers found the more severe the

women's dissociative symptoms (e.g., spacing out, memory problems, flashbacks, derealization, not in your body), the more likely they were to report fair or poor health, r=.35, p=.0003, N=102. Some explained how dissociation helped them survive prostitution. Roughly three-quarters of respondents used drugs or alcohol, and a majority of those who used drugs or alcohol (61%) described the need to "chemically dissociate" from the physical and emotional pain during prostitution. "One woman explained that she used drugs 'so it can numb me, so I can do what they want me to do.' Another stated '...That's why I did a lot of drugs—to numb myself—so I didn't know what was going on and I could just leave my body.'" Women reported that race/ethnic prejudice is integral to prostitution. For example, 42% of the women reported being racially insulted by sex buyers or pimps. Similarly, the majority of women saw connections between colonization and prostitution of AI/AN women. Some identified connections with their cultural identities and support from other AI/AN people as ways of surviving prostitution. The overwhelming majority (92%) of interviewees wanted to escape prostitution, and most identified individual counseling (75%) and peer support (73%) as needs to successfully leave the life. Authors state that "[t]he multiple arrests of these women [starting in childhood] prevented their escape from prostitution, because a criminal record was a barrier to obtaining affordable housing, employment, and frequently even essential social services." Authors recommend legal aid (e.g., criminal record expungement); policy reform to decriminalize victims of prostitution to ensure AI/AN women who have been domestically trafficked receive the same access to services as do international victims of trafficking; and cultural competence in mental health care of AI/AN people (e.g., acknowledge and analyze historical trauma, utilize cultural moderators to embrace traditional healing).

54. **(OFM) Washington State Office of Financial Management. Multiple Agency Fiscal Note Summary, ESSB 5232, 5232-S.E. AMH ELHS H1986.1 (Essential needs program uses). 2025.**
A full Multi-Agency Fiscal Note for ESSB 5232, 5232-S.E. AMH ELHS H1986.1 (Essential Needs program uses) was published on April 4, 2025. The fiscal note includes fiscal estimates and information from local governments and the Washington State Health Care Authority and Departments of Commerce; Health; and Social and Health Services.

55. **Medical Care Services (MCS) Program. 2023; Available at: https://www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/medical-care-services-mcs-program. Accessed 3/30/2025.**
This Washington State Health Care Authority (HCA) webpage provides information about the Medical Care Services (MCS) Program, including the purpose of the program and relevant WAC.

56. **ESA Find an Office. Available at: https://www.dshs.wa.gov/esa/esa-find-office. Accessed.**
This DSHS webpage provides information about the Community Services Division which provides direct client services.

57. **Commerce Washington State Department of. Guidelines for the Consolidated Homeless Grant. In: Commerce WSDo, ed. 2 ed. Olympia, WA2024.**

The Washington State Department of Commerce publishes guidelines for the Consolidated Homeless Grant. Section 5 of the Guideline outlines requirements and guidance for Housing and Essential Needs funded with HEN.

58. **Housing and Essential Needs services effective at reducing homelessness. 2013; 2/14/2013:Available at: https://www.commerce.wa.gov/housing-essential-needs-services-effective-reducing-homelessness/. Accessed.**
This WA State Department of Commerce webpage announced the 2013 release of DSHS Research & Data Analysis Division's analysis of the Housing and Essential Needs Program's effectiveness at reducing homelessness.

59. **Bureau United States Census. QuickFacts Washington. 2024.**
The American Community Survey published 2023 data online, which included housing-related measures in Washington State. The Census Bureau website can be queried for specific data outcomes and measures.

60. **Federal poverty level (FPL). 2025; Available at: https://www.healthcare.gov/glossary/federal-poverty-level-fpl/. Accessed 4/1/2025.**
This HHS website documents the federal poverty level (FPL), a measure of income updated yearly by HHS, which is used to determine eligibility for certain programs and benefits, like Marketplace savings, and Medicaid and the Children's Health Insurance Program (CHIP) coverage.

61. **State U.S. Department of. Trafficking in Persons Report June 2016.Washington, D.C.2016.**
This report provides a global overview of human trafficking as well as country specific information and recommendations specific to protection, prosecution, and prevention.

62. **Laywell K. Housing Access for Immigrant Households. National Low Income Housing Coalition;2023.**
In this report, the National Low Income Housing Coalition provides a summary related to federal housing assistance for immigrant households. Public housing and Section 8 programs must meet immigrantion status eliglibty requirements established under Section 214 of the "Housing and Community Development Act of 1980". Specifically "[people] with the following immigration status are eligible for federal housing assistance programs: U.S. citizens and nationals, lawful permanent residents (people with "green cards"), "Violence Against Women Act" (VAWA) self-petitioners, asylees and refugees, parolees, persons granted withholding of removal, victims of trafficking, [people] residing in the U.S. under COFA, and immigrants admitted for lawful temporary residence under the "Immigration Reform and Control Act of 1986." Being ineligible for housing assistance is not equivalent to being undocumented. Immigrants with student visas, Temporary Protected Status, U nonimmigrant status, and other statuses are also not eligible for federal housing subsidies."

63. **Obtaining a Social Security Number. no date; Available at: https://studyinthestates.dhs.gov/students/work/obtaining-a-social-security-**

number#:~:text=The%20Social%20Security%20Administration%20(SSA,resource%20page. Accessed 3/28/2025.
This U.S. Department of Homeland Security webpage provides information about obtaining a Social Security Number (SSN), including information about who is eligible for a SSN.

64. **Request Social Security Number for the first time. no date; Available at: https://www.ssa.gov/number-card/request-number-first-time. Accessed 3/28/2025.**
This U.S. Social Security Administration webpage provides information about who can request a Social Security Number.