April 25, 2022

Samantha Deshommes
Chief, Regulatory Coordination Division
U.S. Citizenship and Immigration Services Department of Homeland Security
20 Massachusetts Avenue NW Washington, DC 20529-2140
Submitted via www.regulations.gov

Re: DHS Docket No. USCIS-2021-0013; Comments on Public Charge Ground of Inadmissibility

Dear Chief Deshommes:

The Association of Asian Pacific Community Health Organizations (AAPCHO), California Primary Care Association (CPCA), National Association of Community Health Centers and the 35 undersigned member health centers/organizations submit these comments in response to the NPRM put forward by USCIS on the public charge ground of inadmissibility.

The proposed regulation restores and improves upon the public charge policy that was in use from the late-1990s through the late 2010s, and that was consistent with longstanding public charge policy. Importantly, the NPRM recognizes that use of core health, nutrition, and housing assistance programs should in no way be linked to the INA's public charge provision. They represent our country's policy choices about how to help all workers and families succeed. This is a common sense foundation on which to build. We commend DHS for proposing significant improvements to the 1999 guidance. These improvements – especially proposed definitions and instructions for adjudicating officers – will reduce the bias and harm resulting from the application of the INA's public charge provision. "Primarily dependent" is the appropriate standard for a public charge determination and we support its use.

For the reasons stated in this letter, we recommend that the following be addressed and resolved within this NPRM:

1. Do not consider Medicaid – even for institutional long term care – in a public charge determination because including any Medicaid coverage causes confusion and contributes to the chilling effect.
2. Exclude programs funded completely by state, local, tribal and territorial governments.
3. In addition to ensuring that the public charge test is narrow and does not amount to a wealth or income test, the public charge regulations must be clear to avoid furthering confusion for immigrant families, which can cause immigrants and their family members to avoid public benefits, known as the chilling effect.
4. The Biden Administration should conduct education and outreach efforts to address the chilling effect. It is imperative that the Biden Administration provide resources to fund

community outreach programs to combat misinformation and fear among immigrant communities.

5. Specify that use of benefits while an individual is a child, pregnant or in an exempt status will not be included in a public charge determination, nor will benefits used when applying for an exempt status.

6. Exclude any use of benefits by survivors of domestic violence and other serious crimes and by anyone during public emergencies.

We support the following proposed public charge NPRM:

1. DHS's proposal not to define the five statutory factors described in the INA: the applicant's age, health, family status, assets, resources and financial status, and education and skills.

2. The rule's proposal to require adjudicators to explain their reasoning for determination of the 5 factors in denials while also requiring every denial decision to be in writing, and articulate a reason for the determination.

3. The new provision in the rule Section 212.22(e) which clarifies that benefits used while eligible for refugee resettlement assistance are not considered in the public charge determination.

4. The provision in the rule that states the affidavit of support will be considered favorably.

5. The clarification that only benefits for which the applicant is listed as a beneficiary will be considered.

<u>Community Health Centers (CHCs) and their Patients</u>

CHCs are federally-funded or federally-supported nonprofit, community-directed provider clinics that serve as the health home for over 29 million people, including 1 in 5 Medicaid beneficiaries and 1 in 3 people living in poverty nationwide. It is the collective mission and mandate of nearly 14,000 FQHC sites around the country to provide access to high-quality, cost-effective primary and preventative medical care as well as dental, behavioral health, and pharmacy services and other "enabling" or support services that facilitate access to care to individuals and families located in medically underserved areas, regardless of insurance status or ability to pay.

Having been created through the Civil Rights movement, CHCs have, from their inception, been partners in fighting for health equity, expanding health care access, and helping to address social determinants of health. By mission CHCs focus on providing culturally and linguistically diverse services to low income and non-English speaking communities regardless of their ability to pay and immigration status. Health center patients are predominately members of racial/ethnic minority groups. CHCs provide care to 10 million Latinx; over 1.6 million Asian American (AAs), American Indian/Alaska Native, and Native Hawaiian/Pacific Islander (NH/PI); and over 5 million Black patients. CHCs are a medical lifeline, communicating accurate, scientific information and providing holistic, high quality, coordinated services. CHCs provide care to disproportionately more limited English proficient (LEP) patients than the average health facility, recognizing that effective care requires reducing language barriers.

AAPCHO, CPCA, NACHC and our member CHCs have seen the chilling effects of public charge on our patients, who have foregone essential services, disenrolled from benefits for which they are eligible, or just not shown up to receive necessary health care. Specifically, under the Trump Administration, CHCs throughout the country saw a dramatic increase in immigrant families choosing to not enroll in or disenrolling from the Children's Health Insurance Program (CHIP) and Medicaid. According to a report from the Urban Institute, more than one in seven adults in immigrant families reported that they or a family member avoided a non-cash government benefit program, such as Medicaid, the Children's Health Insurance Program (CHIP), the Supplemental Nutrition Assistance Program (SNAP), or housing subsidies in 2019 for fear of risking future green card status. Immigration laws should not discourage immigrants and their family members from seeking physical or mental health care, nutrition, or housing benefits for which they are eligible.

CHCs have also experienced significant declines in Medicaid enrollment and patient numbers as a result of the chilling effect. AAPCHO members reported a reduction in enrollment since the 2019 public charge rule started to chill participation in public benefits. In a KFF survey conducted with AAPCHO member CHCs between January to March of 2021, one quarter (25%) of Asian health center patient respondents say that they or a member of their household did not apply for or stopped participating in a government program to help them pay for health care, food, or housing in the past year due to immigration-related fears.[1]

a. Associations Representing CHCs

- The Association of Asian Pacific Community Health Organizations (AAPCHO) is a national membership organization of CHCs and community-based organizations that works to improve the health status and access of medically underserved Asian Americans (AA), Native Hawaiians, and Pacific Islanders (NH/PI).
- The California Primary Care Association represents California's more than 1,300 CHCs who serve 7.2 million patients of which 363,485 are homeless patients and 860,745 are migrant and seasonal farmworkers. CPCA's mission is to lead and position CHCs, and their networks through advocacy, education and services as key players in the healthcare delivery system to improve the health status of their communities.
- The National Association of Community Health Centers (NACHC) is the national membership organization for federally qualified health centers (also known as FQHCs or health centers).

I. RECOMMENDATIONS TO IMPROVE THE PUBLIC CHARGE RULE:

[1] "Asian Patients Confront Multi Pandemics: Racism, Immigration, and COVID-19." Association of Asian Pacific Community Health Organizations https://aapcho.org/asian-patients-confront-multi-pandemics-racism-immigration-and-covid-19-advocacy-brief/

1. *The Biden Administration should NOT consider Medicaid – even for institutional long-term care – in a public charge determination.*

CHCs have a statutory obligation to provide care to all patients, regardless of their ability to pay or immigration status. CHCs care for approximately 20 percent of all Medicaid beneficiaries across the nation, with over 45% of CHC patients enrolled in Medicaid or CHIP. The vacated 2019 Final Rule created fear and hesitation that led to immigrants disenrolling or not enrolling in public benefits, including Medicaid. In order for CHCs to serve uninsured and underinsured patients, it is imperative that patients enroll in health care coverage when they are eligible.

In our experience, allowing any type of Medicaid coverage to be considered in a public charge determination causes confusion among our members' patients and deters them from seeking to enroll in Medicaid coverage or seek care when they need it. It also perpetuates the chilling effect caused by the 2019 public charge rule. Research on the "chilling effect" makes clear that fear and confusion surrounding public charge extends well beyond the programs written into the rule[2]. CHCs have reported a significant drop in participants in the WIC program; this is particularly true for programs that served Latinx patients. This downturn is highly correlated with fear and confusion around public charge and immigration policy. Specifically, one AAPCHO member reported that it had to completely close its WIC program due to a lack of enrollment.

The best way to mitigate the chilling effect is to exclude Medicaid full stop. Many people living in the U.S. will one day rely on Medicaid for their long-term care needs. According to the Kaiser Family Foundation, in the U.S., one in three people turning 65 will require nursing home care in their lives, and Medicaid is the primary payer for long-term care in the US, covering six in ten nursing home residents. We should not penalize immigrants for the problems in the country's health care system that make it difficult to get care at home and force people into institutional care. In addition, including any type of Medicaid benefit will confuse people and lead them to forego health care.

Given that the Trump-era public charge rule listed Medicaid as a benefit that would count towards the public charge determination, CHCs saw many patients express concerns in obtaining this public benefit. We fear that by listing long term care in the public charge rule, since it's primarily funded by Medicaid, it would lead to the same confusion and cause patients to disenroll from Medicaid, a benefit they legally have a right to access. CPCA conducted a financial analysis of its members in 2018 and again in 2019 and determined that CA CHCs could see 101,000 to 305,000 patients disenroll from Medicaid and become uninsured. The growth in the number of uninsured patients and loss of Medicaid reimbursements would have created a financial loss of $56 million to $170 million per year in California's CHCs. If we look at California as a whole, and not just health center patients, we would see 1.5 million patients disenroll from Medicaid, which would cause a projected loss of $7 billion in Medicaid/CHIP funds for California, based on the 60% decline of public services use seen in 1996, when the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) was adopted. The lead up to and rollout of the Trump

[2] 7 Hamutal Bernstein, Jorge Gonzale, Dulce Gonazalez, Jahnavi Jagannath, Urban Institute, "Immigrant-Serving Organizations' Perspectives on the COVID-19 Crisis" August 2020 https://www.urban.org/research/publication/immigrant-servingorganizations-perspectives-covid-19-crisis.

public charge policy created a pronounced and persistent "chilling effect," that caused immigrants and their family members to disenroll from or fail to enroll in critical health, nutrition, and economic supports for which they were eligible. Given this precedent, and the trauma immigrant communities experienced under the Trump administration, any mention of Medicaid within the public charge final rule could lead to immigrant patients choosing to disenroll from health benefits.

2. *The Biden Administration should exclude programs funded completely by state, local, tribal and territorial governments.*

We oppose the proposed rule's inclusion of programs funded by state, local, tribal, and territorial governments as factors in a public charge determination. We urge the administration to reconsider this proposal and exclude all state, local, tribal, and territorial government programs–including if they provide cash assistance–from the public charge test. These types of assistance programs are exercises of the powers traditionally reserved to the states and jurisdictions that could have a compelling reason to extend health, safety, economic, and other assistance to their residents that should not be negatively weighed in federal immigration policies. Failure to exclude non-federal programs, including cash assistance programs, would undermine states' efforts to mitigate social problems and inequity, as well as complicating messages about the policy, undermining nationwide efforts to combat the persistent chilling effect.

Additionally, including state, local, tribal, and territorial government programs in a public charge test would negatively impact our CHC members. It would add additional administrative and financial barriers on CHCs that are already stretched thin and operate at the margins, and it would force them to navigate the complex web of federal and non-federal programs. When the Trump-era public charge rule went into effect, CHCs needed assistance, at times legal assistance, to determine if a person's use of benefits could potentially hinder their ability to adjust or change their status in the future since the state could not guarantee that certain programs were not receiving a federal match. CHC patients and staff were fearful that enrolling immigrant patients into public benefits could lead to their deportation if that patient or their family member were to adjust or change their status in the near future. By making clear in the final public charge rule that state, local, tribal, and territorial government programs are not considered, it will help both CHCs and patients continue to access these services without fear of causing immigrant patients harm in the future.

3. *In addition to ensuring that the public charge test is narrow and does not amount to a wealth or income test, the public charge regulations must be clear to avoid furthering confusion for immigrant families, which can cause immigrants and their family members to avoid public benefits, known as the chilling effect.*

DHS should define someone likely to become a public charge for inadmissibility purposes as a person who is "likely to become primarily and permanently reliant on the federal government to avoid

destitution." This would be consistent with the congressional intent and historical understanding of public charge as applying to a narrow set of immigrants who are likely to become "public charges". It is also consistent with case law. In 2020, the Second Circuit Court of Appeals relied on the Board of Immigration Appeals' interpretation of 'public charge' to mean a person who is "unable to support herself, either through work, savings, or family ties."

Under this definition, reliance on the government should not be taken into account unless:

- The government provides the primary source of income. Many people receive modest public benefits that supplement their earnings by improving their access to nutrition, health care, and other services. Using these supplemental benefits will not make someone a public charge.
- The reliance is permanent.
- The reliance is necessary to avoid destitution.

The definition "likely to become primarily and permanently reliant on the federal government to avoid destitution" should guide any assessment of an applicant's benefit use. This reform is crucial to ensure the administrability of the public charge rule and to mitigate the "chilling effect" of the 2019 public charge policy. According to a new survey from the Protecting Immigrant Families (PIF) coalition – three out of four immigrant families were unaware the harsh public charge rule changes from the prior administration were repealed.[3] The findings confirm that confusion and fear kept many eligible immigrant families, including U.S. citizen children in mixed-status households, from accessing programs that help feed, house, and keep them healthy.

CPCA strongly believes that many immigrants and their families continue to have concerns due to large participation rates for community trainings hosted by the CPCA and its immigrant partners regarding public charge, and the questions / comments shared during those trainings. CHC's also witnessed patients being afraid to take advantage of benefits like cash and food assistance during the pandemic because of their fear that it could put their future immigration status at risk. These concerns weren't specifically identified as being due to public charge, but it was the end result of what the rule had done. In September 2021, PIF fielded a nationwide poll of 1,000 mostly Latinx and AAPI individuals in immigrant families. In the September 2021 PIF poll, two in five respondents (41%) polled continued to believe that "applying for assistance programs could cause immigration problems." Comparatively, only one in four (25%) did not believe that seeking assistance would cause immigration problems.[4]

Reversing the 2019 public charge rule was an important first step, but it's not enough. The policy's chilling effect persists with both immigrants and their U.S. citizens' family members who are confused and afraid to access programs that could help feed, house and care for their children. It is imperative that the Biden administration take steps to curb the chilling effect, making clear that the Trump public

[3] "Research Documents Harm of Public Charge Policy during the COVID-19 Pandemic." Protecting Immigrant Families, https://protectingimmigrantfamilies.org/wp-content/uploads/2022/01/PIF-Research-Document_Public-Charge_COVID-19_Jan2022.pdf.

[4] Id.

charge policy has permanently ended and immigrants and their family members can get the care and help they need.

4. *The Biden Administration should conduct education and outreach efforts to address the chilling effect. It is imperative the Biden Administration provide resources to fund community outreach programs to combat misinformation and stigma among immigrant communities.*

The NPRM requests comments on communications strategies. Fed. Reg. at 10615: *DHS welcomes public comments regarding the most effective ways to communicate to the public that, with respect to Federal public benefits covered by this rule, DHS would only consider past or current receipt of SSI, TANF for cash assistance for income maintenance, or Medicaid (only for long-term institutionalization at government expense) by those categories of noncitizens identified in Table 3, above. For example, DHS welcomes comments on how to communicate to parents of U.S. citizen children that the receipt of benefits by such children would not be considered as part of a public charge inadmissibility determination for the parents.*

CHC's are trusted sources of information for their communities, including immigrant families. For example, given the questions that CHC staff were receiving from immigrant patients and their family members, CHCs created resource hubs / tables where patients could obtain information to better understand the changes to the public charge rule while also offering training for staff and community members. More specifically, CHCs have dedicated significant time and resources to train staff to understand policy changes they may not have been familiar with in order to respond to increased numbers of patient inquiries. As a member organization, CPCA created resources including training, factsheets (translated into multiple languages), talking points, social media posts, paid advertisements and more to help address the chilling effect CHCs saw from patients. At the same time, we worked to prepare our providers to respond to inquiries and understand the intricacies of the rule. As an organization CPCA has expended over $100,000 to build these resources and to run training, conduct meetings and operate a website to inform provider and patient communities about the public charge. In 2020-2021 alone, CPCA helped host 7 service provider trainings while assisting in materials development for 7 additional community trainings.

DHS should financially support CHCs, and other community-based organizations who are trusted messengers in sharing information about the new public charge rule directly to immigrant families and patients. We are fearful that with the public charge rule again being changed, even if the changes are for the better, will cause confusion and potentially lead to another chilling effect that could keep patients from feeling safe in accessing public benefits, such as Medicaid. We would also like to see the administration create messaging / factsheets that can be used by CBOs, like CHCs, while also supporting a messaging campaign through social media and other media outlets. Despite the reversal of the changes that went into effect in 2020, the public charge rule continues to have important implications. A study conducted by the California Health Care Foundation showed how misinformation and advice from the media, family, and community members increased the chilling effects. The study found that messaging is key to combating the chilling effects and respondents identified sources of incorrect information on public charge from media channels, social media like Facebook and WeChat,

newspapers, and word of mouth.[5] It is imperative that the Biden administration provides funding for community outreach programs to provide trusted and reliable public charge information in key community locations and through channels that immigrants and their families can rely on.

Funding from DHS can help cover costs so that more CHCs, and other CBOs, can have support in managing disenrollment and re-enrollment processes (aka "churn") that adds unnecessary costs to CHCs. Some have also set up a public charge multilingual "helplines," organized newsletters and instituted other ways to disseminate immigration-related information to patients, all managed by health center staff. These activities required additional staff training and the development of new workflows, while siphoning off of time and resources from the actual provision of health care. As a result, these health-care providers have diverted resources from their core missions to address community and individual patient concerns about the public charge determination. Some CHCs have diverted as much as $1 million as a result of the 2019 public charge rule.

5. *The Biden Administration should specify that use of benefits as a child or pregnant women will not be included in a public charge determination, nor will benefits used when applying for an exempt status.*

We recommend that if a person uses any programs considered in a public charge determination to overcome hardships caused by a temporary situation, that use should not be considered an indication of primary dependence. Examples include the use of such programs by survivors of domestic violence, serious crimes, disasters, accidents, or by children, pregnant or recently pregnant persons. Similarly, we support DHS's proposal to clarify that an individual's use of safety net programs while in an exempt immigration status will not be considered.

DHS should also clarify the scope of protection for VAWA self-petitioners, qualified battered immigrants, and individuals who have applied for or obtained U or T status, by stating that, consistent with the statute, they are exempt from a public charge determination, regardless of their pathway to adjustment of status. Additionally, DHS should propose that benefits received by children and pregnant women—whose long- term economic contributions are generally bolstered by childhood receipt of benefits—be excluded from consideration.

6. *The Biden Administration should exclude any use of benefits by survivors of domestic violence and other serious crimes and by anyone during public emergencies.*

Benefits used by survivors of domestic violence or other serious crimes or used by anyone during natural disasters or other extraordinary circumstances, such as the COVID-19 pandemic or in the aftermath of

[5] "Message Testing to Combat Public Charge's Chilling Effect ..." *California Health Care Foundation*, https://www.chcf.org/wp-content/uploads/2020/03/MessageTestingCombatPublicCharge.pdf.

hurricanes and wildfires, should not be included as factors in a public charge determination. Use of these benefits is due entirely to external events and does not provide any information on the recipient's likelihood of becoming primarily reliant on government assistance at a future date.

As the preamble recognizes, on p 106623, Congress expressed a policy choice to allow certain individuals to receive benefits without risking adverse immigration consequences, and DHS has determined that penalizing such individuals for seeking admission or adjustment of status through other pathways after having received benefits while in a protected category would not be reasonable and would undermine Congressional intent. The same logic applies to penalizing an individual for the underlying conditions that may have caused that person to seek the benefit, such as a temporary illness or temporarily diminished income (e.g. domestic violence, a natural disaster, an accident, or other circumstances beyond the individual's control.)[6] Further guidance via the inclusion of clarifying language in the preamble or Policy Manual would serve the protective justifications behind **§**212.22(d) and mitigate the risk that adjudicators may, albeit unintentionally, create an absurd end-run around this provision, harming the vulnerable immigrants it was crafted to protect.

II. SUPPORT FOR THE FOLLOWING IN THE PROPOSED PUBLIC CHARGE RULE:

1. *DHS's decision not to define the five statutory factors described in the INA: the applicant's age, health, family status, assets, resources and financial status, and education and skills.*

Defining the statutory factors would result in far more complexity and discretion, unnecessarily adding administrative burdens and opening the door to bias. An applicant's age should not be a defining factor of the public charge inadmissibility determination. Being of advanced age and not working in the formal economy should not be viewed as a negative, particularly when an older member of the family is providing care for a spouse, a child, or other family member. In addition, if an older person has a sponsor, family or community that will support them, they will be unlikely to become primarily and permanently dependent on the government. Minors (under 18) should be entirely exempted from public charge inadmissibility determination. Use of benefits as a child or when in an exempt group should not be defining factors in a public charge determination, nor should benefits used when applying for an exempt status, regardless of a person's pathway to legal status. In addition, we recommend that DHS retain the proposed language regarding the term "totality of the circumstances," where no one factor other than an insufficient affidavit of support, if required, should be the sole criterion for determining whether an applicant is likely to become a public charge. Use of healthcare services, including prevention and chronic disease management, are predictive of better health outcomes. Receipt of health care, nutrition or housing assistance is not an indication that a person is or will become primarily or permanently reliant on the government. These factors should not be treated negatively in a public charge determination.

[6] *See Matter of Mesa*, 12 I&N Dec. 432 (BIA Deputy Assoc. Comm'r 1967).

2. *The rule's proposal to require adjudicators to explain their reasoning for determination of the 5 factors in denials while also requiring every denial decision to be in writing, reflect consideration of each of the five statutory factors and articulate a reason for the determination.*

This practice will reduce the risk that the adjudicator is failing to consider all aspects of the totality of circumstances and will require the adjudicator to justify the decision. It will also be helpful to the applicant seeking any reopening or reconsideration of the denial.

3. *The new provision in the rule Section 212.22(e) which clarifies that benefits used eligible for refugee resettlement assistance are not considered.*

We support this provision, which protects immigrants from public charge consequences for any benefits received at any time in the past while the immigrant was eligible for resettlement assistance, entitlement programs, and other benefits typically reserved for refugees, without regard to whether the immigrant has been granted refugee/asylum status. The protection appropriately applies not only to survivors of trafficking and Afghan evacuees, but to other humanitarian immigrants who are eligible for these benefits. This provision will provide these vulnerable populations with safer access to the benefits they may need to recover from the conditions that qualify them for humanitarian protection.

4. *The provision in the rule that states the affidavit of support will be considered favorably.*

We recommend that, consistent with longstanding Department of State instructions, a valid affidavit of support be deemed sufficient to overcome a public charge test, unless "significant public charge factors" are present, under the totality of the circumstances. A person is not likely to become a public charge if they are able to work, have adequate resources or a sponsor or other family member or friends willing to assist with their financial support. If any one of these three factors is present, the person is presumably unlikely to become a public charge. If an intending immigrant has someone willing to assist them financially, as evidenced by an Affidavit of Support, this fact should be considered favorably in the totality of circumstance.

5. *The clarification that only benefits for which the applicant is listed as a beneficiary will be considered.*

The proposed rule modernizes the 1999 guidance by defining "receipt" of safety net benefits for the purpose of public charge determinations. Under the proposal, applying for benefits, being approved for

benefits in the future, assisting another to apply for benefits, or being in a household or family with someone who receives benefits does not count as receipt of benefits. The proposed rule is clear that benefits used by an applicant's family members or sponsors do not count as factors in the applicant's public charge test. This is critical in minimizing the chilling effect of the public charge rule on access to benefits by people, including citizen children, who are not subject to a public charge determination but whose family members may seek LPR status in the future. CHC staff, like community health workers and medical providers, have shared that patients have come into appointments in tears for fear that their visit may hinder the ability for a family member to adjust or change their immigration status. As an example, a youth in California who had recently been diagnosed with leukemia attempted to commit suicide because they believed that their use of benefits could lead to the deportation of their parents. Misinformation combined with confusion almost led to the untimely death of a teenager. In cases like this, it is very important that the rule clearly excludes family members' use of benefits.

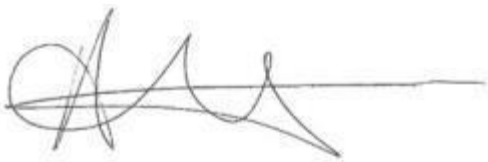
II. CONCLUSION

For the reasons stated in this letter, we urge the Biden Administration to take the recommendations mentioned throughout this letter, including making sure the public charge rule does NOT include health programs within the public charge determination. If we want our communities to thrive, everyone in those communities must be able to stay together and get the care, services and support they need to remain healthy and productive.

We also strongly believe that to combat the chilling effect, it is imperative that the Biden administration provides financial resources to fund community outreach programs to combat misinformation and stigma among immigrant communities.

Thank you for the opportunity to submit comments on the ANPRM. Please do not hesitate to contact Adam Carbullido at acarbullido@aapcho.org, Vacheria Tutson at vtutson@nachc.org, or Elizabeth Oseguera loseguera@cpca.org to provide further information or help answer any questions.

Sincerely,



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Community Clinic Association of Los Angeles County

Community Health & Wellness Partners

Community Health Centers, Inc.

Community Health Service Inc.

Ensuring Opportunity Campaign to End Poverty in Contra Costa

Florida Association of Community Health Centers, Inc.

Health Center Association of Nebraska

International Community Health Services

Maine Primary Care Association

Massachusetts League of Community Health Centers

Minnesota Association of Community Health Centers

Mission Neighborhood Health Center

Montana Primary Care Association

North East Medical Services (NEMS)

Northeast Valley Health Corporation

Operation Access

PA Association of Community Health Centers

Pacific Islands Primary Care Association

Sawtooth Mountain Clinic

Services, Immigrant Rights and Education Network (SIREN)

South Carolina Agricultural Worker Health Program

South Carolina Primary Health Care Association

Southside Community Health Services, Inc.

Strengthening Sanctuary Alliance

Tennessee Primary Care Association

The Children's Partnership

Waimanalo Health Center