

HEALTH POLICY

Baseline Findings from the California Guaranteed Income Pilot Program Evaluation

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Baseline Findings from the California Guaranteed Income Pilot Program Evaluation

Guaranteed income (GI) programs, or targeted unconditional cash payments, are being tested across the country in response to restrictive, time-limited, and inadequate government social safety net programs. The California legislature is investing in the state’s Guaranteed Income Pilot Program and evaluation to inform future income support models for lower-income residents. The pilots are designed to provide financial stability to two groups experiencing vulnerable life transitions—pregnant women¹ with low incomes and youth aging out of foster care. The Urban Institute (Urban) is evaluating the implementation and impact of the pilots using mixed methods, including a longitudinal participant survey. This report describes the program, study design, and findings from the baseline participant survey.

Background

GI provides recipients with unconditional cash payments with the goal of improving financial security and helping low-income individuals meet their basic needs.² Unlike traditional welfare and safety-net programs, GI programs generally do not impose conditions (such as program participation) on the receipt of benefits or restrict how recipients use their received income. GI and other cash assistance programs also typically have lower administrative costs (Murray 2008).

Numerous cash payment programs are being delivered worldwide on the premise that financial strain is a primary barrier to well-being and that cash is a straightforward, administratively simple solution (Bidadanure 2019; Friedman 1962; Widerquist et al. 2013). In August 2023, the California Department of Social Services launched a pilot GI program in seven sites across the state to provide unrestricted monthly payments of \$600 to \$1,200 for 12 or 18 months to two groups experiencing

¹ Fewer than 1 percent of pregnant program participants identified as transgender; therefore, we use the term “women” throughout, but recognize that not all people who are pregnant identify as women.

² “California Guaranteed Income Pilot Program,” California Department of Social Services, accessed February 5, 2026, <https://www.cdss.ca.gov/inforesources/guaranteed-income-pilot-program>.

major life transitions:³ (1) pregnant women in their first or second trimester who also have low-incomes, and (2) youth aging out of extended foster care at age 21.

California chose to focus limited resources on these two populations to shore up their financial stability, mitigate risks, and promote success across domains associated with these critical transitions, including housing, employment, education, and health care. The California Guaranteed Income Pilot Program (the pilot) waives safety-net income eligibility rules through benefits waivers (box 1), thereby allowing recipients to maintain other benefits they may qualify for, including CalFresh (California’s Supplemental Nutrition Assistance Program), CalWORKs (California’s Temporary Assistance for Needy Families program), and Medi-Cal (California’s Medicaid program). The waivers effectively allow the evaluation to test the effectiveness of cash plus safety net benefits rather than cash in lieu of benefits. The state selected seven pilot sites, considering the following criteria: (1) ability to implement proposed approach—including likelihood of securing adequate matching funds, adequate staffing, and reliable estimates of the eligible population (150 participant minimum) and (2) geographic diversity—California is large and diverse geographically and there was interest in understanding how implementation worked in various contexts. For example, the variation in payment amounts reflects each pilot’s theory of change regarding what would be required to improve the financial security of people in their local target populations.⁴

As an initial research report, this document presents the theory of change that informed the GI program and evaluation design and describes the characteristics of participants at the time of enrollment into the study. We set the stage for subsequent data analysis by presenting participants’ circumstances and needs, and the potential impacts of GI for the two participant groups (samples). We first describe a general theory of change for GI programs and then apply that reasoning to the pilot’s target populations.

³ One of the pregnant participant sites is implementing its GI program in four counties; the duration is 12 months in Alameda, Contra Costa, and Riverside counties and 18 months in Los Angeles County. All other pilot sites are offering 18 months of cash assistance. GI amounts were determined by individual pilot sites and are roughly pegged to cost-of-living estimates.

⁴ For a complete description of the seven pilot programs see Loftus et al. Forthcoming.

BOX 1

California's Guaranteed Income Pilot Program

The California Department of Social Services funded seven pilot sites to provide a monthly guaranteed income ranging from \$600 to \$1,200 to two groups facing critical life transitions:

- Low-income pregnant women in their first or second trimester, OR
- Youth aging out of extended foster care at age 21.

Five out of seven pilots implemented a randomized controlled trial design.

The Urban Institute was hired to conduct a statewide implementation and impact evaluation of the program utilizing interviews, focus groups, surveys, and administrative data.

Guaranteed Income Research

As GI programs proliferate in the US and Canada, a growing body of literature assesses the effects of these interventions on financial well-being and health. Prior research indicates that cash assistance—including GI pilot programs and earned income tax credits—is associated with increased financial security and improved health outcomes, including improved birth outcomes (Brownell et al. 2016; Hanna, Agarwal, and Shaefer 2025; Karpman et al. 2022).⁵ Other cash programs implemented in the US have demonstrated temporary, short-lived, and underwhelming impacts (Duncan et al. 2025; Krause et al. 2025; Noble et al. 2025).

A systematic review and meta-analysis (Rizvi et al. 2024) found 27 studies of 10 distinct GI programs. The authors had difficulty drawing firm conclusions because there were so many variations in GI program designs and outcomes. Across several studies, GI was associated with improvements in subjective financial well-being, self-rated life satisfaction, and mental distress. Recipients also reported less income volatility. Overall, these findings suggest that GI may meaningfully ease financial strain and corresponding emotional stress.

One of the first domestic GI pilots, the Stockton (CA) Economic Empowerment Demonstration, randomly selected 125 residents and gave them \$500 per month for 24 months. The cash was unconditional and unrestricted: there were no work requirements or restrictions on how the cash was to be spent (West and Castro 2023). Participants reported less income volatility and less personal

⁵ Magnolia Mothers Trust, "[2020 Evaluation Report](#)," Springboard to Opportunities, accessed January 2, 2026.

distress. Urban’s evaluation of the THRIVE program implemented in Prince George’s County, MD, observed mental health benefits for seniors enrolled in the program but not for former foster youth (Kumari et al. 2025). In the Baby’s First Years study, mothers with low incomes who received unconditional cash transfers in four cities (New York City, Greater New Orleans, the Omaha metro area, and the Twin Cities of Minneapolis and St. Paul, Minnesota) did not find significant reductions in perceived stress, anxiety, and parenting stress (Magnuson et al. 2025). The Open Research randomized controlled trials recruited participants from 19 counties in Texas and Illinois and found null or short-term effects on stress and mental or physical health, suggesting that more targeted programs may be preferable (Miller et al. 2024).

Evaluations of Manitoba’s Healthy Baby Prenatal Benefit (monthly unconditional cash to pregnant women with low incomes) found lower risks of preterm birth and low birthweight and higher birthweight for mothers who received a supplement equivalent to a 10 percent increase in income (Brownell et al. 2016). However, a more recent analysis showed that the impact was not sustained, perhaps because the stipend amount stayed the same for 20 years, while incomes and costs rose (Enns et al. 2025). Analyses of the earned income tax credit largely reveal improvements in birth outcomes and maternal mental health (Evans and Garthwaite 2014; Hamad and Rekhopf 2015; Hoynes et al. 2015) and reduced involvement with child protective services (Rittenhouse 2023). Some studies of the 2021 expanded child tax credit found reductions in low birthweight and small size for gestational age (Margerison et al. 2025). Findings for other universal cash programs like Alaska’s Permanent Fund Dividend are mixed, with recent work showing minimal effects on birthweight (Wyndham-Douds and Cowan 2024).

Thus, although evidence from US GI programs is mixed, there are signals that unconditional cash assistance can contribute to reduced hardship without associated administrative burden, and improved financial well-being may be associated with a range of benefits; however, additional rigorous studies and causal evidence are needed to establish clear causal impacts on long-lasting health and well-being outcomes. Moreover, conclusive data on the optimal level and duration of the benefits remains unavailable.

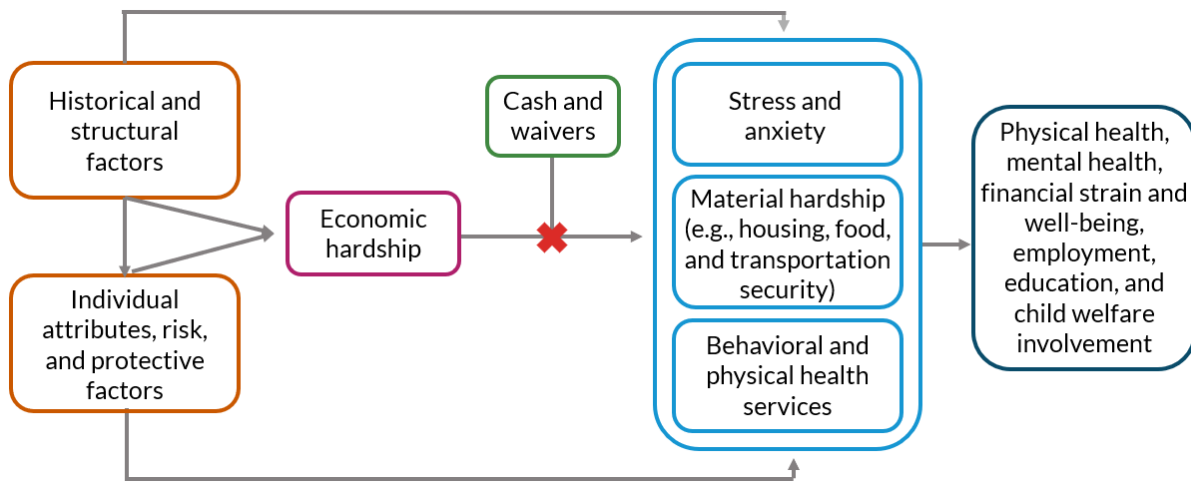
Guaranteed Income Theory of Change

The theory of change for guaranteed income articulates “why” poverty exists and describes the causal pathways by which unconditional payments lead to improved outcomes. From a theoretical standpoint, GI assumes that poverty stems from a lack of resources rather than a fundamental lack of skill or

motivation. Consistent with productive assets theory, GI programs observe that families and communities lacking core assets easily fall into poverty traps that are extremely difficult to escape (Barrett, Carter, and Chavas 2017). Similarly, human capital theory (Becker 1993) suggests that providing resources enables individuals to invest in their education, health, and skills, thereby increasing their productivity and earning capacity and creating pathways out of poverty. Individuals and families with low incomes, particularly those who are pregnant or aging out of foster care, are at higher risk of experiencing a range of negative outcomes such as housing instability, food insecurity, and health and mental health challenges (Courtney et al. 2020; Taylor et al. 2021). In practice, the core mechanism for change in GI is financial support, as it creates reliable cash flow intended to reduce income volatility, help meet basic needs, reduce mental distress, and ideally, increase personal agency—in part because recipients have more time to pursue education, interests, and employment. The added rationale for GI as a means of promoting well-being across domains rests on its simplicity: cash increases purchasing power for goods, services, and time without administrative burden and the corresponding stress and uncertainty it creates.

The theory of change for this pilot is predicated on the well-established connection between financial instability and material hardship, food insecurity, stress, and other concerns. Public benefit programs frequently exacerbate these problems with complex, time-consuming administrative procedures that add additional burdens, complicate access to resources, often carry shame, and delay relief. Therefore, providing guaranteed income to low-income individuals while protecting existing benefits can increase financial stability, reduce administrative burden, minimize the stress associated with those burdens, and ultimately reduce the risk of negative outcomes and increase the likelihood of well-being (figure 1).

FIGURE 1
California Guaranteed Income Pilot Program Theory of Change



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Source: Authors' analysis.

Appendix A presents detailed information on our outcomes of interest and our hypothesized impacts of GI for each of the two population samples. For both former foster youth and pregnant people, we hypothesize that GI will reduce recipients' financial strain and improve their financial well-being by increasing their income through the direct provision of cash. Increased income could allow recipients to purchase needed goods and services, allowing them to meet their housing, food, and transportation needs, while improving overall well-being. It could also allow individuals to increase their savings, thereby reducing stress or concern about their ability to cover their expenses, pay off existing debt, or avoid taking on new debt. Lastly, we hypothesize that GI will allow recipients to make different decisions about how they use their time, which may manifest in prioritizing education, spending additional time with a newborn, or seeking more rewarding and secure employment. Theories of change specific to each study sample are presented below.

Theory of Change: Youth Aging Out of Foster Care

Youth aging out of (extended) foster care⁶ are at increased risk of poor outcomes related to housing, education, employment, and physical and mental health. The *CalYOUTH* study, which followed a cohort

⁶ An early adopter of extended foster care (EFC), CA passed the California Fostering Connections to Success Act in 2010 and has offered EFC since January 2012. Youth who meet one of five participation criteria (school, work, job training, etc.) can remain in care (or leave and re-enter the program) until age 21. Distinct from the general foster care model (e.g., residential placement), EFC offers supports for housing, financial, education/training, case management, and other life domains and activities.

of youth aging out of foster care in California, showed that after facing a benefits cliff upon exiting extended care, youth experiences of challenging life circumstances increased, and protective factors stagnated (Courtney et al. 2020). Unstable housing stands out as a common outcome: about 25 percent of CalYOUTH participants experienced homelessness between the ages of 21 and 23. Nearly half reported economic hardship, and a third reported food insecurity. Other studies have similarly shown that youth aging out of foster care have less stable employment, work fewer hours, and earn lower wages as they enter adulthood (Courtney et al. 2001; Dworsky 2005; Goerge et al. 2002; Hook and Courtney 2011). Compared to their peers in the general population, youth aging out of foster care are less likely to complete high school on time (Font and Palmer 2024) or finish college (Courtney et al. 2020; Day et al. 2011). Recognizing that their adverse experiences can compromise the transition to adulthood, and that former foster youth may lack social and material supports that foster success, numerous public and private initiatives have been developed to address their needs. Most states now recognize that youth need support beyond age 18 to successfully transition to adulthood, and most states and tribes offer extended foster care. Furthermore, California offers many benefits to former foster youth beyond age 21, such as subsidized housing and supportive services to age 24 or 25, Medi-Cal to age 26, higher education supports such as Chafee grants up to age 26, and the California Foster Youth Tax Credit through age 25, all of which may reduce the effects of GI.

Human capital formation (Heckman and Corbin 2016) explains why GI may lead to upward mobility for former foster youth in the longer term by buffering against the benefits cliff foster youth face on their 21st birthday. The human capital literature is clear that skills beget skills (Cunha and Heckman 2007; Heckman 2000) and that the accumulation of skills marks the transition to adulthood (Wulczyn, Parolini, and Huhr 2021). Economic hardship can indirectly curtail skill formation through psychological and physical stress, already a barrier for youth aging out of foster care by virtue of their maltreatment histories. Additionally, economic hardship can restrict one's ability to pursue or persist in higher education or begin a career, hindering youth's human capital development.

We hypothesize that California's GI pilot program will alter economic conditions for these youth by increasing their income; along with some preserved means-tested safety net benefits, this will allow individuals to achieve improved financial stability. Subsequently, we expect this may improve long-term outcomes by increasing economic security, reducing stress, and improving financial access to stable housing, education, employment, medical care, nutritious food, and transportation, thus freeing youth to build their skills and human capital.

Theory of Change: Pregnant Women

Pregnancy can be a time of excitement and anticipation, but it can also exacerbate existing life stressors, including financial insecurity, chronic health conditions, depression, and anxiety. Several recent studies have documented the prevalence of financial strain during the perinatal period and associated these hardships with poor outcomes (Hamilton et al. 2023; Taylor et al. 2021).

Although the drivers of adverse pregnancy and birth outcomes are numerous, financial strain contributes to health and social challenges—including stress—during the prenatal period that have been specifically associated with pregnancy conditions and poor birth outcomes (Blumenshine et al. 2010; Braveman et al. 2010). If adverse outcomes result from material needs associated with stress, GI could improve pregnancy and birth outcomes by supporting people’s ability to purchase needed health care, food, housing, and other needed goods and services.

In California, we observe higher rates of preterm birth and low birthweight among Medi-Cal beneficiaries compared with those who have private health insurance during pregnancy (CDPH 2024). Like women with low income nationally, women with low income in California are also more likely to experience poor health and nutrition, with more than one-third reporting food insecurity during pregnancy and a majority reporting another maternal hardship (Lararia et al. 2022). They were also more likely to report hardships and social needs and were less likely to receive recommended prenatal care than those with higher incomes.

Postpartum, demands on household resources increase while maternal earnings decline, resulting in increased rates of poverty after childbirth (Hamilton et al. 2023) and declines in household economic well-being, even after accounting for safety net programs (Stanczyk 2020). In the *Listening to Mothers in California* study of women who gave birth in California hospitals in 2016, women with Medi-Cal and those with incomes below poverty returned to or started paid jobs more quickly than those with private insurance and higher incomes. Among all women who were working a paid job postpartum, only 48 percent reported they could stay home with their baby as long as they wanted (Sakala et al. 2018). Increased income from GI may allow new parents to have more time at home with their newborn following birth (Rossin-Slater, Ruhm, and Waldfogel 2013). Economic insecurity following childbirth shapes family and child well-being throughout the lifecycle (Currie and Rossin-Slater 2015). Ultimately, improvements in birth outcomes and/or family well-being could enhance long-term outcomes for pregnant people and their infants. GI could help to mitigate these hardships and improve overall well-being.

Program and Study Design

The evaluation includes an implementation and an impact study. Five of the seven pilot sites are conducting a randomized controlled trial (RCT) in which enrolled participants were randomized to receive GI or to a control group that receives \$20 per month.⁷ Two of the seven pilot sites are providing GI to all enrolled participants, and the impact of GI will be studied through a quasi-experimental design (QED). Table 1 summarizes the features of each pilot site.

TABLE 1
Pilot Sites in the California Guaranteed Income Pilot Program

Site	Catchment area	Population	Monthly disbursement	Enrolled participants: Treatment group/control group	Study design
Expecting Justice	Los Angeles, Riverside, Alameda, and Contra Costa counties	Pregnant women	\$616–\$1,186 ^a	461/578	RCT
National Council of Jewish Women—Los Angeles	Los Angeles County	Pregnant women	\$1,000	182/169	RCT
McKinleyville Family Resource Center	Humboldt County	Pregnant women	\$1,000	150/78	RCT
Inland Southern California United Way	Riverside and San Bernardino counties	Pregnant women; Former foster youth	\$600; \$750	409/132;35/15	RCT
iFoster	Statewide ^b	Former foster youth	\$750	354/352	RCT
San Francisco Human Services Agency	San Francisco	Former foster youth	\$1,200	150/NA ^c	QED
Ventura County Human Services Agency	Ventura County	Former foster youth	\$1,000	150/NA ^c	QED

Source: Authors' analysis.

Notes: RCT = randomized controlled trial; QED = quasi-experimental design.

^a Amount depended on the county of residence at the time of application, or, for youth aging out of foster care, the county responsible for their child welfare case.

^b Excluded counties served by another pilot.

^c The San Francisco and Ventura sites served their entire eligible population and did not have a control group.

⁷ One PP site did not provide monthly payments to the control group.

Eligibility Criteria

The eligibility criteria for each target population were the following:

- Former foster youth (FFY)
 - » Low income (income eligibility criteria varied by site)⁸
 - » Exiting/exited foster care on their 21st birthday during the site’s enrollment period⁹
 - » Eligible county varied by site
- Pregnant participants (PP)
 - » Low income (specific income eligibility criteria varied by site)
 - » Within the first 27 weeks of pregnancy at the time of application
 - » Eligible county varied by site
 - » Some sites had additional criteria based on risk factors for perinatal complications

Application, Randomization, and Enrollment

Each of the seven pilot sites followed its own referral process and outreach to potential program participants. People who wished to participate completed an application online hosted by AidKit (a platform for managing and distributing aid programs, including cash assistance) to determine if they met the pilot site’s eligibility criteria. Those who were eligible and interested then enrolled in the study.

Urban conducted randomization for RCT sites. Applicants who were determined eligible were randomized weekly. All study participants received a link to Benefit Kitchen, a self-guided benefits assessment that helped them determine any additional benefits for which they may be eligible and, for the treatment group, any benefits that the receipt of GI may impact. Some sites also followed up with in-person benefits counseling for those who expressed interest.

⁸ Many sites used the Insight Center’s Family Needs Calculator to determine income eligibility thresholds based on the participant’s county of residence and household composition at the time of application, see “County Fact Sheets,” Insight Center, accessed February 12, 2026, <https://insightcced.org/family-needs-calculator/>. Some sites used other methods to determine income eligibility. For example, one FFY site used the Department of Housing and Urban Development’s definitions of low-income, and one PP site used Medi-Cal enrollment to determine that participants were low-income.

⁹ The two quasi-experimental design sites serving FFY had an expanded eligible age range and enrolled youth who aged out of foster care prior to the enrollment period.

Survey Design and Methods

Baseline Survey Design

All study participants could participate in voluntary, compensated surveys that assess the impact of GI. A comprehensive survey is offered at baseline, at the time of program exit (12 or 18 months, depending on the site), and six months after program exit.¹⁰ Study participants also receive brief midpoint surveys at three and nine months post-randomization.

This research report presents findings from the baseline survey, which was developed to collect information on domains not available in administrative data or not sufficiently detailed to detect changes over time. Specifically, we collected information on financial health, material security, housing, employment, education, physical health, mental health and well-being, time use, planned use of additional income, and pregnancy history (PP only). We also used basic demographic information from the application.

Where possible, we used the shortest, most reliable, validated instruments to measure these domains. In select cases, we were required to develop our own questions to capture information specific to the target population and outcomes of interest. Appendix B shows the validated measures selected for each domain.

Baseline survey drafts were shared with the California Department of Social Services, pilot programs, and our guidance committee, comprising program staff and community members, for feedback. We considered and integrated feedback while maintaining the integrity of validated measures. We did cognitive testing in Spanish and English with 14 individuals who were either FFY or pregnant/recently pregnant. When tested, the baseline survey took approximately 15 to 20 minutes to complete.

Baseline Survey Distribution

The baseline survey was distributed to all applicants who passed initial eligibility checks. Applicants were offered the survey after they completed their application and before they were randomized to treatment or control group (for the RCT sites) and before they enrolled in treatment (for the quasi-

¹⁰ Only RCT site participants are receiving the six-month post-exit surveys.

experimental design sites). The survey was distributed through AidKit, the same online platform that participants used to complete their application.

Reminders to complete the survey were sent one and two days after the application was completed. No further reminders were sent to ensure that the baseline survey was completed before the participant was randomized or enrolled in GI. Participants completed the baseline survey between October 2023 and October 2024. Participants received a \$25 cash incentive for completing the baseline survey, which was either deposited directly into their bank account or on their virtual debit card, depending on how they received their monthly cash disbursements.

Baseline Survey Analysis

Our analytic sample at baseline included all participants randomized to the treatment or control groups (or assigned to treatment at the non-RCT sites), regardless of whether they chose to enroll in monthly payments.¹¹

Before conducting our baseline analysis, we examined the data for missingness at both the survey and item levels. Questions with “don’t know” and/or “prefer not to answer” responses were coded as missing. We did not impute any missing values with one exception: for scales that are sum scored (e.g., PHQ-8 depression scale, GAD-7 anxiety scale), we imputed the mean of nonmissing items if a participant was missing one or two items on the scale. Participants’ scores on sum-scored scales were coded as missing if they were missing more than two item responses on the scale.¹² We did not remove any outliers, unless the value was impossible for the field (e.g., negative weeks gestation) in which case we considered the value to be a data entry error and coded it as missing. We also did not weight the sample for this descriptive analysis.

Results

We expect, as described in the theory of change, that GI may have different effects by population, but for concision, we report each outcome domain by population and in total. In some cases, we point out notable results for the overall population or make comparisons between the populations when the

¹¹ We used a baseline data extract from March 5, 2025, for the analyses in this paper.

¹² For the Food Security Scale score, we used the specific imputation guidance from the USDA: “[Guide to Measuring Household Food Security](#),” USDA, 2000.

outcome is expected to impact both populations, and examine the pilot’s overall investment in both populations.

Baseline Survey Response Rates

Table 2 shows the baseline survey response rates. About 82 percent of the total sample (86 percent PP and 74 percent FFY) consented to complete the baseline survey either immediately after application or at a later time, and about 74 percent of the total sample (77 percent PP and 66 percent FFY) completed at least 70 percent of the questions on the survey.

In all subsequent tables displaying the baseline survey results, the number of participants eligible to answer the question (i.e., consented to the survey and met skip pattern criteria) is used as the denominator when calculating item missingness. The PP, FFY, and total column percentages are calculated using those with nonmissing data.

TABLE 2
Baseline Response Rates

Sample	N	Consented to baseline	Completed 70% or more of baseline
Pregnant participants	2,284	86%	77%
Treatment	1,227	85%	76%
Control	1,057	87%	79%
Former foster youth	1,080	74%	66%
Treatment	701	72%	65%
Control	379	78%	69%
Total	3,364	82%	74%
Treatment	1,928	80%	72%
Control	1,436	85%	76%

Source: Authors’ analysis.

Demographics

Full demographics for the sample can be found in table 3. The average age of the entire sample was 27.6 years. About 40 percent of the sample was Black, 39 percent was Hispanic, 12 percent was white, and 9 percent was another race. One-third of the sample was from Los Angeles¹³ (33 percent), 8 percent were from rural counties, and 59 percent were from other counties. For annual income at baseline, 36

¹³ One pilot program focused on pregnant women in Los Angeles County. One pilot program had multiple sites, including Los Angeles County. And one program was statewide.

percent reported that they had no income. Annual income was low among those with an income. About 47 percent of the sample were parenting at baseline.

TABLE 3
Baseline Demographics—Full Sample by Target Population and Pooled

Item/measure	PP % or mean	FFY % or mean	Total % or mean	% missing ^a
N	2,284	1,080	3,364	18%
Age at time of randomization	30.5 (5.8)	21.4 (1.0) ^b	27.6 (6.4)	0%
Weeks gestation at time of randomization (sd)	20.2 (6.0)	-		0%
Gender identity				1%
Woman	99%	58%	86%	
Man	*	38%	*	
Another gender	*	4%	*	
Race/ethnicity				3%
Hispanic	34%	51%	39%	
Non-Hispanic Black	49%	22%	40%	
Non-Hispanic white	9%	18%	12%	
Non-Hispanic, another, or mixed race	9%	10%	9%	
Primary language				0%
English	96%	97%	96%	
Another language	4%	3%	4%	
County of residence				0%
Los Angeles	38%	23%	33%	
Rural	11%	2%	8%	
Other	51%	75%	59%	
Household size				0%
1	31%	72%	44%	
2	27%	19%	24%	
3	21%	7%	17%	
4	11%	*	*	
5+	10%	*	*	
Annual income				0%
No income	32%	45%	36%	
\$1 to \$20,000	25%	30%	27%	
\$20,001 to \$40,000	23%	21%	22%	
Over \$40,000	20%	4%	15%	
If any income, percent of federal poverty level^c				0%
50% or less	18%	20%	19%	
51 to 100%	27%	28%	27%	
101 to 150%	20%	23%	21%	
More than 150%	36%	28%	34%	
Relationship status				0%
Single	40%	64%	48%	
Married, living together	18%	*	*	
Married, not living together	5%	*	*	
In a relationship, living together	16%	13%	15%	
In a relationship, not living together	22%	20%	22%	
Current parent	59%	20%	47%	0%
Benefits received at baseline				0%
CalWORKs	23%	2%	16%	

Item/measure	PP % or mean	FFY % or mean	Total % or mean	% missing ^a
CalFresh	51%	34%	46%	
MediCal	76%	79%	77%	

Source: Authors' analysis.

Notes: PP = pregnant participants; FFY = former foster youth. * Values are masked due to small cell sizes.

^a For this table, the entire sample was used as the denominator to calculate missingness rates, since the fields in this table came from the application and not the baseline survey.

^b The two quasi-experimental design sites serving FFY had an expanded eligible age range and enrolled youth who were over 21 during the enrollment period.

^c 2025 Federal Poverty Level was obtained from "[2025 Poverty Guidelines: 48 Contiguous States \(all states except Alaska and Hawaii\)](#)," ASPE, accessed January 2, 2026.

Financial Health

Overall, program participants indicated high financial need and financial stress (table 4). Nearly three-quarters of participants were always or often stressed about having enough money to pay their bills. Just over 80 percent had current debt, and three-quarters of those with debt were behind on their payments. Participants reported a variety of debt types, with the most common being credit card debt (66 percent of the sample), car loans (42 percent), and student loans (36 percent).

Although rates of self-reported financial stress were about equal between the two target populations, PP generally reported more debt than FFY. Nearly 90 percent of PP and 61 percent of FFY participants had current debt. More than three-quarters of PP (78 percent) and two-thirds of FFY (7 percent) were behind on payments. Nearly one-third of PP (31 percent) reported debt exceeding \$20,000.

TABLE 4

Baseline Financial Health—Full Sample by Target Population and Pooled

Item/measure	PP % or mean	FFY % or mean	Total % or mean	% missing
N	2,284	1,080	3,364	18%
CFPB Financial Well-Being Scale score				7%
Very low	11%	4%	9%	
Low	24%	17%	22%	
Medium low	48%	46%	48%	
Medium high	13%	25%	17%	
High or very high	3%	9%	5%	
Stressed about having enough money to pay bills				5%
Rarely/never	5%	4%	5%	
Sometimes	21%	20%	21%	
Always/often	74%	76%	74%	
Any current debt				8%
Yes	89%	61%	81%	
No	7%	31%	14%	
Don't know	4%	8%	5%	
If any debt, behind on debt payments	78%	67%	75%	8%
If any debt, how much total debt				7%
\$1 to \$5,000	35%	62%	41%	
\$5,001 to \$10,000	19%	12%	17%	
\$10,001 to \$20,000	16%	12%	15%	
More than \$20,000	31%	13%	27%	
If any debt, debt type:				0%
Credit card	69%	55%	66%	
Car loan	44%	34%	42%	
Student loan	40%	21%	36%	
Medical bills	28%	14%	25%	
Private loan from family/friends	22%	18%	22%	
Delinquent/late rent	21%	14%	19%	
Other debt	16%	21%	17%	
Private loan from a bank	14%	7%	13%	
Payday loan	13%	7%	12%	
Home mortgage	7%	*	*	
If any debt, number of debt types	2.7 (1.4)	1.9 (1.0)	2.6 (1.4)	0%

Sources: Authors' analysis.

Notes: PP = pregnant participants ; FFY = former foster youth. * Values are masked due to small cell sizes.

Material Security

Participants also reported high material needs (table 5). About 45 percent had very low food security, and 43 percent had moderate or high transportation insecurity. Both food and transportation security were lower for FFY participants than for pregnant participants.

TABLE 5

Baseline Material Security—Full Sample by Target Population and Pooled

Item/measure	PP % or mean	FFY % or mean	Total % or mean	% missing
N	2,284	1,080	3,364	18%
Food Security Scale Score				10%
High or marginal food security	29%	27%	28%	
Low food security	28%	23%	27%	
Very low food security	43%	50%	45%	
Transportation Security Index Scale Score				8%
No transportation insecurity	41%	31%	38%	
Marginal/low transportation insecurity	20%	17%	19%	
Moderate/high transportation insecurity	40%	53%	43%	
Primary mode of transportation				7%
Own vehicle	63%	40%	56%	
Public transportation	13%	28%	17%	
Get rides or borrow vehicle	19%	19%	19%	
Other	6%	13%	8%	

Sources: Authors' analysis.

Notes: PP = pregnant participants; FFY = former foster youth.

Housing

Most people (60 percent) were renting an apartment or home (table 6) when they applied to the program. About 7 percent of the sample was unhoused at baseline; however, about one-third reported being homeless or couch surfing in the last 12 months. Only 6 percent of participants owned a home. Participants reported housing precarity: 42 percent reported being worried about losing their housing. Only 29 percent reported being very satisfied with their living situation. The most common reasons for dissatisfaction included housing that was too small, wanting to own their home, and housing being too expensive.

Housing stability concerns were higher among FFY than the pregnant participants, with 50 percent of FFY reporting that they were worried about losing their housing compared with 39 percent of pregnant participants. This difference was expected because FFY were approaching their transition out of extended foster care at the time of the baseline survey. About one-quarter of FFY were living in a group home, foster home, or transitional housing at baseline.

TABLE 6

Baseline Housing—Full Sample by Target Population and Pooled

Item/measure	PP % or mean	FFY % or mean	Total % or mean	% missing
N	2,284	1,080	3,364	18%
Housing status at baseline				11%
Renting an apartment or house	65%	47%	60%	
Living with friends or family rent-free	12%	11%	12%	
Group home, foster home, transitional	1%	23%	7%	
Own apartment or home	7%	3%	6%	
Shelter, hotel, place not meant for housing	8%	5%	7%	
Other	8%	12%	9%	
Monthly rent amount^a				13%
No rent	15%	28%	19%	
\$1 to \$500	15%	21%	16%	
\$501 to \$1,000	20%	26%	22%	
\$1,001 to \$2,000	32%	20%	29%	
More than \$2,000	19%	5%	15%	
Government agency helps pay for housing	10%	40%	20%	0% ^b
Worried about losing housing^a	39%	50%	42%	15%
Homeless or couch surfed—last 12 months	31%	34%	31%	10%
Current housing satisfaction^a				12%
Very dissatisfied	15%	11%	14%	
Somewhat dissatisfied	18%	17%	18%	
Somewhat satisfied	41%	35%	39%	
Very satisfied	26%	37%	29%	
Dissatisfaction reasons^c				20%
Too small	44%	32%	42%	
Want to own home	43%	32%	41%	
Too expensive	32%	34%	32%	
Want to live alone	24%	38%	26%	
Low quality	23%	28%	24%	
Unsafe	21%	21%	21%	
Neighborhood does not have services	8%	8%	8%	
Other	11%	12%	11%	
Housing preference in the next year^a				28%
Stay in same housing unit	37%	36%	37%	
Move to new unit, same neighborhood	13%	12%	13%	
Move to a new neighborhood	43%	44%	43%	
Other	7%	9%	8%	

Source: Authors' analysis.

Notes: PP = pregnant participants; FFY = former foster youth.

^a This question was not asked if respondent indicated they lived in a shelter, hotel, or place not meant for housing.

^b This question was asked on the application not on the baseline survey.

^c This question was only asked if a respondent indicated that they were not very satisfied with their current housing.

Employment

Participants could select any single response or combination of responses that best represented their employment status. About 37 percent of the sample indicated that they were unemployed and looking for work, and 46 percent indicated that they were doing paid work (table 7). Among those doing paid

work, most had only one job (87 percent), and most were working full time (51 percent). Among those working more than one job, 58 percent cited the main reason as the need to earn additional income. Participants' reasons for working part-time were more varied—25 percent said they could only find part-time work, 18 percent said they are in school, and 15 percent said they lack child care. In terms of job benefits, just over half of employed participants reported that their job provides paid sick or personal leave, and only one-quarter reported that their job offers employer-sponsored health insurance.

TABLE 7
Baseline Employment—Full Sample by Target Population and Pooled

Item/measure	PP % or mean	FFY % or mean	Total % or mean	% missing
N	2,284	1,080	3,364	18%
Employment status				12%
Paid work	44%	49%	46%	
Unpaid work	2%	*	*	
Unemployed, looking	35%	40%	37%	
Unemployed, not looking	8%	2%	6%	
Full-time caregiver	8%	3%	6%	
Student	9%	23%	13%	
On leave from work	7%	3%	6%	
If doing paid work, looking for additional work, or a new job?				2%
Yes, looking for a new job	32%	34%	33%	
Yes, looking for more hours at current job	20%	25%	21%	
Yes, looking for an additional job	24%	24%	24%	
No, not looking for additional work or a new job	43%	35%	41%	
If doing paid work, how many jobs				1%
0	*	4%	*	
1	87%	88%	87%	
2	*	9%	*	
If doing paid work, number of hours worked per week				1%
0 to 16	15%	17%	16%	
17 to 34	31%	40%	34%	
35 to 40	44%	32%	40%	
40+	10%	12%	11%	
If doing paid work, does job provide following benefits				2%
Paid vacation or sick leave	57%	39%	51%	
Paid family leave	33%	14%	27%	
Employer-sponsored health insurance	29%	16%	25%	
Employer-provided retirement savings	24%	14%	21%	
Any income from on-demand/gig work				12%
Yes	13%	18%	15%	
No	87%	83%	85%	
If working part-time, main reason				5%
Could only find part-time work	23%	27%	25%	
Only want to work part-time	4%	*	*	
Need to earn additional money	*	7%	*	

Item/measure	PP % or mean	FFY % or mean	Total % or mean	% missing
Work is seasonal	5%	8%	6%	
Lack of child care	20%	6%	15%	
Other family or personal obligations	17%	*	*	
Health or medical limitations	8%	*	*	
In school or training	8%	36%	18%	
Other	13%	8%	11%	
If working more than one job, main reason				2%
Need to earn additional money	60%	50%	58%	
Other ^a	40%	50%	53%	

Source: Authors' analysis.

Notes: PP = pregnant participants; FFY = former foster youth.

* Values are masked due to small cell sizes.

^a Other categories include: could only find part-time work, need to earn additional money, work is seasonal, more flexible, want to gain experience, and other.

Education

Most participants had not yet achieved their desired education level at baseline, with only 11 percent reporting that they had completed their educational goals (table 8). Major barriers to continuing education included the cost of tuition (63 percent) and the need to work full-time (66 percent).

Educational attainment at baseline differed by target population. About 87 percent of FFY had received a high school diploma/GED or higher compared with about 91 percent of the PP. The PP was more likely to have a bachelor's or graduate degree but was also older on balance. About 21 percent of PP were enrolled in school compared with 49 percent of FFY.

TABLE 8
Baseline Education—Full Sample by Target Population and Pooled

Item/measure	PP % or mean	FFY % or mean	Total % or mean	% missing
N	2,284	1,080	3,364	18%
Highest level of education				7%
No high school diploma or GED	9%	13%	10%	
High school diploma or GED	33%	45%	36%	
Some college	26%	35%	29%	
Associate's degree or vocational school	14%	6%	12%	
Bachelor's degree	14%	*	*	
Graduate degree	4%	*	*	
Any professional certificates	38%	22%	34%	9%
Currently enrolled in school	21%	49%	29%	8%
If currently enrolled, part- or full-time				11%
Part-time	50%	43%	47%	
Full-time	50%	57%	54%	
If currently enrolled, program type				0%
High school or GED	12%	15%	14%	

Item/measure	PP % or mean	FFY % or mean	Total % or mean	% missing
College	59%	70%	65%	
Graduate school	10%	*	*	
Vocational school or certificate program	19%	14%	17%	
Educational goal				12%
Already completed educational goals	13%	8%	11%	
High school diploma or GED	7%	9%	7%	
Some college	6%	9%	7%	
Associate's degree	10%	11%	10%	
Bachelor's degree	22%	22%	22%	
Vocational certificate or license	19%	20%	19%	
Graduate degree	21%	19%	21%	
Other	2%	3%	3%	
Reasons not to stay or enroll in school^a				
<i>Cost of tuition</i>				20%
Not a reason	11%	31%	18%	
Minor reason	17%	25%	20%	
Major reason	72%	44%	63%	
<i>Need to work full-time</i>				20%
Not a reason	12%	18%	14%	
Minor reason	20%	23%	21%	
Major reason	69%	59%	66%	
<i>Classes do not fit schedule</i>				20%
Not a reason	49%	49%	49%	
Minor reason	29%	30%	29%	
Major reason	23%	21%	22%	
<i>Transportation issues</i>				19%
Not a reason	55%	42%	51%	
Minor reason	20%	23%	21%	
Major reason	25%	35%	28%	
<i>Child care</i>				20%
Not a reason	23%	73%	39%	
Minor reason	19%	9%	16%	
Major reason	59%	18%	46%	

Source: Authors' analysis.

Notes: PP = pregnant participants; FFY = former foster youth.

Values are masked due to small cell sizes.

^aThis question was not asked if respondent indicated they have already completed their educational goals.

Physical Health

Most participants self-reported good health, with 72 percent reporting good, very good, or excellent health (table 9). About two-thirds of participants had a physical check-up with a doctor within the last year, but just under 20 percent reported delaying medical care in the last 12 months because they could not afford it. Almost half delayed medical care for other reasons, with the most common reason being no transportation. PP were more likely to have seen a doctor in the last year (not including for a prenatal visit) (71 percent) than former foster youth (56 percent).

About half of the sample had seen a dentist for a check-up within the last year, but just under 40 percent delayed getting dental care in the last 12 months because they could not afford it. About half delayed dental care for another reason, with the most common reasons being no transportation and no insurance. These findings are fairly consistent for both populations.

TABLE 9
Baseline Physical Health—Full Sample by Target Population and Pooled

Item/measure	PP % or mean	FFY % or mean	Total % or mean	% missing
N	2,284	1,080	3,364	18%
Self-reported health status				11%
Poor	4%	7%	5%	
Fair	22%	27%	23%	
Good	41%	34%	39%	
Very good	23%	20%	22%	
Excellent	10%	13%	11%	
Ever been diagnosed with				11%
Hypertension/high blood pressure	11%	5%	9%	
Type 1 or type 2 diabetes	5%	3%	4%	
Asthma	16%	19%	17%	
Depression	29%	43%	32%	
Anxiety	30%	46%	35%	
Ever been diagnosed with other serious health/mental health condition	15%	18%	16%	14%
Number of chronic health or mental health conditions				15%
None	46%	40%	45%	
1	22%	16%	20%	
2	18%	22%	16%	
3+	14%	22%	16%	
How long since last routine doctor checkup				16%
Within the past year	71%	56%	67%	
More than 1 year but less than 2 years ago	14%	22%	16%	
More than 2 years but less than 5 years ago	10%	16%	12%	
5 or more years ago	4%	*	*	
Never	2%	*	*	
How long since last routine dentist checkup				16%
Within the past year	51%	50%	51%	
More than 1 year but less than 2 years ago	21%	22%	22%	
More than 2 years but less than 5 years ago	17%	23%	19%	
5 or more years ago	9%	*	*	
Never	1%	*	*	
Delayed/did not receive medical care because could not afford it, last 12 months	19%	20%	19%	13%
Delayed/did not receive medical care for another reason, last 12 months	45%	53%	47%	22%
If delayed medical care for another reason, what was the reason				0%
Did not have transportation	41%	60%	47%	
Did not have child care	25%	9%	20%	
Did not have insurance	29%	16%	25%	
Could not find office that accepted insurance	20%	33%	24%	

Item/measure	PP % or mean	FFY % or mean	Total % or mean	% missing
Could not get an appointment	32%	30%	31%	
Office did not have convenient hours	16%	19%	17%	
Delayed/did not receive dental care because could not afford it, last 12 months	41%	33%	39%	13%
Delayed/did not receive dental care for another reason, last 12 months	51%	52%	51%	23%
If delayed dental care for another reason, what was the reason				0%
Did not have transportation	31%	54%	38%	
Did not have child care	18%	9%	15%	
Did not have insurance	42%	21%	36%	
Could not find an office that accepted insurance	26%	36%	28%	
Could not get an appointment	23%	25%	24%	
Office did not have convenient hours	13%	15%	14%	

Source: Authors' analysis.

Notes: PP = pregnant participants; FFY = former foster youth.

* Values are masked due to small cell sizes.

Mental Health

Participants reported high levels of mental health concerns. About 40 percent met criteria for major depression on the PHQ-8, and the same number met criteria for generalized anxiety disorder on the GAD-7 (table 10). Just under three-quarters indicated moderate or high stress. Foster youth were more likely to screen positive for depression and anxiety than pregnant survey respondents.

TABLE 10
Baseline Mental Health and Well-Being—Full Sample by Target Population and Pooled

Item/measure	PP % or mean	FFY % or mean	Total % or mean	% missing
N	2,284	1,080	3,364	18%
PHQ-8—met criteria for major depression	36%	46%	40%	11%
PHQ-8, categorical				11%
No/minimal depression	35%	26%	32%	
Mild depression	30%	29%	29%	
Moderate depression	19%	18%	19%	
Moderately severe depression	11%	17%	13%	
Severe depression	6%	11%	8%	
GAD-7—met criteria for generalized anxiety disorder	36%	47%	39%	10%
GAD-7, categorical				10%
No/minimal anxiety	35%	30%	34%	
Mild anxiety	29%	23%	27%	
Moderate anxiety	18%	20%	19%	
Severe anxiety	18%	27%	20%	
Perceived Stress Scale Score^a				13%

Item/measure	PP % or mean	FFY % or mean	Total % or mean	% missing
Low stress	27%	24%	27%	
Moderate stress	60%	60%	60%	
High stress	13%	16%	14%	
Cantril well-being ladder—now	5.4 (2.1)	5.4 (2.1)	5.4 (2.1)	8%
Cantril well-being ladder—5 years	8.4 (1.7)	8.2 (1.9)	8.4 (1.7)	8%

Source: Authors' analysis.

Notes: PP = pregnant participants; FFY = former foster youth.

^a After baseline data collection was nearly complete, we discovered that the response options on the PSS were programmed incorrectly. The response options should be on a 0 to 4 scale and include never, almost never, sometimes, fairly often, and very often. Instead, the response options were programmed as not at all, several days, more than half the days, and nearly every day. Thus, we coded the responses on a 0 to 3 scale for scoring purposes. Those who scored from 0 to 10 were coded as low stress, 11 to 20 were coded as moderate stress, and 21 to 30 were coded as high stress.

Time Use

We asked participants to indicate whether they had enough time to engage in specific activities. Overall, 28 percent of participants disagreed that they had enough time to cook healthy meals; 38 percent disagreed that they had enough time to engage in hobbies; and 30 percent disagreed that they had enough time to spend with family and friends (table 11). Findings are consistent for both populations.

TABLE 11
Baseline Time Use—Full Sample by Target Population and Pooled

Item/measure	PP % or mean	FFY % or mean	Total % or mean	% missing
N	2,284	1,080	3,364	18%
Have enough time to cook healthy meals				9%
Strongly/somewhat disagree	27%	30%	28%	
Neutral	28%	30%	29%	
Strongly/somewhat agree	45%	40%	44%	
Have enough time to engage in hobbies/activities				10%
Strongly/somewhat disagree	39%	34%	38%	
Neutral	28%	28%	28%	
Strongly/somewhat agree	33%	38%	34%	
Have enough time to spend with family/friends				10%
Strongly/somewhat disagree	30%	30%	30%	
Neutral	29%	32%	30%	
Strongly/somewhat agree	42%	38%	41%	

Source: Authors' analysis.

Notes: PP = pregnant participants; FFY = former foster youth.

Additional Income Use

We asked participants how they would use additional income if their household income increased in the coming year. Participants were asked to select up to three items from a list, and the most common responses were pay bills (69 percent), pay off debt (55 percent), and save (41 percent; table 12).

TABLE 12
Baseline Planned Additional Income Use—Full Sample by Target Population and Pooled

Item/measure	PP % or mean	FFY % or mean	Total % or mean	% missing
N	2,284	1,080	3,364	18%
Pay bills	70%	66%	69%	12%
Pay off debt	59%	43%	55%	12%
Save additional income	38%	51%	41%	12%
Find a new place to live	33%	29%	32%	12%
Buy things I need	32%	30%	31%	12%
Reduce stress/anxiety	15%	13%	14%	12%
Seek schooling/training	10%	14%	11%	12%
Health, dental, or mental health care	6%	10%	7%	12%
Find a new job/seek promotion	4%	9%	5%	12%
Buy/do things that make me happy	4%	6%	4%	12%
Child care ^a	4%	1%	3%	12%

Source: Authors' analysis.

Notes: PP = pregnant participants; FFY = former foster youth.

^aThis response option was inadvertently omitted from the baseline surveys before June 25, 2024. Approximately 1,954 participants who consented to the baseline survey (71 percent of total participants who consented) did not see this response option.

Pregnancy

Among the pregnant participants, most had previously been pregnant (80 percent) and given birth (66 percent; table 13). One-fifth of those with a previous birth had at least one premature birth, 13 percent had at least one low birthweight infant, and 32 percent had previously been diagnosed with a pregnancy-related condition—factors that are associated with a higher likelihood of an adverse outcome during a subsequent birth.

PP report receiving prenatal care; 92 percent had a prenatal visit by the time of the baseline survey, 86 percent of whom initiated care during the first trimester (weeks 0–12). Most were insured when they found out they were pregnant (88 percent), and the vast majority (97 percent) were insured at the baseline survey.

TABLE 13
Baseline Pregnancy Module—Pregnant Participants Only

Item/measure	Total % or mean	% missing
N	2,284	14%
Number of previous pregnancies^a		10%
0	20%	
1	21%	
2	20%	
3	15%	
4	9%	
5	5%	
6+	9%	
Number of previous births		10%
0	34%	
1	29%	
2	19%	
3	10%	
4+	8%	
If any previous births, any previous premature births	21%	2%
If any previous births, any previous low birthweight births	13%	2%
If any previous pregnancy, diagnosed with any previous pregnancy-related condition	32%	0%
If any previous pregnancy, previous pregnancy-related diagnoses		0%
Gestational hypertension	11%	
Preeclampsia	11%	
Gestational diabetes	10%	
Other pregnancy-related condition	11%	
Had first prenatal visit by the time of baseline survey	92%	10%
If had first prenatal visit, weeks gestation at first prenatal visit		0%
0-12	86%	
13-26	13%	
27-40	0%	
Had health insurance when found out about pregnancy	88%	10%
Had health insurance at the time of baseline survey	97%	10%
Exercised in last month	51%	12%
Days exercised in last month	9.2 (7.3)	3%
Average minutes exercised per day in last month	38.3 (28.1)	3%
Sleep quality last week		10%
Very bad	7%	
Fairly bad	22%	
Neither	36%	
Fairly good	27%	
Very good	8%	

Source: Authors' analysis.

Notes: PP = pregnant participants; FFY = former foster youth.

^a Among those reporting one pregnancy, 34 percent reported no previous birth. This is consistent with estimates of the share of US pregnancies in 2020 that ended in abortion or fetal loss (32 percent). See Kathryn Kost, "Pregnancy Trends in the United States," New York: Guttmacher Institute, 2024, <https://www.guttmacher.org/fact-sheet/pregnancy-trends-united-states>. Participants were asked to report previous pregnancies, not including their current pregnancy. Some respondents may have included their current pregnancy in their response.

Discussion

The California GI Pilot Program is designed to support (a) youth aging out of extended foster care at age 21 and (b) pregnant people in their first or second trimester, with the intention of mitigating risks and promoting success in domains including housing, employment, education, and health. Baseline data indicate that program participants in both populations have high financial needs, consistent with program eligibility criteria. More than one-third of participants reported no income at baseline, and only 15 percent reported earning more than \$40,000.¹⁴ Nearly three-quarters were always or often stressed about having enough money to pay their bills, just over 80 percent had current debt, and most were behind on their payments. These high financial needs suggest an opportunity for GI to improve financial outcomes through the direct provision of cash.

A systematic review and meta-analysis found that the evidence of GI's impact on subjective financial well-being appears mixed; however, GI with more generous benefits than existing social assistance appears to yield beneficial results. Because the California GI Pilot Program includes a relatively large disbursement amount (\$600–\$1,200) while allowing participants to maintain eligibility for government assistance programs (e.g., CalFresh, WIC, CalWORKs, Medi-Cal, and, in some cases, housing subsidies), the potential to positively affect financial well-being is strong (Rizvi et al. 2024).

Unsurprisingly, participants reported high rates of material need, with almost half reporting very low food security, 43 percent reporting moderate or high transportation insecurity, about one-third reporting being homeless or couch surfing in the past year, and 42 percent reporting they were worried about losing their housing. These rates are somewhat higher than those observed among CalYOUTH participants and notably higher than among pregnant Medi-Cal enrollees, highlighting that the GI Pilot Program serves an especially high-need population (Courtney et al. 2020).¹⁵ GI could reduce material needs by providing participants with the cash necessary to purchase food, secure transportation, and housing. The extent to which material needs will reduce depends on whether the \$600 to \$1,200 monthly payment is adequate to cover the financial costs of meeting these needs, and tradeoffs that participants will face between meeting current needs and paying off debt. When asked how they thought they would spend GI money, 69 percent responded that they would pay bills, and 55 percent

¹⁴ Only earned income was included in the measure of baseline income.

¹⁵ “Maternal and Infant Health Assessment (MIHA) Data Snapshots Dashboard,” California Department of Public Health, accessed January 2, 2026, <https://www.cdph.ca.gov/Programs/CFH/DMCAH/MIHA/Pages/Data-Snapshots-Dashboard.aspx>.

responded that they would pay off debt. Since cash is fungible, use of GI to pay bills could free additional resources to purchase food, for example. In particular, GI has been found to significantly reduce self-reported rates of food insecurity (Rizvi et al. 2024).

The relationship between GI and labor market participation is more complex, as individuals have different preferences for the levels and types of employment and education. At baseline, most participants did not report having met their labor market preferences. More than one-third of participants reported they were unemployed and looking for work, and, among workers, nearly half were working part-time, a quarter of whom reported they could only find part-time work. Only 11 percent reported they had accomplished their educational goals, citing the cost of tuition and needing to work full-time as barriers. GI could support participants during labor market transitions and mitigate barriers to continuing education or seeking preferred employment. We also expect outcomes related to education and employment may differ by target population and may not be generalizable to other adult populations. For instance, monthly GI payments may allow new mothers to spend more time with their infants postpartum and delay a return to work. Foster youth may be able to focus on schooling and may be able to avoid work, or to work fewer hours, in the service of that goal.

Overall, participants were generally healthy at baseline but reported challenges accessing care. Nearly three-quarters reported their physical health as good, very good, or excellent, but 20 percent reported they had delayed receiving medical care, and 40 percent delayed dental care in the past year because they could not afford it. Nearly 50 percent reported delaying care for other reasons, such as a lack of transportation. GI could mitigate these barriers by helping participants afford the logistical costs of accessing care, such as transportation, time off work, and child care.

Mental health concerns were high, with just under 40 percent meeting criteria for major depression and a similar share meeting criteria for generalized anxiety disorder when screened at baseline. Over three-quarters reported moderate or high levels of stress. GI may lower mental distress by improving economic security (Rizvi et al. 2024; West and Castro 2023), however, Magnuson and colleagues (2025) found that unconditional cash transfers to mothers with low incomes may not significantly impact levels of perceived stress, anxiety, and parenting stress. Thus, the extent to which mental health is affected by GI likely depends on individual causes of stress and anxiety and the adequacy of the cash assistance to mitigate those stressors.

Participants reported being unable to use their time as they desired, with close to or more than 30 percent reporting insufficient time to cook healthy meals, engage in hobbies, or spend time with family

and friends. These outcomes may change after participation, as GI payments have been found to increase leisure time (Vivalt 2024).

Although pregnancy outcomes are not observable at baseline, data indicate that most PP have had a prior pregnancy (80 percent) and birth (66 percent)—experiences that will influence their current pregnancy and outcomes. Those who have previously experienced preterm birth or a low birthweight infant will be at greater risk of experiencing those outcomes during the current pregnancy. The California GI Pilot Program’s ability to affect birth outcomes will depend on the extent to which associations among poverty, material hardship, and adverse birth outcomes are causal; whether the program’s impact can offset prior poor pregnancy risk factors; whether the timing of GI receipt among participants is early enough during pregnancy to affect birth outcomes; and whether the disbursement amount is high enough to mitigate harms of economic distress.

Looking ahead, California GI Pilot Program study participants are surveyed throughout their participation—at three months, nine months, program completion, and a post-program follow-up. Data from these surveys will be combined with administrative data to compare changes in key financial, housing, employment, education, and health outcomes over time between cash recipients and control group participants. These findings will provide evidence on the effects of the California GI Pilot Program itself; differential impacts of GI for the high-need populations of youth aging out of foster care and pregnant people; and the effects of GI overall. Lessons from this evaluation can inform the design of government programs to address poverty and financial insecurity for targeted populations.

Appendix A. Target Populations and Hypothesized Effect of Guaranteed Income Per Program Design Objectives

APPENDIX TABLE A.1

Target Populations and Hypothesized Effect of Guaranteed Income Per Program Design Objectives: Baseline Wave

Wave and survey domain	Former foster youth	Pregnant participants
Financial strain and well-being	Reduce strain and improve financial well-being by increasing their income through the direct provision of cash; could allow recipients to increase savings, avoid taking on debt, or pay off existing debt.	Reduce strain and improve financial well-being by increasing their income through the direct provision of cash; could allow recipients to increase savings, avoid taking on debt, or pay off existing debt.
Food security	Increase food security. Reduce food insecurity among those who were food insecure at baseline and/or avoid food insecurity for those who were not food insecure at baseline.	Increase food security. Reduce food insecurity among those who were food insecure at baseline and/or avoid food insecurity for those who were not food insecure at baseline.
Education	<p>Improve educational attainment by providing increased income that allows them to remain in school.</p> <p><i>Note:</i> The study timeline may not be long enough to observe changes in educational attainment, but we anticipate observing increases in the share of participants enrolled in school. We do not anticipate GI to affect educational attainment measures among recipients who report having completed their educational goals.</p>	<p>Improve educational attainment by providing increased income that allows them to remain in school.</p> <p><i>Note:</i> The study timeline may not be long enough to observe changes in educational attainment, but we anticipate observing increases in the share of participants enrolled in school. Further, people may pause educational pursuits surrounding pregnancy, independent of financial considerations. We do not anticipate GI to affect educational attainment measures among recipients who report having completed their educational goals.</p>
Employment	Increase the share of recipients who have their preferred employment status. We expect fewer participants will report working multiple jobs or looking for additional work because they need more income. We may see more pregnant participants taking time off work to be with their children, and we may see more FFY working less to balance their educational pursuits.	Increase the share of recipients who have their preferred employment status. We expect fewer participants will report working multiple jobs or looking for additional work because they need more income. We may see more pregnant participants taking time off work to be with their children, and we may see more FFY working less to balance their educational pursuits.

Wave and survey domain	Former foster youth	Pregnant participants
Housing security	Increase the share of recipients who have their preferred housing status, report increased satisfaction with their housing situation and decrease the share of recipients who are homeless or living in a place not intended for housing, and the share who report being worried about losing their current housing.	Increase the share of recipients who have their preferred housing status, report increased satisfaction with their housing situation and decrease the share of recipients who are homeless or living in a place not intended for housing, and the share who report being worried about losing their current housing.
Transportation security	Increase recipients' transportation security; recipients who were not transportation insecure at baseline may avoid experiencing transportation insecurity.	Increase recipients' transportation security; recipients who were not transportation insecure at baseline may avoid experiencing transportation insecurity.
Overall well-being	Improve recipients' overall well-being by reducing financial stress and providing them with flexible, increased income to change their spending behavior to achieve goals.	Improve recipients' overall well-being by reducing financial stress and providing them with flexible, increased income to change their spending behavior to achieve goals.
Mental health	Improve recipients' mental health by reducing financial stress that may contribute to overall perceived stress, depression, and anxiety.	Improve recipient mental health by reducing financial stress that contributes to perceived overall stress, depression, and anxiety. <i>Note:</i> Effects may be limited if perinatal mood disorders arise during the study period.
Physical health and health care access	Improve self-reported health by reducing financial stress that may contribute to poor perceived health and by providing increased income that could improve access to routine health care (either by reducing financial barriers to care or providing resources to help reduce nonfinancial barriers like travel, child care, and time off of work).	Improve self-reported health by reducing financial stress that may contribute to poor perceived health and by providing increased income that could improve access to routine health care (either by reducing financial barriers to care or providing resources to help reduce nonfinancial barriers like travel, child care, and time off of work).
Time use	Improve recipients' self-reported feelings of having enough time to do things they enjoy by providing additional income that recipients can spend to increase their leisure time or improve health behaviors (like exercise and sleep).	Improve recipients' self-reported feelings of having enough time to do things they enjoy by providing additional income that recipients can spend to increase their leisure time or improve health behaviors (like exercise and sleep).

Sources: Stacia West and Amy Castro, "Impact of Guaranteed Income on Health, Finances, and Agency: Findings from the Stockton Randomized Controlled Trial," *Journal of Urban Health* 100 (2), April 2023: 227–44, <https://doi.org/10.1007/s11524-023-00723-0>.

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Anita Rizvi, Madeleine Kearns, Michael Dignam, et al. “Effects of Guaranteed Basic Income Interventions on Poverty-Related Outcomes in High-Income Countries: A Systematic Review and Meta-Analysis,” *Campbell Systematic Reviews* 20 (2; June 2024): e1414, <https://doi.org/10.1002/cl2.1414>.

Eva Vivalt, Elizabeth Rhodes, Alexander W. Bartik, David E. Broockman, Patrick Krause, and Sarah Miller, “The Employment Effects of a Guaranteed Income: Experimental Evidence from Two US States,” NBER Working Paper 32719 (2024), <https://doi.org/10.3386/w32719>.

Adriana S. Hines and Lindsay Gietzen, “Universal Basic Income Policy and Its Potential Impact on Welfare Reform,” *Pacific Journal of Health* 7 (1; 2024), <https://doi.org/10.56031/2576-215X.1091>.

APPENDIX TABLE A.2

Target Populations and Hypothesized Effect of Guaranteed Income Per Program Design Objectives: Subsequent Waves

Wave and survey domain		Former foster youth	Pregnant participants
Prenatal and postpartum care	N/A		Increase receipt of adequate prenatal and postpartum care by providing increased income that could improve access to prenatal health care (either by reducing financial barriers to care or providing resources to help reduce nonfinancial barriers like travel, child care, and time off of work).
Birth outcomes	N/A		Reduce preterm birth and low birthweight for infants born to recipients by reducing financial stress that may contribute to preterm birth and by providing increased income that could improve maternal health (such as by reducing food insecurity) during the prenatal period, potentially improving birth outcomes. <i>Note:</i> Evidence indicates that birth outcomes are extremely difficult to change through social and health policy interventions. Effects may be limited for recipients with prior adverse birth outcomes, which increase the likelihood of an adverse birth outcome in subsequent pregnancies, and for recipients with high risk pregnancies or pregnancy conditions associated with adverse birth outcomes (such as preeclampsia). Effects may be limited for recipients who enroll in the program later in pregnancy and may be limited for all recipients if the pathway through which low socioeconomic status is associated with adverse birth outcomes occurs before conception or very early in pregnancy.

Wave and survey domain	Former foster youth	Pregnant participants
Postpartum well-being	N/A	Improve postpartum well-being by reducing financial stress that may contribute to poor physical or emotional well-being. Increased income could improve access to services related to physical health and emotional well-being (either by reducing financial barriers to services or providing resources to help reduce nonfinancial barriers like travel, child care, and time off of work).
Diaper and formula security	Improve diaper and formula security by providing increased income that can be used to purchase diapers and/or formula.	Improve diaper and formula security by providing increased income that can be used to purchase diapers and/or formula.
Infant feeding	N/A	Increase the share of recipients who report initiating breastfeeding and longer duration of breastfeeding among those who initiate; increased income may allow recipients to maintain employment supportive of breastfeeding and/or purchase supplies needed for pumping and feeding breast milk.
Child care	A larger share of recipients will have their preferred child care situation by providing increased income that may allow recipients to afford their preferred child care.	A larger share of recipients will have their preferred child care situation by providing increased income that may allow recipients to afford their preferred child care.
Parenting stress	Reduce parenting stress by reducing financial stress that may contribute to parenting stress and by providing increased income that may allow recipients to access services that could reduce their stress (such as mental health care and/or child care)	Reduce parenting stress by reducing financial stress that may contribute to parenting stress and by providing increased income that may allow recipients to access services that could reduce their stress (such as mental health care and/or child care)
Health-related quality of life	Increase perceived physical and mental health over time as a result of reduced stress and increased free time associated with reductions in financial strain.	Increase perceived physical and mental health over time as a result of reduced stress and increased free time associated with reductions in financial strain.
Physical activity	Improved ability to participate in physical activity resulting from increased free time and perhaps improved mood.	Improved ability to participate in physical activity resulting from increased free time and perhaps improved mood.
Sleep	Improve sleep by reducing perceived stress/strain and increasing free time.	Improve sleep by reducing perceived stress/strain and increasing free time.
Diet	Improve diet as a result of being able to afford higher-quality foods.	Improve diet as a result of being able to afford higher-quality foods.
Unexpected shocks	Improve the ability to handle an unexpected expense due to increased income.	Improve the ability to handle an unexpected expense due to increased income.

Sources: Stacia West and Amy Castro, "Impact of Guaranteed Income on Health, Finances, and Agency: Findings from the Stockton Randomized Controlled Trial," *Journal of Urban Health* 100 (2), April 2023: 227–44, <https://doi.org/10.1007/s11524-023-00723-0>.

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Katherine A. Magnuson, Greg J. Duncan, Hirokazu Yoshikawa, et al. "Effects of Unconditional Cash Transfers on Family Processes and Well-being Among Mothers with Low Incomes," *Nature Communications* 16 (7517; 2025), <https://doi.org/10.1038/s41467-025-62438-x>.

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Appendix B. Survey Measures

APPENDIX TABLE B.1

Survey Measures: Mental Health and Well-Being

Sub-domain	Instrument	Citations
Depression	PHQ-8	Kroenke, Kurt, Tara W. Strine, Robert L. Spitzer, Janet B. W. Williams, Joyce T. Berry, and Ali H. Mokdad. 2009. "The PHQ-8 as a measure of current depression in the general population." <i>Journal of Affective Disorders</i> 114 (1-3):163-73.
Anxiety	GAD-7	Spitzer Robert L., Kurt Kroenke, Janet B. W. Williams, and Bernd Löwe. 2006. "A Brief Measure for Assessing Generalized Anxiety Disorder: The GAD-7." <i>Arch Intern Medicine</i> 166 (10):1092-1097.
Perceived stress	PSS-10	Lee, Eun-Hyun. 2012. "Review of the psychometric evidence of the perceived stress scale." <i>Asian Nursing Research</i> 6 (4): 121-127.
Well-being	Cantril Well-Being Scale	Levin, K. A., and C. Currie. 2014. "Reliability and validity of an adapted version of the Cantril Ladder for use with adolescent samples." <i>Social Indicators Research</i> 119(2): 1047-1063.

Source: Authors' analysis.

APPENDIX TABLE B.2

Survey Measures: Financial Health

Sub-domain	Instrument	Citations
Financial stress	PRAMS Financial Stress Instrument	Centers for Disease Control and Prevention. 2017. "Pregnancy Risk Assessment Monitoring System (PRAMS) Phase 8 Standard Questions." Washington, DC: Centers for Disease Control and Prevention.
Financial well-being	CFPB Financial Well-being Instrument	Consumer Financial Protection Bureau. 2015. Measuring financial well-being: A guide to using the CFPB Financial Well-Being Scale. Washington, DC: Consumer Financial Protection Bureau.

Source: Authors' analysis.

APPENDIX TABLE B.3

Survey Measures: Physical Health

Sub-domain	Instrument	Citations
Health care delay	NHIS	National Center for Health Statistics. 2019 National Health Interview Survey (NHIS) Questionnaire. Washington DC: Centers for Disease Control and Prevention. https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Survey_Questionnaires/NHIS/2019/EnglishQuest.pdf .
Health care utilization	BRFSS	Pierannunzi, Carol, Shaohua Sean Hu, and Lina Balluz. 2013. "A systematic review of publications assessing reliability and validity of the Behavioral Risk Factor Surveillance System (BRFSS), 2004-2011." <i>BMC Medical Research Methodology</i> 13 (49). https://doi.org/10.1186/1471-2288-13-49 .

Source: Authors' analysis.

APPENDIX TABLE B.4

Survey Measures: Material Security

Sub-domain	Instrument	Citations
Food insecurity	USDA Short Form	Blumberg, Steven J., Alexandra K. Bialostosky, William L. Hamilton, and Ronette R. Briefel. 1999. "The effectiveness of a short form of the Household Food Security Scale." <i>American Journal of Public Health</i> 89 (8): 1231-1234.
Transportation security	Transportation Security Index Short Form	Murphy, Alexandra K., Alix Gould-Werth, and Jamie Griffin. 2021. "Validating the Sixteen-Item Transportation Security Index in a Nationally Representative Sample: A Confirmatory Factor Analysis." <i>Survey Practice</i> 14 (1). https://doi.org/10.29115/SP-2021-0011 .

Source: Authors' analysis.

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STATEMENT OF INDEPENDENCE

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