ALL ABOUT KIDS

FACTSHEETS ABOUT GEORGIA'S CHILDREN

2026 EDITION

Voices for Georgia's Children

G·san
GEORGIA STATEWIDE AFTERSCHOOL NETWORK

ACKNOWLEGEMENTS

Voices for Georgia's Children and the Georgia Statewide Afterschool Network (GSAN) would like to thank the Governor's Office, the Georgia General Assembly, and state agency leadership, all of whom have committed years of hard work to ensure that Georgia's children are healthy and safe. Voices and GSAN would also like to express gratitude to all those who helped in the development of these factsheets by sharing their data, perspectives, expertise, and time.

ABOUT VOICES FOR GEORGIA'S CHILDREN

Voices for Georgia's Children believes every child can thrive when given the opportunity. Through research and analysis, public education, and convening and engaging with decision-makers, we advance laws, policies, and actions that improve the lives of children — particularly those furthest from opportunity. Our work is framed in a holistic "whole child" perspective that allows us to identify how different policies impact children and propose solutions that benefit children on multiple levels.

For more information, visit georgiavoices.org.

ABOUT GEORGIA STATEWIDE AFTERSCHOOL NETWORK (GSAN)

The Georgia Statewide Afterschool Network (GSAN) is a public-private collaborative that envisions a day when all communities in Georgia have the resources to provide exceptional afterschool programming. Our mission is to advance, connect, and support quality afterschool programs to promote the success of children and youth throughout Georgia.

Fore more information, visit afterschoolga.org.

All About Kids: Factsheets about Georgia's Children is a resource designed to equip policymakers with the latest data to inform policy decisions and prioritize the needs of our youngest citizens. Each factsheet provides a snapshot of how Georgia's children are doing across key indicators and is intended to support your work in ensuring all children have the opportunity to thrive.

As you review the data, please note that some indicators are no longer being updated because the source data are no longer being collected or published. Where this is the case, we've provided the most recent available figures and included a notation indicating that newer data are not available. We recognize how important reliable, up-to-date data are in making sound policy decisions and will continue advocating for their collection and accessibility.

On behalf of Georgia's children and families, thank you for your continued commitment to their wellbeing. Your dedication to investing in their health, education, safety, stability, and overall wellbeing lays the foundation for a brighter future for every child—and every community—in our state.

We look forward to working together to keep kids at the center of your policy priorities.

Sincerely,
The Team at Voices for Georgia's Children
and Georgia Statewide Afterschool Network

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CWD3 Early Childhood Developmental Milestones

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Each of the enclosed factsheets can be found individually by scanning this QR code or by visiting our website, georgiavoices.org.

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TWO GENERATION "2GEN" APPROACH

The Two-Generation (2Gen) Approach is a framework for policies and programs that disrupts cycles of poverty and negative outcomes by addressing the whole family's needs together. 2Gen approaches strengthen family well-being by working with both children and their parents or caregivers at the same time. Any policy, program, or service – including early care and education, health, housing, child welfare, and juvenile justice – can have a greater impact by using a 2Gen approach.[1]

THE TWO-GENERATION CONTINUUM

child-focused

child-focused with parent/caregiver elements

(e.g., early childhood development with parenting skills; family literacy with health screenings)

whole family

adult-focused with child elements

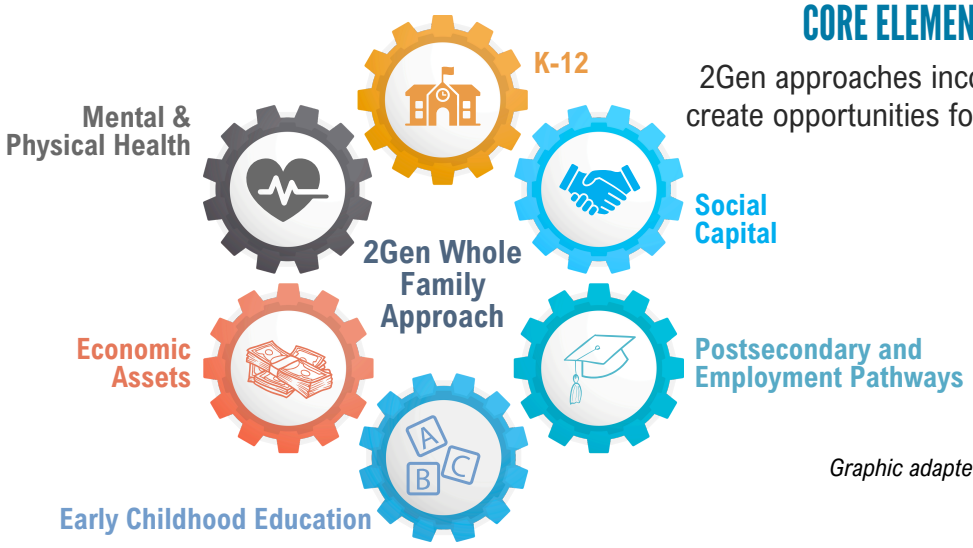
(e.g., workforce programs offering child care referrals; food and nutrition supports for student parents)

adult-focused

Graphic adapted from Ascend at the Aspen Institute

CORE ELEMENTS OF THE 2GEN APPROACH

2Gen approaches incorporate multiple policies to create opportunities for the whole family to thrive.



Graphic adapted from Ascend at the Aspen Institute

Mental & Physical Health
- Coverage and access to care
- Adverse childhood experiences and toxic stress

Economic Assets
- Housing supports
- Financial capacity
- Transportation

Early Childhood Education
- Head Start/Early Head Start
- Child care partnerships
- PreK
- Home Visiting

K-12
- Kindergarten readiness
- 3rd grade reading skills
- Parent engagement
- Graduation & postsecondary prep

Social Capital
- Peer & family networks
- Coaching
- Cohort strategies

Postsecondary and Employment Pathways
- Community college
- Training & credentials
- Workforce & employer partnerships

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THE IMPACT OF 2GEN APPROACHES

Improving access to childcare could address an estimated **$2.52 billion** economic loss to the state by reducing missed work and increasing economic opportunities for parents of young children.[2]

A **$1,000 increase** in a caregiver's income can raise a child's academic achievement by the equivalent of two extra months of schooling.[3]

Children with college savings between **$1 and $499** are **3 times more likely** to go to college and **4 times more likely** to graduate.[4]

2Gen Models* in Georgia

Childcare and Parent Services (CAPS) Program[5]

administered by the Department of Early Care and Learning (DECAL)

- Provides affordable, high-quality early learning opportunities for families with low incomes
- Helps young learners achieve school readiness for greater academic gains in the long-term
- Helps families achieve stability and self-sufficiency by offering financial assistance for childcare

Grants Administered by DECAL to support 2Gen:

- **2Gen Innovation Grants for Student Parent Success** (available to select technical colleges) enhances children's access to high-quality early education while also improving parents' ability to secure family-supporting jobs.[6]
- **2Gen Community Literacy Grants** improve literacy skills across generations by combining adult education, early childhood education, and family engagement to create supportive learning environments.
- **Community Transformation Grants** address the unique needs of local populations and local early childhood gaps through building partnerships to increase access to services like mental health, developmental support, and trauma-informed care.

Boost Child Care Initiative[7]

administered by Quality Care for Children (QCC)

- Boosts state funding to childcare to strengthen Georgia's workforce
- Helps reduce the CAPS eligibility gap
- Extends childcare subsidy eligibility to parents attending college

Georgia's Maternal, Infant, Early Childhood Home Visiting (MIECHV) Program[8]

administered by Georgia Department of Public Health (DPH)

- Teaches positive parenting skills
- Encourages early learning and language development through strong parent-child communication
- Connects families to needed services and resources as appropriate
- Provides guidance on breastfeeding, nutrition, safe sleep practices, injury prevention, and more
- Provides screening and referral services to address developmental delays, postpartum depression, substance misuse, and family violence

**This is not a comprehensive list of 2Gen models in Georgia. Other examples include FYF Teen Summits' Caregiver Cafe and Nana grants.*

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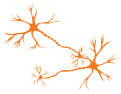
BRAIN DEVELOPMENT BASICS

The early years of a child's life are important for later health and development. This is particularly true for brain development. Although the brain continues developing and changing into adulthood, the first eight years build a foundation for future learning, health, and success.[1]

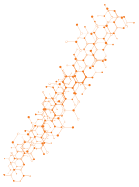
STAGES OF BRAIN DEVELOPMENT

Different structures of the brain develop at different rates and times.[2] Brain development can be disrupted by chronic exposure to stress hormones (e.g., cortisol, adrenaline, etc.).[3] Significant adversity in childhood can lead to a viscous cycle of stress that is toxic to important brain structures. *See our Child Maltreatment: Effects on the Brain factsheet for more.*



Early Child Brain Development:[4]

- Neurons are created and form connections both before and after birth.
- Brainstem and midbrain fully develop first, governing functions necessary for life, like heart rate, breathing, eating, and sleeping.



Young Child Brain Development:[5]

- Formation of synapses occur at a high rate.
- Higher function brain regions (governing emotions, language, and abstract thought) grow rapidly in the first three years.
- By age two, a child has formed 100 trillion synapses.
- Synapses are eliminated as experiences deem them unnecessary. This is known as pruning.
- By age three, a child's brain is nearly 90% of its adult size.

Adolescent Brain Development:[6]

- Prior to puberty, there is a growth spurt in the areas of the brain governing planning, impulse control, and reasoning.
- While these areas develop, teenagers can act impulsively, make poor decisions, and take increased risks (all normal behaviors for this stage).
- More pruning occurs in the teenage years.
- Limbic system grows and transforms.

Terms to Know

Neuron: nerve cells that send messages across the body to allow you to do everything from breathing to talking, eating, walking and thinking[7]

Synapse: the place where neurons connect and communicate with each other[8]

Pruning: the selective elimination (or "weeding out") of non-essential synapses based on a child's specific experiences[9]

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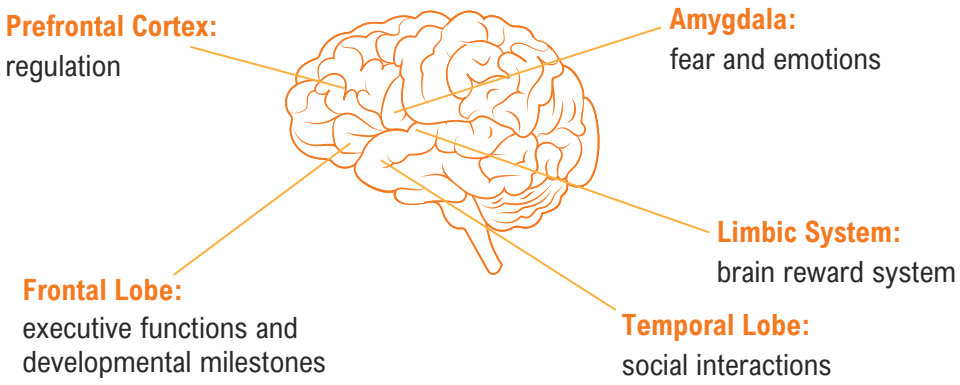
PARTS OF THE BRAIN AND THEIR FUNCTIONS



Amygdala: the processing center for emotions; associated with survival instincts (e.g., fight or flight); also plays a role in aggression, learning through rewards and punishment, handling unconscious memory (e.g., tying a shoes or riding a bike), learned behaviors related to addiction, and ties emotions we connect to memories[10]

Brainstem: responsible for many of the vital functions in life, such as breathing, consciousness, blood pressure, heart rate, and sleep[11]

Frontal lobe: one of the five lobes of the brain; handles reasoning, social understanding, executive functions, voluntary muscle movements, and learning and recalling information[12]

Limbic system: assists in various processes relating to cognition, including spatial memory, learning, motivation, emotional processing and social processing[13]

Midbrain: the highest part of the brainstem which is responsible for certain reflexes, helps with visual and auditory process, contributes to the control of eye movement, regulating auditory and visual processing, motor control, arousal, and alertness[14]

Prefrontal cortex: one of the last places in the brain to mature; the prefrontal cortex manages insight, foresight, and planning capabilities[15]

Temporal lobe: a pair of areas on the brain's left and right sides, which play a role in managing emotions, processing information from senses, storing and retrieving memories, and understanding language[16]

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EARLY CHILDHOOD DEVELOPMENTAL MILESTONES

A child's early years are critical for later health and development.[1] Missing key milestones during this crucial period may indicate developmental delays. Early detection and intervention can help kids stay on track, so it is critical to know what to expect during the early stages of a child's development. Between birth and age 5, a child's brain develops more than any other time in life.

90% of brain growth happens by kindergarten.[2]

HIGHLIGHTS OF KEY DEVELOPMENTAL MILESTONES

Every child develops at their own pace, but child development experts have a well-established understanding of typical developmental milestones from birth to age 5, as well as indicators that may suggest a developmental delay.[3]

THE FIRST YEAR OF LIFE

Skills Babies Typically Develop	Signs that *Could* Suggest a Developmental Delay
0 to 3 months:	
• Holds head up when on stomach • Begins to smile • Learns to briefly calm self (e.g., brings hand to mouth and suck on hand)	• Doesn't focus and follow a nearby object side to side • Doesn't notice hands by two months • Crosses eyes most of the time (occasional crossing of the eyes is normal)
3 to 6 months:	
• Copies movements and sounds • Begins to babble • Rolls from stomach to back	• Doesn't bring objects to mouth by 4 months • Doesn't push down with legs when feet are placed on a firm surface • Cannot support head well at 3 months
6 to 9 months:	
• Begins to sit with support • Plays peek-a-boo • Knows familiar faces	• Reaches with one hand only • Does not turn head to locate sounds • Doesn't roll over in either direction
9 months to 1 year:	
• Crawls and pulls to stand • Uses simple gestures (e.g., shakes head, waves) • Responds to simple spoken requests	• Does not crawl • Cannot stand when supported • Says no single words ("mama" or "dada")

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THE SECOND YEAR OF LIFE

Skills Babies Typically Develop

1 to 2 years:

- Walks alone
- Stands on tiptoe
- Uses pincer grasp
- Uses simple phrases
- Uses two- to four-word sentences
- Points to object or picture when it's named for him
- Finds hidden objects easily

Signs that *Could* Suggest a Developmental Delay

- Drags one side of body while crawling
- Does not search for objects that are hidden while he watches
- Does not learn to use gestures, such as waving or shaking head
- Does not point to objects or pictures

THE THIRD YEAR OF LIFE

Skills Babies Typically Develop

2 to 3 years:

- Calms down within 10 minutes after caregiver leaves (like at childcare drop off)
- Engages in conversation
- Says first name, when asked
- Begins to runs
- Follows instructions with 2-3 steps

Signs that *Could* Suggest a Developmental Delay

- Cannot grasp a crayon between thumb and finger
- Ignores other children
- Doesn't engage in fantasy play
- Does not use two-word sentences by age 2

THE FOURTH YEAR OF LIFE

Skills Babies Typically Develop

3 to 4 years:

- Hops and stands on one foot up to five seconds
- Kicks ball forward
- Copies square shapes
- Uses scissors
- Tells stories
- Correctly names some colors

Signs that *Could* Suggest a Developmental Delay

- Cannot throw a ball overhand
- Doesn't use sentences of more than three words
- Cannot copy a circle
- Resists dressing, sleeping, using the toilet

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QUALITY EARLY LEARNING IN GEORGIA

Quality early care and learning is essential to the growth and development of Georgia's youngest learners. Multiple studies have shown how quality early care and learning impacts outcomes for young children in their early years and well beyond.

WHAT IS QUALITY? [1]

- Have low child-teacher ratios
- Implement individualized instruction
- Ensure a clean and safe environment
- Support academic growth particularly in language and literacy
- Engage and support families
- Promote proper physical, social, and emotional development
- Provides supports for dual-language learners
- Employ qualified and well-trained teachers

QUALITY INITIATIVES IN GEORGIA

Georgia Early Learning and Development Standards (GELDS) [2]

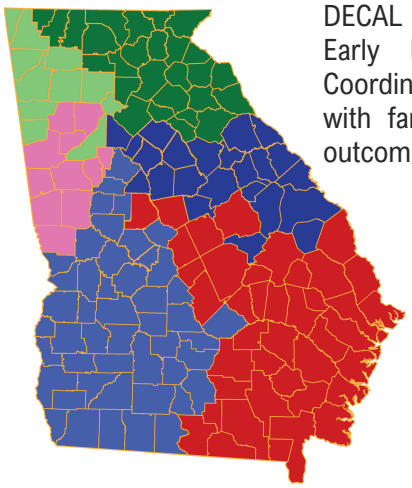
The GELDS provide a research-based, age-appropriate framework for children from birth to age five. Flexible by design, the GELDS respect each child's developmental pace, learning style, and cultural context while guiding high-quality early learning experiences.

The standards address the question, **"What should children from birth to age five know and be able to do?"** and align with the Georgia Standards of Excellence (GSE) for K-12, as well as the Head Start Early Learning Outcomes Framework and the Work Sampling System. Organized by age bands, the GELDS form a continuum of skills, behaviors, and concepts that support children's growth during their earliest years.

GELDS' Five Domains of Learning

- PDM — Physical Development and Motor Skills
- SED — Social and Emotional Development
- APL — Approaches to Play and Learning
- CLL — Communication, Language, and Literacy
- CD — Cognitive Development and General Knowledge

Early Education Community Partnerships Team [3]



DECAL continues to strengthen community outreach and engagement through its Early Education Community Partnerships (EECP) Team. Six Community Coordinators, each serving one of DECAL's administrative regions, work directly with families and local organizations to share resources and improve learning outcomes for young children.

The EECP Team builds connections between state programs and community efforts, prioritizing strategies that expand access to high-quality care through Georgia's Quality Rated Child Care system. Regional Coordinators:

- Partner with local stakeholders to align services for children birth to age 8.
- Increase public awareness of early education resources.
- Serve as a regional point of contact for all DECAL programs and services.
- Convene birth-to-eight collaboratives and child care engagement networks.

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QUALITY RATED IN GEORGIA

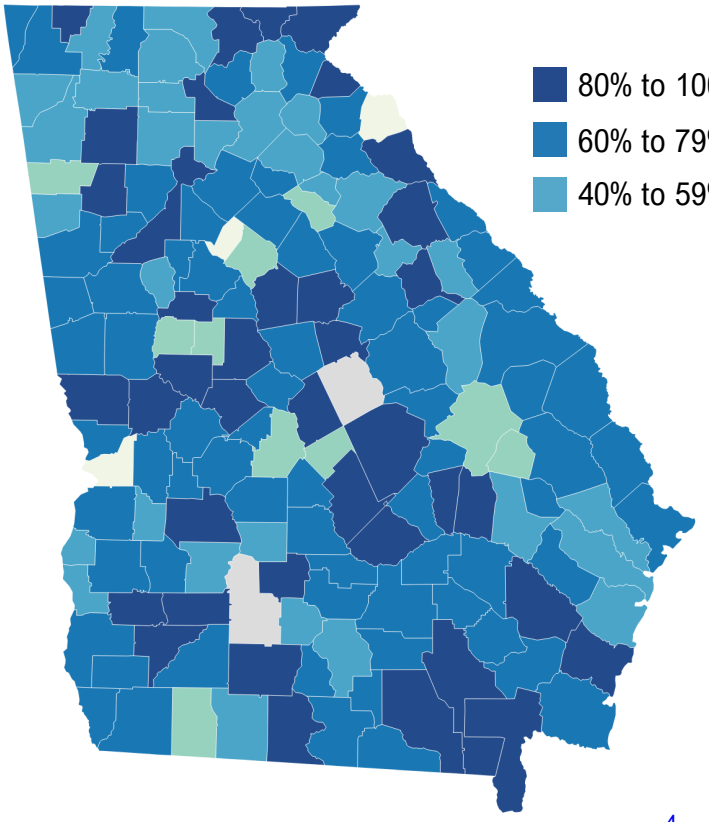
WHAT IS IT?

Quality Rated in a voluntary rating and improvement system for early and school-age care programs administered by DECAL. The goal of Quality Rated is to assess, improve, and communicate the level of quality within Georgia's child care programs.

Programs become Quality Rated by completing an online portfolio and classroom observations, which together determine their Star Rating.

Quality Rated programs earn 1, 2, or 3 stars based on standards for health, safety, interactions, learning, and more.

WHERE ARE GEORGIA'S QUALITY RATED PROGRAMS?



Of the 4,375 eligible centers, 2,930 (or 67%) are Quality Rated.

Percentage of Quality Rated Centers, by County [4]

BENEFITS

For parents:

QualityRated.org is a free, trusted resource where families can find high-quality child care and pre-k programs, with details on safety, rates, ages served, and more. Families can also call the Quality Rated Family Support Call Center at 1-877-ALL-GA-KIDS for additional assistance.

For the state:

Regardless of their rating, all participating programs are dedicated to going beyond Georgia's licensing standards to improve quality. Quality Rated also fosters a shared commitment to continuous improvement at both the community and state levels.

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CHILDCARE AND PARENT SERVICES (CAPS)

The Childcare and Parent Services (CAPS) program assists families with low-incomes with the cost of child care while they work, go to school, receive training, or participate in other work-related activities.[1] Subsidies can be used to pay for quality child care, afterschool, and summer programs for children up to age 12 and for children up to age 17 with special needs.[2]

WHAT IS THE PURPOSE OF THE CAPS PROGRAM? [3]

1. Provide access to high-quality and affordable early learning, afterschool, and summer environments for families with low incomes
2. Increase positive school readiness outcomes
3. Assist families in achieving and maintaining self-sufficiency by providing financial supports for child care costs

CAPS FUNDING: FEDERAL AND STATE [4]

Federal Funding

Federal funding is provided from the Child Care and Development Fund (CCDF) and is administered by the Department of Early Care and Learning (DECAL). Georgia received **$309 million** in federal child care subsidy funds in state fiscal year (SFY) 2025.

State Funding

In SFY25, Georgia appropriated and made available approximately **$76 million** for CAPS.

PRIORITY FOR CAPS SCHOLARSHIPS

Because CAPS scholarships are limited, children in the following situations are given priority:

- Child Protective Services
- Custody of the Division of Family and Children Services
- Domestic violence situations
- Disability status
- Enrolled in Georgia's Pre-K Program
- Participating in, or transitioning from, Temporary Assistance for Need Families (TANF)
- Experienced a natural disaster
- Lack fixed, regular, and adequate housing
- Very Low Income, as defined by CAPS[5]
- Grandparents raising grandchildren
- Minor parents
- Need to protect
  (e.g., family with substantiated Child Protective Services case closed with the last 12 months, caregiver other than biological or adoptive parents has taken over full-time care of child
- Student parent

Currently, CAPS serve 17.2% of Georgia's potentially eligible children.[6] Continued investments in CAPS are crucial to reaching eligible families who apply for Child Care Subsidy Scholarships.

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INCOME ELIGIBILITY

Families must earn less than 40% of the state median income (SMI) at the initial eligibility determination and can remain enrolled in CAPS as long as their income remains at or below 85% SMI, and they can meet other CAPS eligibility requirements.[7]

For example, a **family of four** cannot make more than **$44,295** a year.

To qualify for the Very Low Income priority group, a **family of four** cannot make more than **$9,645** a year.[8]

PARENT APPROVED ACTIVITIES

Parents who received CAPS must complete an average of **24 hours per week** of approved activities to stay eligible for the CAPS scholarship.[9]

Approved activities can include: [10]

Employment

Paid employment or volunteering at Head Start or Early Head Start facilities

Education

Participation in middle or high school, GED programs, vocational training programs, technical college, technical credits, associate's degree and bachelor's degree programs**

Job Search

Parents who lose their job or stop attending state-approved training or education programs may be authorized for up to 13 weeks of job search***

**For parents enrolled with the Technical College System of Georgia (TCSG), as well as parents participating in any education or vocational training program: every credit hour equals two hours towards the required 24 hours per week of approved activities. For example, if a parent is enrolled in a class that counts as 3 credit hours with TCSG, they earn 6 credit hours per week towards the required 24.[11]

***To be eligible for CAPS services, the parent(s) must participate in one, or a combination of, the activities listed in this section. Most parents must participate in the stated activity for an average of at least 24 hours per week, except as noted in CAPS Eligibility Requirements Policy, section 6. For parents participating in one, or a combination of state-approved activities listed in this section, staff must verify the activity hours for the stated activity.[12]

CHANGES TO THE CHILD CARE DEVELOPMENT FUND (CCDF)

Federal stimulus funds were used to pay the family fee on behalf of CAPS since May 2021. Families resumed paying the family fee in October 2023. However, to ensure child care is affordable, family fees are limited to no more than **7%** of the family's income.[13]

All providers serving children receiving CAPS subsidies are required to participate in Quality Rated.[14]

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GEORGIA PRE-K PROGRAM

Georgia's Pre-K Program has served more than 2 million students since it began in 1992.[1] This voluntary, free program is open to all four-year-olds in Georgia, regardless of parental income. The program continues to be nationally recognized for its success.

2024-2025 Participation

- **70,000** students[2]
- **3,785** classes[3]
- Operating in **159** counties in **1,912** locations[4]
- At the end of the year, **4,762** were on the waitlist[5]
- **45%** were located in public school systems[6]
- **55%** were located in private centers[7]

How is the program structured? [8]

Maximum of **20 students** per classroom

Full day program, **180 days** per year

Lead and assistant teachers must meet **credential requirements**

Curriculum is based on the **Georgia Early Learning and Development Standards** GELDS

In 2022-2023, Georgia ranked **9th best** in the nation for access to pre-k for four-year-olds.[9]

More than half of Georgia's Pre-K providers are Quality Rated, a voluntary, quality rating system for early and child care programs.[10]

HOW GEORGIA PRE-K IS IMPROVING OUTCOMES

The Georgia Department of Early Care and Learning (DECAL) and the Frank Porter Graham Institute conducted a multi-year evaluation to understand the short- and long-term benefits of the Georgia Pre-K program. The study followed children from the program through fourth grade and found that children:[11]

- **Are more prepared for kindergarten** compared to four-year-olds who did not attend any pre-k program.
- **Experienced larger than expected growth in their pre-k year in literacy, math, and social skills.** These gains were sustained during kindergarten and another period of higher than expected growth occurred in 4th grade.

Children in Georgia Pre-K showed significant growth across all learning domains, including:

Math skills · Language and literacy skills · Social-emotional skills

All students—regardless of gender or income—showed gains that lasted through kindergarten, with another boost in achievement appearing in 4th grade.

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HOW IS GEORGIA PRE-K FUNDED?

Georgia Pre-K is funded by the Georgia Lottery. **$541,423,948** lottery dollars were allocated to the program for FY25.[12]

Research shows **low pay** is a significant factor in an early childhood teacher's decision to leave the profession.[13] **High turnover rates** have been linked to lower program quality and shown to negatively impact a child's social and emotional development and relationships between teachers, children, and parents.[14]

Georgia's Pre-K teachers are responsible for delivering high-quality educational and instructional services to children aged four and five. The school year consists of 180 days with at least 6.5 hours dedicated each day to direct classroom instruction. Base-level salaries for Fy26 are as follows:[15]

4-year degree	4-year degree and certified	Master's degree and certified	Specialist degree and certified	Doctorate degree and certified
$41,717	**$43,592**	**$48,706**	**$53,803**	**$58,676**

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SCHOOL READINESS IN GEORGIA

Children entering kindergarten with school readiness skills are more likely to experience academic success and better lifetime well-being than their peers.[1] Cognitive abilities alone are not sufficient for a child to be considered ready for school.

WHAT DOES SCHOOL READINESS LOOK LIKE? [2]

- Early identification and appropriate care for potential physical or mental disabilities
- Evident early literacy and language skills
- Emerging social and interpersonal skills
- Possession of a general knowledge about the world
- Demonstrated enthusiasm, curiosity, and persistence in learning
- Awareness of feelings of both self and others

School readiness can be influenced by a child's development, family, community, schools, and the services to which they have access. Multiple studies of pre-k have shown that participation in high-quality pre-k can greatly improve school readiness skills and can offset some challenges children may face. [3]

GEORGIA'S COMMITMENT TO SCHOOL READINESS

Georgia Pre-K and the **Summer Transition Program**, offered by Georgia's Department of Early Care and Learning (DECAL), help children build the skills they need to start kindergarten ready to learn.

Georgia Pre-K

MORE THAN 2 MILLION

students have been served by Georgia Pre-K since 1992.[4]

Outcomes for Georgia Pre-K Students:

Children in Georgia Pre-K showed significant growth in all areas of learning, including: [5]

- Math
- Language and literacy
- Relationships and feelings

A key strength of Georgia Pre-K is building foundational literacy skills for reading.[6]

Evaluations have found children enrolled in Georgia Pre-K: [7]

- ✓ Are more prepared for kindergarten compared to four-year-olds in other forms of care
- ✓ Have increased cognitive development and improved educational outcomes in later grades.

Dual language learners showed growth across all skills in English and most skills in Spanish.[8]

Summer Transition Program

The Rising Kindergarten and Rising Pre-K Summer Transition Programs are offered by DECAL as additional supports for students who may need then (e.g., children identified by teacher as needing additional academic support, dual language learners, etc.).[9]

2025 Reach:

395 classes at **308** locations [10]

See Voices' Georgia Pre-K Program and Summer Transition Program factsheets for more details.

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SUMMER TRANSITION PROGRAM

The Georgia Department of Early Care and Learning (DECAL) offers two intensive five-week academic programs to support children and prepare them for kindergarten and pre-k.

RISING KINDERGARTEN SUMMER TRANSITION PROGRAM

2025 Participation[1]

- **4,042** students
- **326** classes
- Operating in **60** counties in **231** locations
- **19%** were located in public school systems
- **81%** were located in private centers

Who is eligible? [2, 3]

To participate, a child must be age-eligible for kindergarten in the upcoming school year and meet one of the following:

1. Did not attend Georgia Pre-K or Head Start in 2024-2025, **OR**
2. Attended, but not for the full school year, **OR**
3. Attended the full year and belongs to one of the following priority groups:
   - Needs additional academic support
   - Dual language learner (home language is not English)
   - In foster care
   - Experiencing homelessness (per McKinney-Vento Act)
   - Has an Individualized Education Program (IEP)

How is the program structured? [4]

Maximum of 14 students per classroom

6.5 hours a day

Two adults (lead, assistant, and/or substitute teacher) and one transition coach per classroom

Assists in coordinating care before and after school as needed through the Childcare and Parent Services (CAPS) program

What is a transition coach? [5]

Each class has a half-time transition coach who:

- Identifies eligible students
- Assists families with health screenings and paperwork
- Leads weekly parent workshops or engagement activities
- Connects families to community resources, upon request
- Supports families in preparing for kindergarten registration
- Provides individualized transition materials for each enrolled student

SCAN BELOW TO SEE FACTSHEET CITATIONS

RISING PRE-KINDERGARTEN SUMMER TRANSITION PROGRAM

2025 Participation[6]

- **763** students
- **69** classes
- Operating in **20** counties in **52** locations
- **25%** were located in public school systems
- **75%** were located in private centers

Who is eligible? [7]

1. A child who is registered to attend a Georgia Pre-K program or Head Start program in the 2025-2026 school year, **AND**
2. Child's home language is Spanish

How is the program structured? [8]

- Maximum of 12 students per classroom
- Instruction is provided in both English and Spanish
- Teacher trained to work with Dual Language Learners
- Two adults (lead, assistant, and/or substitute teacher) and one transition coach per classroom
- At least one teacher AND the transition coach must be bilingual and biliterate in English and Spanish

Why are bilingual and biliterate teachers and transition coaches important?

An estimated 24% of Georgia's children ages 0 to 5 are Dual Language Learners (DLLs), most of whom speak Spanish. Research from the Frank Porter Child Development Institute shows: [9]

1. Spanish-speaking DLLs are **less likely** to enroll in early care, impacting school readiness.
2. Participating children **improved** both their English and Spanish-language skills.
3. The program **boosted** comfort with school routines and **increased** independence.
4. Despite progress, **a meaningful gap** remained between DLLs and their peers.

In 2025, the Rising Kindergarten and Pre-K Summer Transition Programs combined hosted:

4,805 children in **395** classes

The total budget for both Summer Transition Programs is **$10.8 million**.
That's approximately $2,338 being spent per child.[10]

SCAN BELOW TO SEE FACTSHEET CITATIONS

FARM TO EARLY CARE AND EDUCATION

Georgia's Early Care and Education (ECE) programs serve more than 330,000 children, many of whom consume 1-3 meals and 2 snacks a day onsite. [1, 2]

WHY FARM TO EARLY CARE AND EDUCATION?

Research shows Farm to School initiatives improve children's health and nutrition. Most of these programs start in K-12 schools, but children can be reached earlier with Farm to Early Care and Education (FTECE).[3]

TOP REASONS PROVIDERS CHOOSE TO PARTICIPATE IN FTECE

- Teach children where food comes from and how it is grown
- Improve child health
- Provide children with experiential learning

STRATEGIES THAT WORK

Parent education and engagement [4, 5]

Meal planning and preparation [6, 7]

Curriculum where kids touch and taste food [8, 9]

Gardening with kids [10, 11]

Fruit and vegetable boxes for home consumption [12]

HOW FTECE SUPPORTS HEALTHY HABITS AND LIFELONG SKILLS

- Increased fruit and vegetable consumption, some of which may increase vitamins A, C, and E intake [13]
- Improved healthy food consumption at home [14]
- Encouraged willingness to try new foods [15]
- Improved development of motor skills [16]
- Improved life skills, social skills, and self-esteem [17]
- Increased physical activity [18]
- Reduced diet-related diseases among children [19]
- Reduced food waste

FTECE AND AGRICULTURE

FTECE benefits children, as well as supports Georgia farmers. FTECE encourages childcare providers to:

- Purchase and serve fresh, nutritious, local foods for their children
- Host on-site farmers markets for parents and staff
- Partner with local farmers and impact Georgia's multi-billion dollar agriculture economy [20]

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GEORGIA SUPPORTS FARM-TO-ACADEMIA

Georgia's Farm-to-Early Care and Education (FTECE) Coalition[21]

- Supports children **ages 0 to 5**
- During the 2022-2023 school year:
  - **55+** FTECE Coalition members
  - **83** farm-to-academia professional development or activities (e.g., presentations, trainings, technical assistance, etc.)
- Members funded **53+** positions and contributed **29,000** hours of work supporting FTS and FTECE programs.

Farm-to-School (FTS) Alliance[22]

- Serves **K-12 students** in increasing knowledge, experiences, and exposures with local foods
- During the 2021-2022 school year:
  - **30+** FTS Alliance members
- FTS Alliance provided approximately **35** grants, trained **1,200** practitioners, and purchased more than **$11 million** from local farmers.

Eat, Learn, Grow Georgia, powered by Quality Care for Children, is a comprehensive hub for FTECE resources. It features a Farm to ECE map connecting providers with local food sources, Georgia's Harvest of the Month curriculum and materials, and a searchable library with menus, gardening tips, and more.

POLICY RECOMMENDATIONS

- ✓ Explore models which allocate funding to support local food purchasing in ECE and K-12 settings.
- ✓ Develop and fund a pilot for ECE providers to purchase larger quantities of food from local farmers.

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EVIDENCE-BASED HOME VISITING PROGRAMS

Evidence-based home visiting (EBHV) programs provides new parents the supports they may need when having a baby.[1] EBHV provides training for at-risk pregnant women, new moms, and families with children 0-5 years old and equips them with the skills they need to raise healthy children.[2]

GOALS OF HOME VISITING PROGRAMS

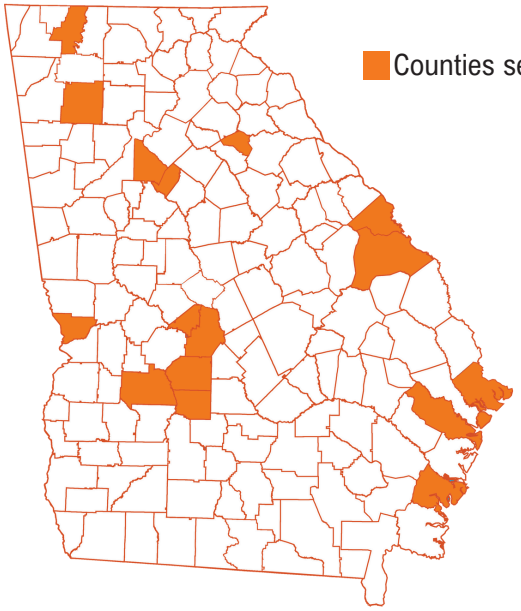
The overall goals of home visiting programs are to:

- increase healthy pregnancies,
- improve parenting skills,
- improve child health and development,
- strengthen family connectedness to community support, and
- reduce child abuse and neglect.

EVIDENCE-BASED HOME VISITING IN GEORGIA

Georgia's evidence-based home visiting program is administered through the Department of Public Health (DPH) and is primarily funded through the federal Maternal, Infant, Early Childhood Home Visiting (MIECHV) program. There are some state dollars to support some administrative aspects of the program.

From October 2023 to September 2024, 19,916 home visits were conducted for 1,617 Georgia families through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program.[3]



Counties served by Georgia's EBHV program

Implemented Home Visiting Models

- Healthy Families Georgia (HFG)
- Parents as Teachers (PAT)
- Nurse-Family Partnership (NFP)

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OUTCOMES OF GEORGIA'S MIECHV HOME VISITING PROGRAMS

Georgia's home visiting programs support families with young children through proven, evidence-based approaches that lead to healthier, more stable outcomes.[6]

By the numbers:

For children:

- 99% were **not involved in maltreatment investigations**
- 98% **spent quality time** with a caregiver (e.g., read a story, sang songs)
- 87% were **screened for developmental delays** at the appropriate time
- 100% of children referred to early intervention services for developmental delays **received timely services**

For primary caregivers:

- 92% **received postpartum care**
- 93% were **screened for depression**
- 89% were **using safe sleep practices**
- 96% were **screened for intimate partner violence**
- 72% **maintained health insurance** for at least 6 months of the year

WHAT TO EXPECT DURING A HOME VISIT [4]

- Visits occur weekly to monthly, tailored to family needs
- Each visit lasts 1-1.5 hours
- Screenings for developmental delays, depression, and domestic violence
- Referrals to local community resources
- Encouragement of prenatal and well-child healthcare visits
- Guidance on child development and parenting practices
- Promotion of engaged, positive parenting practices
- Support for parents' education and employment goals

ELIGIBILITY FOR HOME VISITING [5]

To be eligible, parents must need ongoing support and meet one or more of the following criteria:

- Low-income
- First time parent
- Younger than 21 years old
- Lack of employment or stable housing
- Low educational attainment
- Lacking access to prenatal care
- Experienced child abuse or neglect
- History of, or ongoing, substance abuse or mental health challenges
- Is receiving, or has received, special education services
- Has veteran or active military members in the family

Learn more about Georgia's Home Visiting Program by visiting tinyurl.com/VoicesFSDPHHomevisiting.

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GEORGIA DEPARTMENT OF PUBLIC HEALTH'S HOME VISITING PROGRAM

Initially funded with $1.68 million in FY2024 to serve 13 counties, DPH's Home Visiting Program expanded to 50 counties in FY 2025 and will grow to include 75 total counties in FY 2026 through additional appropriations. The program provides clinical services to pregnant women with high-risk conditions and their infants.

WHAT DOES THE HOME VISITING PROGRAM OFFER?[1]

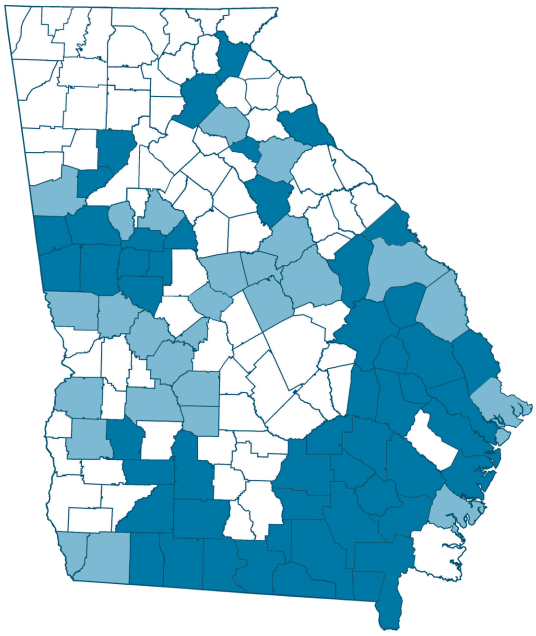
Maternal Assessments and Screenings

- ✓Blood pressure checks
- ✓Screening for pregnancy and postpartum warning signs and symptoms
- ✓Fetal heart tones
- ✓Depression

Infant Assessments

- ✓ Feeding
- ✓ Weight
- ✓ Head circumference
- ✓ Developmental screening

WHERE ARE SERVICES OFFERED?



Current Home Visiting Sites [2]

New Sites Coming in FY 26 [3]

SERVICES PARTICIPANTS CAN RECEIVE[4]

- Outreach and enrollment assistance for:
  - WIC
  - SNAP
  - TANF
  - Medicaid
- Transportation assistance
- Local community resources

Learn more about Evidence-Based Home Visiting by visiting tinyurl.com/VoicesFSEBHV

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SCAN BELOW TO SEE FACTSHEET CITATIONS

THE COST OF CHILD CARE, AFTERSCHOOL, AND SUMMER LEARNING

High-quality early education and out-of-school programs are essential for children's growth, youth workforce development, family support, job creation, and Georgia's economic vitality.

Early Care and Education [1]

serves children ages birth through preschool

≈340,000 children

5,380 providers

Operating in all 159 counties

Afterschool and Summer Learning [2]

serves children ages kindergarten through high school

≈135,000 children

229 government-funded organizations

Operating 1,386 sites in 120 counties*

**These are government-funded programs in Georgia, but there are many others serving children across the state.*

BENEFITS AND OUTCOMES

For Children and Youth: [3]

Youth who participate in ECE, afterschool, and summer programs tend to have higher academic achievement at age 15, including higher reading comprehension skills and higher math abilities.

ECE programs:

- Promote fine and gross motor skills
- Support cognitive development
- Foster conflict resolution
- Build confidence and peer-to-peer relationships

Afterschool and summer learning programs:

- Improve academic outcomes
- Improve mental health and well-being
- Offer exposure to new skills
- Foster college and career readiness/exploration
- Support working families

For Adults: [4]

Sustainable ECE, afterschool, and summer learning programs also have significant benefits for adults, including:

- Providing safe spaces for the children of working parents and caregivers
- Creating employment opportunities within the ECE and afterschool sector

THE COST OF CARE FOR GEORGIA FAMILIES [5]

The weekly cost of care to families depends on numerous factors, including age, level of engagement and skill building activities, activity types, transportation, and program structure. *Note: the following chart represents how much providers charge, not the actual cost of serving a child.*

Infants and Toddlers:

Average monthly cost:

- $680 for family child care homes
- $893 for child care centers

3-5 year olds:

Average monthly cost:

- $649 for family child care homes
- $785 for child care centers

5-18 year olds:

Average weekly cost:

- $85 for afterschool** programs
- $166.60 for voluntary summer programs

***as reported by parents*

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2025 LEGISLATIVE WINS

The Georgia General Assembly made multiple investments in out-of-school time supports for FY26, including:

$12.5 MILLION for **out-of-school time grants to community and statewide organizations**, which will help sustain the investments made through federal COVID relief funds that established the BOOST program in 2021. *See our BOOST factsheet for more details on the program*

$5.4 MILLION for the **Childcare and Parent Services (CAPS)** program, which assists families with low-incomes with the cost of child care while they work, go to school or training, or participate in other work-related activities. *See our CAPS factsheet for more details on the program*

CHILD CARE, AFTERSCHOOL, AND SUMMER LEARNING AND ENRICHMENT PROGRAMS WITH DESIGNATED FUNDING AND AGENCY OVERSIGHT

Program and Description	Funding Amount	Environment Served	Agency
21st Century Community Learning Centers (CCLC)[6] Provides opportunities for academic enrichment and tutorial services	• $39,348,814 *(federal)*	Afterschool Summer Learning	GaDOE
Building Opportunities in Out-of-School Time (BOOST) Supports the expansion of access to, and improved programmatic quality of, evidence-based afterschool and summer learning programs	• $12,500,00 *(state)*	Afterschool Summer Learning	GaDOE, in partnership with the Georgia Statewide Afterschool Network
Childcare and Parent Services (CAPS)[7] Provides scholarships via the Child Care and Development Fund (CCDF) to assist families with low incomes with the cost of childcare while they work, go to school, receive training, or participate in other work-related activities	• $309,000,000 *(federal)* • $5,472,365 *(state)*	Early Care and Education School-age child care (ages 6-12, up to age 17 for children with disabilities)	DECAL
Georgia Pre-K Program[8] A voluntary, free pre-kindergarten program available to all four-year-olds in Georgia	• $563,040,616	Early Care and Education	DECAL
Out-of-School Services Program[9] Provides funding to organizations serving communities with low-to-moderate incomes and the foster care system when kids are not in school	• $15.5 million via TANF	Afterschool Summer Learning	DFCS

Key:
GaDOE: Georgia Department of Education
DECAL: Department of Early Care and Learning
DFCS: Division of Family and Children Services
TANF: Temporary Assistance for Needy Families

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GEORGIA AFTER 3PM: DEMAND & SUPPORT FOR AFTERSCHOOL

Afterschool programs keep youth safe, accelerate learning, teach new skills, and keep them engaged. They also help working families keep their jobs and have peace of mind. In Georgia, however, the need for afterschool programs greatly exceeds the available options.[1]

Parents of more than
1 million Georgia children
want afterschool programs[2]

THE UNMET DEMAND FOR AFTERSCHOOL IN GEORGIA

✓ **236,308 or** 13%
children are enrolled in afterschool programs[3]

✗ **853,224 or** 54%
children are ***not*** enrolled in an afterschool program, but would if one were available[4]

Nearly **4 in 5** Georgia children are missing out.[5]

DID YOU KNOW?

231,342
children and youth are alone and unsupervised between the hours of 3 p.m. and 6 p.m.[6]

GEORGIA PARENTS AGREE: AFTERSCHOOL PROGRAMS MATTER

Reported Benefits to Kids:[7]

- **87%** build social & decision-making skills
- **70%** excited about learning and improved school attendance
- **83%** boost teamwork, critical thinking & leadership skills
- **79%** keep youth safe
- **78%** support well-being

Reported Benefits to Parents:[8]

- **97%** reduce parent stress
- **94%** improve overall wellbeing
- **87%** boost work productivity
- **81%** help keep jobs/work more hours

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AFTERSCHOOL WORKS[13]

Research shows high quality programs improve outcomes, including:


Higher academic performance


Better behavior


Higher classroom attendance rates

HOW GEORGIA PARENTS RATE THEIR AFTERSCHOOL PROGRAMS

100% are satisfied with their child's afterschool program[9]

97%
satisfied with program safety

81%
see reading & writing support

93%
rated their child's program as "good" or "very good"[10]

95%
trust caring, skilled staff

WHAT GEORGIA FAMILIES SAY PREVENTS ENROLLMENT[11]

AFFORDABILITY

58%
say programs cost too much

ACCESSIBILITY

49%
lack safe transportation

46%
report inconvenient locations

AVAILABILITY

40%
have no local programs

OVERWHELMING SUPPORT FOR PUBLIC FUNDING

9 IN 10 PARENTS
support public funding for afterschool[12]

There is broad, bipartisan support for increased public investment.


94%


87%


86%

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support public funding for afterschool[12]

There is broad, bipartisan support for increased public investment.

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FUNDING AFTERSCHOOL AND SUMMER LEARNING PROGRAMS IN GEORGIA

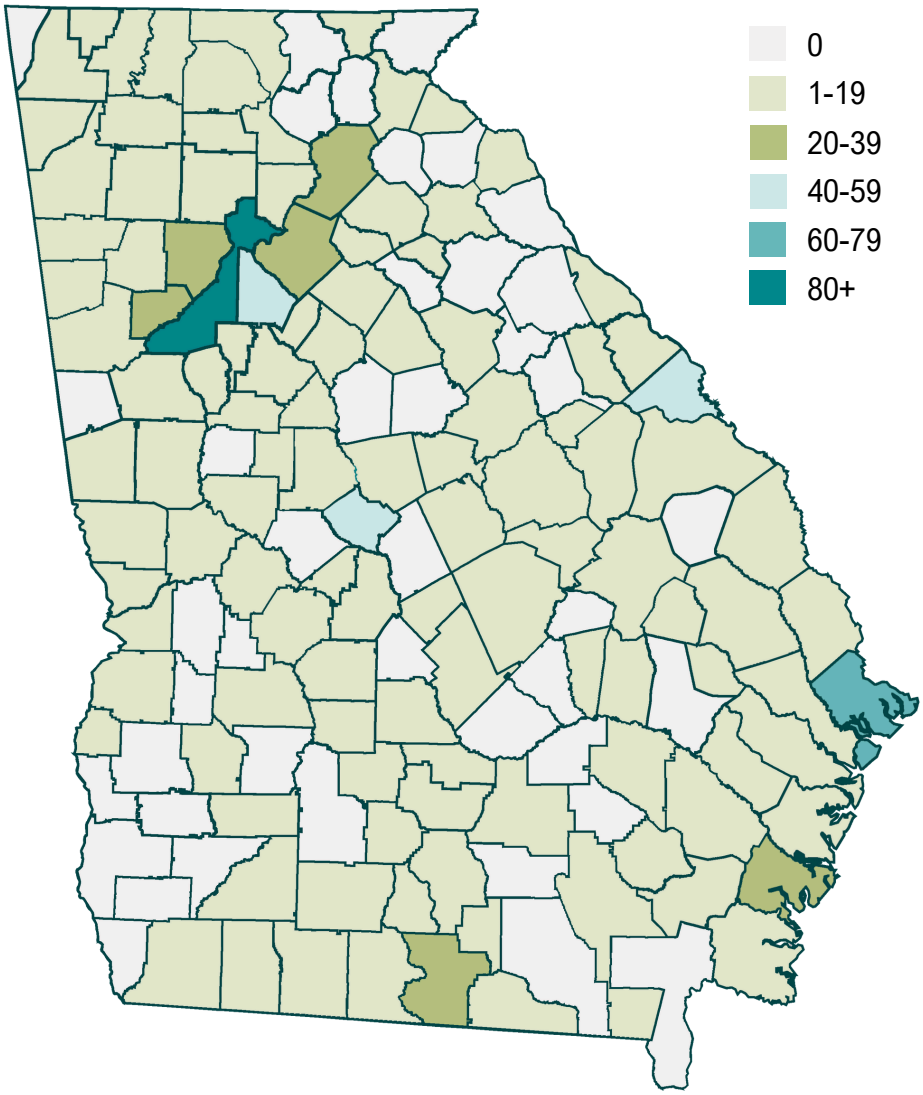
Investing in afterschool and summer learning programs in Georgia helps expand access to high-quality educational opportunities that support academic achievement, enrichment, and youth development across communities.

WHERE FUNDING COMES FROM IN FY2026

$53.2 MILLION in federal funding **&** **$12.5 MILLION** in state funding

has been invested in these programs to serve young people serving from Pre-K to High School.

WHERE FUNDED PROGRAMS OPERATE



121
counties are served by at least 1 program

but

38 of 159
counties do nothave any government-funded programs

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A SNAPSHOT OF 21ST CCLC IN GEORGIA

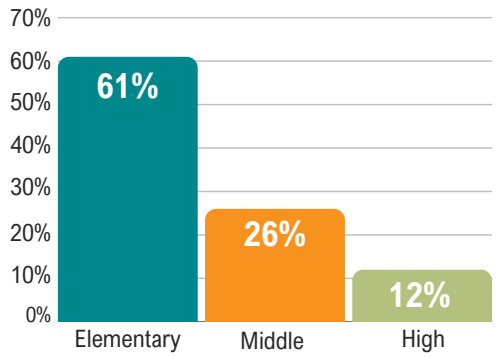
The 21st Century Community Learning Centers (CCLC) Program is the only federal funding stream dedicated to afterschool, before school, and summer learning.

BY THE NUMBERS IN FY2024[1]

27,024
kids participated in 21st CCLC

$41 million
was awarded for 21st CCLC programming

WHO IS SERVED BY GEORGIA'S 21ST CCLC PROGRAMS?[2]



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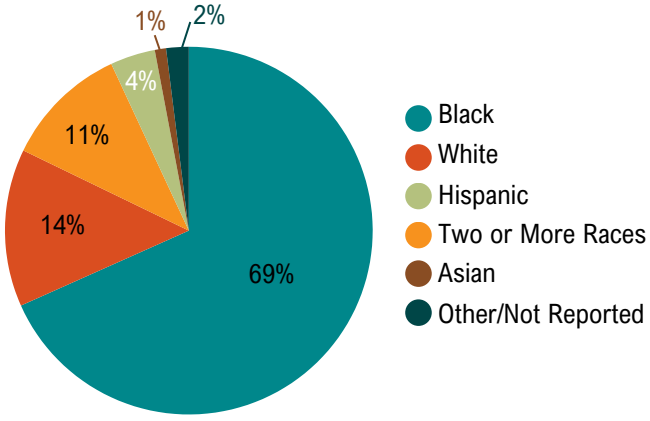

RACE

WHERE ARE 21ST CCLC PROGRAMS LOCATED?

Out of the **129** program sites that serve Georgia's children:

61% are in schools[3]

36% are in community-based organizations[4]

3% are in institutions of higher education[5]

84% are in urban areas[6, 7]

16% are in rural areas[8, 9]

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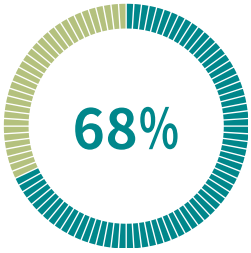
TOP 5 ACTIVITIES OFFERED IN 21ST CCLC [10]

- Science, Technology, Engineering, and Mathematics (including computer science)
- Academic enrichment
- Literacy Education
- Well-rounded education activities (including credit recovery or attainment)
- Healthy and active lifestyle

OUTCOMES FOR GEORGIA STUDENTS[11]

Georgia's 21st CCLC programs offer students the equivalent of, at least, **45** **additional school days**

76% of surveyed students demonstrated increased engagement in learning



of students with a school day attendance rate at or below 90% in the prior school year demonstrated an improved attendance rate in the current school year

To learn more about Georgia's 21st CCLC Program, please visit www.gadoe.org.

QUALITY AFTERSCHOOL: WHAT IT IS & WHERE GEORGIA IS HEADING

Georgia's afterschool and youth development programs provide thousands of youth - from kindergarten through high school - with a safe and enriching place to go after the school day ends. High quality afterschool programs keep Georgia's young people on track to succeed in school, careers, and life - but what does high quality mean?

WHAT IS QUALITY?

High quality afterschool and summer learning programs offer: [1]

- Flexible, well-rounded daily schedules
- Activities that are well organized, appropriate, and provide the opportunity for learning new skills
- Opportunities to build on what young people are learning during the school day
- Safe and clean environments that reflect the needs and interests of all youth
- Environments that nurture positive relationships
- Opportunities for physical activity and to practice healthy habits
- Great staff and volunteers
- Professional development opportunities for staff
- A clear mission, defined goals, and good financial management
- Positive engagement with families and communities in the program

WHY DOES QUALITY MATTER?

High-quality afterschool and summer learning programs can accelerate learning, enhance academic achievement, improve school attendance, teach new skills, and support behavioral and mental health. Furthermore, these programs prepare youth for their futures by fostering necessary workforce skills such as communication and problem-solving while inspiring interest in STEM or other in demand careers.

Regular participation in these programs can lead to:

- Improved school attendance
- Gains in reading and math
- Improved work habits and classroom behavior
- Increased graduation rates [2, 3]
- Cognitive, social, and emotional development [4]
- Improved health and nutrition [5]
- Developing positive decision-making skills, self-control, and self-awareness
- Reduced instances of risky behavior (i.e., substance use and misuse) [6, 7]

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WHERE IS GEORGIA HEADING?

Georgia Afterschool & Youth Development (ASYD) Quality Standards

A collaboration between the Georgia Statewide Afterschool Network (GSAN) and GUIDE, Inc., the Georgia Afterschool & Youth Development (ASYD) Initiative is supported by the Georgia Division of Family and Children Services and the Georgia Departments of Education, Public Health, Early Care and Learning, and Behavioral Health and Developmental Disabilities. The Georgia ASYD Quality Standards, released in December 2015, are Georgia's first quality standards for afterschool programming and provide a framework for afterschool providers to evaluate and continuously improve the quality of their programming. The Georgia ASYD Initiative provides training, coaching, and resources to providers across the state to support their quality improvement journey.

Georgia Afterschool & Youth Development (ASYD) Conference

The biennial Georgia ASYD Conference serves youth development professionals across the state of Georgia. Hosted by The Georgia ASYD Initiative, this engaging conference provides three dynamic days of research-based best practices; information, tools and resources framed by Georgia's ASYD Quality Standards; over 70 workshops to choose from; and opportunities for networking and partnership formation.

For more information on the Georgia ASYD Quality Standards and Conference go to www.georgiaasyd.org.

Quality Supports

GSAN brings free to low-cost training opportunities and technical assistance that supports more robust and formalized quality improvement practices. Through curated resources from the most respected and well-known leaders of youth development experts in the state, toolkits, activity guides, and content specific resources are made easily accessible and downloadable to youth program providers. Professionals have the opportunity for collaboration and quality improvements through peer learning cohorts led by subject matter experts throughout the year and Quality Coaches are also engaged to support youth programs. For more information on Quality Supports in Georgia, go to www.afterschoolga.org.

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WHAT ARE THE GEORGIA AFTERSCHOOL & YOUTH DEVELOPMENT (ASYD) QUALITY STANDARDS?

A Unified Vision to Serve Georgia's Youth

The Georgia ASYD Quality Standards provide a framework for programs and professionals to evaluate and continuously improve the quality of their programming. The Georgia ASYD Initiative provides training, coaching, and resources to providers across the state to support their quality improvement journey.

QUALITY ELEMENTS

Georgia's ASYD Standards are organized into nine categories called "Quality Elements."

- Programming and Youth Development
- Linkages with the School Day
- Environment and Climate
- Relationships
- Health and Well-being
- Staffing and Professional Development
- Organizational Practices
- Evaluation and Outcomes
- Family and Community Partnerships

Each of these nine quality elements includes a series of related standards or best practices, as well as indicators to help programs understand what successful implementation looks like.

UNDERSTANDING THE STANDARDS

The ASYD Quality Standards are grounded in research from multiple fields, including **education**, **child development**, **psychology**, **organizational management**, and **public health**. Each standard reflects evidence-based best practices designed to support positive outcomes for youth—both in the short and long term.

The Standards are designed especially for well-established programs that:

- Serve children and youth ages 5-18
- Serve youth who attend regularly and over a long period of time
- Offer youth a range of enriching experiences

DRIVING PROGRAM QUALITY

Programs can use the Quality Standards as a tool for quality awareness and improvement, facilitating important conversations and goal-setting with staff.

Research indicates that programs implementing a continuous quality improvement system are likely to experience improvements in instructional quality provided by staff and in the retention rates of short-term employees.

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AFTERSCHOOL SUPPORTS HEALTHY LIFESTYLES

Afterschool and summer learning programs support youth by providing healthy food, physical activity, and lifelong healthy habits.

THE STATE OF CHILDHOOD OBESITY IN GEORGIA

Georgia ranked **21ST in the nation** for childhood obesity in 2023. [1]

Among children aged 6-17 years old: [2, 3]

17%	17%	16%	16%
are overweight	are obese	of males were obese	of females were obese

FACTORS THAT IMPACT CHILD WELL-BEING

Food Insecurity

496,110 of Georgia's children were food insecure - lacking reliable and regular access to food in 2023 [4]

Lack of Physical Activity Opportunities:

20% of children ages 6-17 are physically active for at least 60 minutes daily [7]

Hungry children are more likely to experience: [5, 6]

- Poor health, developmental delays and decreased school readiness
- Absenteeism, tardiness, and poor educational outcomes
- Behavioral, mental health, and social-emotional challenges

Inactive children are more likely to experience:

- Obesity, heart disease, type 2 diabetes, and weakened bones and muscles [8]
- Reduced cognitive function (attention, memory, and problem-solving) [9]
- Depression, anxiety, and stress [10]

HOW AFTERSCHOOL HELPS FUEL HEALTHY FUTURES

What Georgia parents are saying (in 2019): [11]

83% reported their child's afterschool program offered healthy meals and/or snacks

86% reported their child's afterschool program offered opportunities for physical activity

Federal Programs that Support Child Nutrition:

- **130,174** youth served daily (FY24) by the Child and Adult Care Food Program (CACFP) [12]
- **112,495** youth served daily by the summer nutrition programs (Summer Food Service Program and Seamless Summer Option) [13]

SCAN BELOW TO SEE FACTSHEET CITATIONS

IMPACT OF AFTERSCHOOL AND SUMMER LEARNING PROGRAMS

Youth who actively participate in high-quality afterschool programs show less prevalence of obesity when compared to their non-participating peers.[14]

Afterschool provides opportunities for:[15]

- Snacks and meals
- Nutrition education
- Additional time for physical activity
- Safe space and materials
- Structured activities
- Adult support
- Team sports lead to;
  - Conflict resolution skills
  - Decreased stress
  - Improved communication

Regular physical activity and healthy eating leads to:[16]

- Strong bones and muscles
- Improved cardiorespiratory fitness
- Reduced symptoms of anxiety and depression
- Decreased likelihood of serious health conditions as an adult (heart disease, Type 2 diabetes, and cancer)
- Higher academic achievement
- Improved classroom behavior
- Improvement in indicators of cognitive skills (concentration, memory, and verbal skills)

RECOMMENDATIONS

Afterschool and summer learning programs are a key part of the solution in improving the health and well-being of Georgia's youth, particularly among underserved populations. GSAN recommends the following to support the healthy lifestyles of Georgia's young people:

Increase investment in afterschool and summer learning programs that support healthy and active lifestyles as a way to reduce Georgia's high prevalence of child obesity.

Increase access to CACFP and Summer Nutrition Programs across Georgia, particularly in rural areas.

Strengthen partnerships at the local, regional, and state level between school districts and community-based organizations, such as food banks and afterschool programs, to support healthy nutrition and physical activity beyond the school day.

Increase access to professional development opportunities that help afterschool and youth development providers support the physical well-being of the youth they serve.

AFTERSCHOOL BUILDS GEORGIA'S STEM WORKFORCE

Afterschool and summer learning programs spark student interest in science, technology, engineering, and math — and help build the state's future STEM workforce.

THE FUTURE OF STEM CAREERS IN GEORGIA

STEM careers in Georgia are expected to grow **13%** by 2027.[1]

A FOUNDATION FOR SUCCESS IN STEM FIELDS

Strong math skills are the foundation for success in STEM fields, making math achievement a key indicator of future workforce readiness.

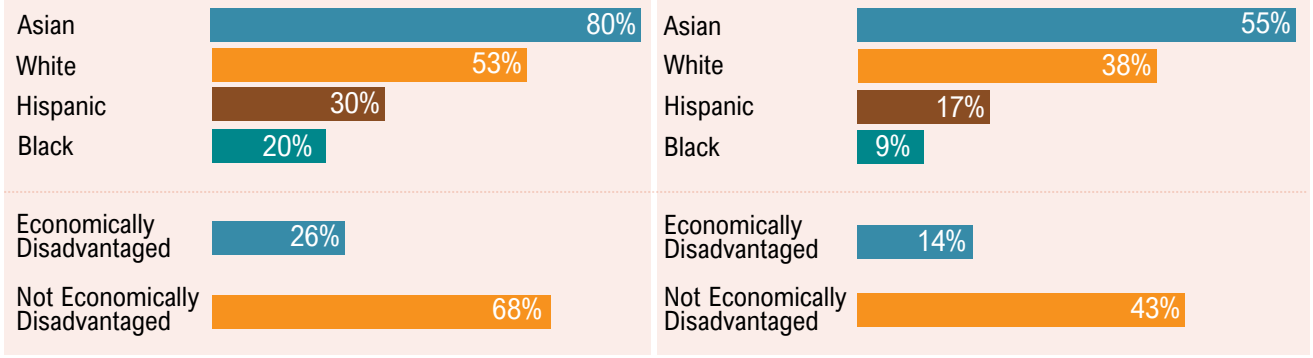
38% of Georgia's 4th graders **&** **24%** of Georgia's 8th graders

performed at or above the National Assessment of Education Proficiency in math in 2024.[2]

OPPORTUNITY & ACHIEVEMENT GAPS IN GEORGIA

Historic lack of opportunities have resulted in unequal outcomes in under resourced communities and continue to prevent a significant number of Georgians from reaching their full potential.

PROFICIENCY PERCENTAGES IN GEORGIA MATH ASSESSMENTS, BY RACE AND INCOME, 2024[3,4]



IN ACTION: STEM LEARNING IN AFTERSCHOOL PROGRAMS

Among surveyed students:

- 73% said they have a more positive STEM identity because of their afterschool experience[5]
  This is considered the strongest indicator of pursuing a STEM career.
- 80% reported their afterschool program was the most important source of support for pursuing a career[7]
- 80% said their STEM career knowledge increased[6]
- 97% reported their afterschool program taught them to set high goals and expectations of themselves[8]

SCAN BELOW TO SEE FACTSHEET CITATIONS

IMPACT OF AFTERSCHOOL AND SUMMER LEARNING PROGRAMS

Afterschool provides opportunities for: [9]

- Enriching STEM activities such as computer science, coding, and robotics
- Critical foundational skills
- Communication skills
- Working collaboratively
- Fostering confidence
- Exposure to career pathways

Regular participation leads to: [10], [11]

- Significant gains in math achievement
- Positive results in reading achievement
- Increases in STEM knowledge and skills
- Higher chances of graduation
- Higher chances of pursuing a STEM career

RECOMMENDATIONS

Afterschool and summer learning programs are a key part of the solution in addressing Georgia's STEM skills gap. GSAN recommends the following to help build Georgia's STEM workforce:

Increase investment in innovative afterschool and summer learning programs that introduce students to new interests and a diverse range of STEM careers.

Include afterschool and summer learning as strategies to support Career Technical and Agricultural (CTAE) learning in Georgia's state plan.

Strengthen partnerships at the local, regional and state levels between school districts, community based organizations, and businesses to extend STEM learning beyond the classroom and provide real-world experiences for students.

Build a robust and diverse workforce of CTAE educators throughout students' in and out-of-school experience by providing joint professional development opportunities for classroom teachers, CTAE instructors and afterschool and summer educators.

AFTERSCHOOL IMPROVES LITERACY IN GEORGIA

Afterschool and summer learning programs can strengthen literacy skills — helping students read, write, and communicate with confidence for lifelong success.

THE CYCLE OF LOW LITERACY

6 OUT OF 10 CHILDREN (61%)
completing third grade in 2024 in Georgia were not prepared to meet the literacy challenges of the next grade level [1]

This leads to a cycle of low literacy, including: [2, 3]

- Struggling with learning and falling behind
- Discipline problems
- Performing poorly in 8th grade math
- Increased risk of becoming a teen parent
- Increased risk of dropping out of high school
- More likely to spend time in prison
- Struggling with unemployment
- Poor health & shorter life expectancy

72%
chance of being at the lowest reading level for children with parents with low literacy levels [6]

NEARLY 800,000 GEORGIA ADULTS
have low literacy and earn approximately $1 million less across their lifetime than adults with a high school diploma [4]

Costs the state **$1.26 BILLION** in social services and lost tax revenue annually [5]

THE STATE OF LITERACY IN GEORGIA

The percentage of fourth-grade students in Georgia who performed at or above the NAEP Proficient level was **30 percent** in 2024. [7]

PROFICIENCY PERCENTAGES IN GEORGIA READING ASSESSMENTS, BY RACE AND INCOME, 2024 [8]

SCAN BELOW TO SEE FACTSHEET CITATIONS

WHY SUMMER IS A CRITICAL TIME

Summer learning loss results in:

2-3 MONTHS
of reading skills lost for low-income children[9]

2/3
of the reading achievement gap between low- and middle-income children by 9th grade.[10]

HOW AFTERSCHOOL BOOSTS LITERACY SKILLS

Afterschool and summer learning programs provide students with the additional supports they need to help build a strong foundation in literacy, including reading, writing, and critical thinking skills.

7 OUT OF 10 PARENTS
report that their children's programs provide opportunities for reading or writing and homework assistance[11]

IMPACT OF AFTERSCHOOL AND SUMMER LEARNING PROGRAMS

Afterschool provides opportunities for: [12, 13]

- Project-based learning opportunities
- Strong literacy foundation
- Group activities
- Peer-to-peer learning
- Critical thinking skills
- Communications skills

Regular attendance leads to: [14, 15]

- Significant gains in reading skills
- Improved grades
- Improved attendance
- Improved attitude towards school
- Higher chances of graduation

RECOMMENDATIONS

Afterschool and summer learning programs are essential to improving literacy rates in Georgia and ensuring the well-being of Georgia's youth. GSAN recommends the following to increase the amount of students reading proficiently:

Increase investment in high quality afterschool and summer learning programs that support literacy efforts, especially in communities with low literacy rates.

Provide grants to libraries to fund summer reading programs, free tutoring, and homework assistance programs and utilize existing resources including books and computers.

Strengthen partnerships at the local, regional, and state level between school districts, afterschool programs, and community-based organizations such as food banks, parks and recreation, and housing authorities to increase stability in students' lives and support literacy gains.

Expand access to literacy training by providing joint professional development opportunities for classroom teachers and afterschool and summer educators to optimize resources and increase student's proficiency in literacy.

SCAN BELOW TO SEE FACTSHEET CITATIONS

AFTERSCHOOL SUPPORTS SAFER COMMUNITIES

Afterschool and summer learning programs help create safer communities by keeping kids engaged, supported, and in supervised, safe environments when not in school.

ADOLESCENT BRAIN DEVELOPMENT

Adolescence (ages 10-19) is a vital time in building cognitive, social, and emotional skills.[1] It is marked by:

Opportunity for positive growth

Possibility of recovery from negative childhood experiences

Increased sensitivity to their environment[2]

THE STATE OF JUVENILE JUSTICE IN GEORGIA

In 2013, the Juvenile Justice Reform Act was passed with the aim to improve public safety, decrease costs, and preserve and strengthen family relationships to allow youth to live in safety and security. Strategies implemented include increased use of evidence-based programs, treating youth in the community rather than in secure facilities, and utilizing the Juvenile Justice Incentive Grant Program to decrease recidivism.

Outcomes for Georgia's youth

Reduction in short-term secure confinement [3]

Reduction in secure detention [4]

More than **16,000 youth** have received evidence-based treatment programming in their home communities.[5, 6]

In 2024, 219 youth in Georgia were admitted to long-term secure confinement facilities. [7]

- Georgia is 1 of just 5 states that processes all 17-year-olds in the adult justice system, regardless of offense. [8]
- It costs roughly $91,000 to house an adolescent every year.[9]
- 50% of screened youth are referred for a more thorough mental health assessment. [10]

Disproportionate responses in misbehavior by youth

Black youth are more than **4.6 times more likely** to be detained or committed to youth facilities when compared to White youth.[11]

Youth from families with low incomes are **more likely** to be disciplined when compared to their peers.[12]

Implicit biases related to race, gender, ethnicity, geography, and income have pushed countless youth into the juvenile justice system, and increased their likelihood of involvement with the justice system as an adult.[13]

SCAN BELOW TO SEE FACTSHEET CITATIONS

IMPACT OF AFTERSCHOOL AND SUMMER LEARNING PROGRAMS

All high-quality afterschool and summer learning programs can serve as prevention programs and those that use evidence-based and trauma-informed practices can also support intervention and diversion.

Afterschool provides opportunities for:

- Safe and supervised environments
- Enrichment activities
- Opportunities to build positive decision-making and communications skills
- Meaningful relationships with caring adults and peers[14]
- Protective factors that contribute to positive developmental experiences
- Mitigation of the effects of risk factors[15, 16]

Regular participation leads to:

- Reduction in crime and juvenile delinquency[17]
- Decreased reports of misconduct in school and disciplinary incidents
- Reduction in risky behaviors such as substance use and misuse[18, 19]
- Self-control and self-awareness
- Increased school attendance
- Improved work habits and classroom behaviors
- Gains in reading and math
- Increased graduate rates[20, 21]

RECOMMENDATIONS

Afterschool and summer learning programs keep youth safe, provide necessary developmental supports, build protective factors, and provide opportunities for positive relationships thereby decreasing a young person's chances of interacting with the juvenile justice system. To ensure these supports are available to all young people, GSAN makes the following recommendations:

Create incentive grants for afterschool programs to use trauma-informed practices and evidence-based programs to build protective factors.

Expand state funding to afterschool and summer learning programs to increase access and ensure affordability.

Expand trauma-informed training to afterschool and youth development professionals.

Strengthen partnerships at all levels between community-based afterschool programs, mentoring programs, school districts, juvenile courts, and other community partners to align services for young people.

Increase funding and accessibility of evidence-based wraparound models to keep youth in their homes, placements, and communities.

Expand trauma awareness and implicit bias training for public safety officers and law enforcement personnel that engage with children in any way.

Expand the jurisdiction of juvenile courts to encompass children under 18 and eliminate provisions that automatically transfer (without juvenile court approval) certain youth to adult courts.

Increase funding and accessibility of behavior aide services and extend them to afterschool and youth development professionals, in addition to families and classroom teachers so they can help youth learn behavior modification techniques, supervise behaviors, and de-escalate situations.

SCAN BELOW TO SEE FACTSHEET CITATIONS

AFTERSCHOOL COMBATS CHRONIC ABSENTEEISM

Afterschool and summer learning programs can help combat chronic absenteeism by improving students' academic outcomes, behavior, and attendance rates.

WHAT IS CHRONIC ABSENTEEISM?

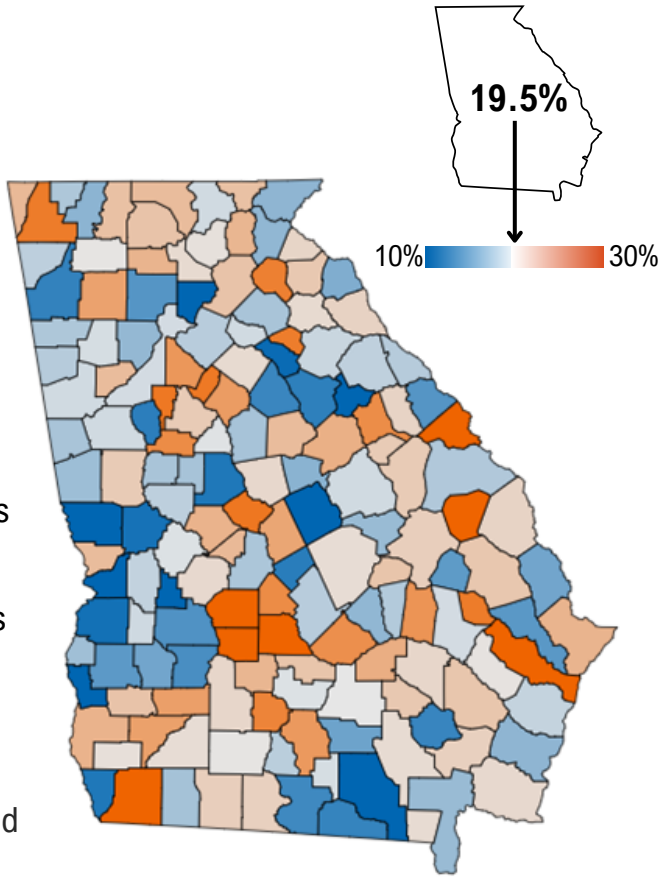
Chronic absenteeism, defined as missing 10% or more of school days[1], is a growing challenge for Georgia's schools. Missing just two days a month amounts to missing about 10% of the school year, which can lead to serious academic setbacks.[2]

Who is chronically absent in Georgia?

In 2025:[3]

- **19.5%** of all Georgia students
- **22.8%** of economically disadvantaged students
- **24.4%** of students with disabilities
- **44.3%** of students experiencing homelessness

The root causes of chronic absenteeism include socio-economic and health barriers to attendance, aversion to school, disengagement from school, and misconceptions about the impact of absences.[4]



Percentage of Chronic Absenteeism, by County

THE IMPACT OF MISSING TOO MUCH SCHOOL

Beyond the obvious - low academic achievement - chronic absence is linked to:[5, 6]

- Low literacy rates
- Increased high school dropout rates
- Socioemotional developmental delays

High levels of chronic absenteeism rates in classrooms and schools can also negatively impact students that do not experience absences themselves due to disruptions in teacher practices and classroom dynamics.[7]

SCAN BELOW TO SEE FACTSHEET CITATIONS

HOW AFTERSCHOOL AND SUMMER LEARNING PROGRAMS CAN HELP

Youth regularly participating in high-quality afterschool and summer learning programs experience improved academic outcomes, better behavior, and higher attendance rates.[8] These programs promote:[9]


School Connectedness


Student Engagement in Learning


Safety


Youth Voice and Connection


Opportunities to Explore Passions and Interests


Supportive Adults and Mentors

The Impact of Georgia's 21st Century Community Learning Centers [10]

- **76%** of surveyed students demonstrated increased engagement in learning
- **68%** of students with prior-year attendance rates at or below 90% in the prior school year demonstrated an improved attendance rate in the current school year

RECOMMENDATIONS

State Agencies and Leadership

- Increase funding for the BOOST program to $20 million to build on the state's annual investment in community-based out-of-school time programs.
- Increase investment in transportation and attendance incentive programs, especially in rural communities.
- Continue to fund and expand the Georgia Apex Program, a statewide comprehensive school-based behavioral health model funded by the Georgia Department of Behavioral Health and Developmental Disabilities.
- Promote the integrated mental health and primary care model into school-based health centers.

School and District Leadership

- Offer affordable, school-based afterschool and summer learning programs by utilizing Elementary and Secondary Education Act (ESEA) funds, including Title I, Title II, and Title IV, Part A funds.
- Partner with afterschool and summer learning programs and share attendance data to leverage data-driven strategies to increase student engagement and attendance.
- Implement early, positive outreach strategies following initial student absences to strengthen relationships, identify barriers, and encourage consistent attendance.
- Utilize attendance data to ensure a comprehensive understanding of student engagement and support needs.

THE BUILDING OPPORTUNITIES IN OUT-OF-SCHOOL TIME (BOOST) GRANTS PROGRAM

The Building Opportunities in Out-of-School Time grants program, or **BOOST**, is a state-funded, competitive initiative administered through a partnership between the Georgia Department of Education and the Georgia Statewide Afterschool Network (GSAN). BOOST supports more than 50,000 youth through high-quality afterschool and summer learning programs that are evidence-based and designed to strengthen academic achievement and promote whole child development.

AFTERSCHOOL ANTICIPATED IMPACT:[1]

50,000 youth in afterschool

594 afterschool sites

SUMMER LEARNING ANTICIPATED IMPACT:[2]

56,000 youth in summer programs

471 summer sites

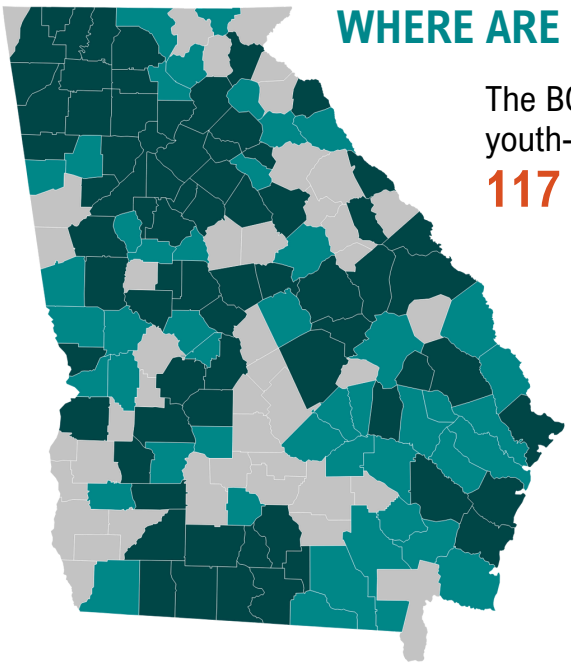
HOW DOES BOOST STRENGTHEN OUT-OF-SCHOOL TIME LEARNING?

Expands access to essential out-of-school time learning across Georgia

Removes barriers like transportation, costs, and limited availability

Strengthens program quality through evidence-based strategies that promote whole-child outcomes

WHERE ARE BOOST PROGRAMS LOCATED?



The BOOST grants program is anticipated to support youth-serving organizations operating sites in **117 of Georgia's 159 counties**.[3]

- High-Priority County with a BOOST Site (n=46)*
- Non-Priority County with a BOOST Site (n=71)

*Priority counties are counties that did not have any afterschool or summer learning programs being supported by government funding at the time of the BOOST application.

SCAN BELOW TO SEE FACTSHEET CITATIONS

AREAS OF IMPACT

% of grantees offering targeted programming in key impact areas

LITERACY (Science of Reading) [4]

- **85%** of community grantees
- **100%** of statewide grantees

NUMERACY [5]

- **82%** of community grantees
- **100%** of statewide grantees

WORKFORCE DEVELOPMENT [6]

- **69%** of community grantees
- **100%** of statewide grantees

INVESTMENT BREAKDOWN

Community Grants [7]

60 grantees

Statewide Grants [8]

3 grantees

A statewide grantee is an organization with a demonstrated track record of success in delivering year-round youth development programming in a minimum of 15 counties within the state through evidence-informed, comprehensive afterschool and summer enrichment programs.

HIGH DEMAND, LIMITED RESOURCES [9]

143 eligible applications submitted

$30.5M requested

Only 44% of top-scoring applicants* received funding

High-quality programs are going unfunded across the state.

**Limited resources means many high scoring applications were not funded – illustrating the quality of Georgia's OST programs and high demand for this funding.*

RECOMMENDATION

Increase BOOST funding to $20 million to build on the state's annual investment in community-based out-of-school time programs.

OUT-OF-SCHOOL TIME WORKFORCE IN GEORGIA

Out-of-school time (OST) professionals play a vital role in supporting children's learning and development beyond the school day. They work with youth ages 5-18 across a wide range of settings, including before- and afterschool programs, summer learning, camps, sports, arts, mentoring, juvenile justice, housing and homelessness services, libraries, museums, and more.[1]

INSIDE THE *POWER OF US WORKFORCE SURVEY*

The **Power of Us Workforce Survey** is a national cross-sector survey that provides insight into the career paths, professional learning, well-being and compensation of the OST workforce. Data collection began on February 22, 2022 and ended on March 31, 2023.[2]

GEORGIA'S RESULTS AT-A-GLANCE

Georgia was among the top 3 states with the highest number of completed staff surveys.

424
Georgia respondents

79% full-time*
16% part-time

90% work directly with youth

84% work for public agencies or nonprofits

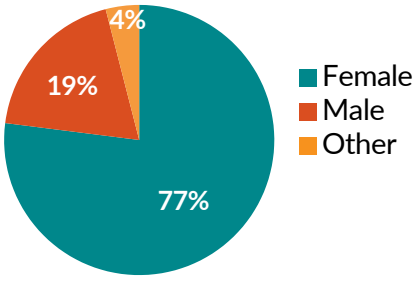
75% located in metro areas

92%
were currently in the OST workforce

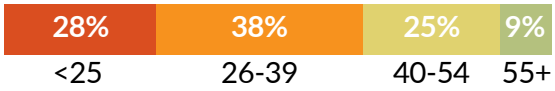
*While the majority of survey respondents were full-time employees, many OST professionals in Georgia are part-time employees.

WHO MAKES UP GEORGIA'S OST WORKFORCE?

Gender

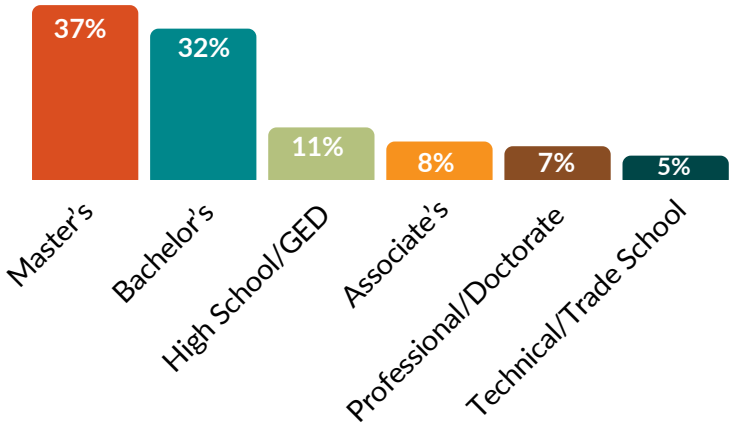


Age



SCAN BELOW TO SEE FACTSHEET CITATIONS

Education Levels



of Professional Certifications

- 1 to 2 certifications: 35%
- 3 to 5 certifications: 15%
- 5+ certifications: 12%

87% say their professional learning meets their needs

WHAT MOTIVATES OST PROFESSIONALS TO JOIN THE FIELD?

- Passion or interest in the subject matter or setting (23%)
- Wanted to work with kids (18%)
- Compelled by a mission or calling (15%)
- Planned to start a career in the field (10%)

WHERE OST PROFESSIONALS COME FROM

Education (38%)
- K-12 (24%)
- Higher Education (14%)

Community/ Social Services (21%)

Healthcare (17%)

Retail (19%)

Hospitality/ Food Service (16%)

Government / Public Policy (11%)

SCAN BELOW TO SEE FACTSHEET CITATIONS

STRENGTHS AND STRESSORS IN OST WORK

Strengths

86% feel valued

88% feel they belong

86% are satisfied with growth opportunities

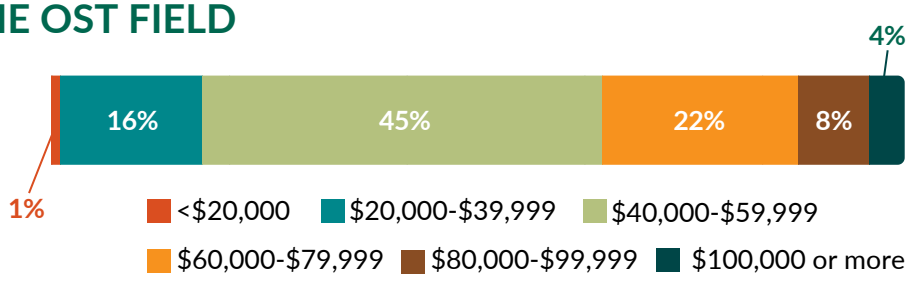
Stressors

42% feel burned out

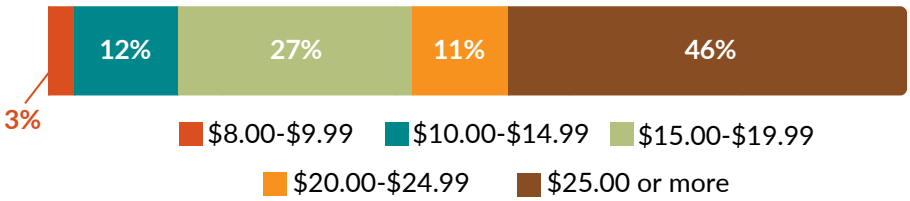
31% want less stress

COMPENSATION IN THE OST FIELD

64% were salaried staff



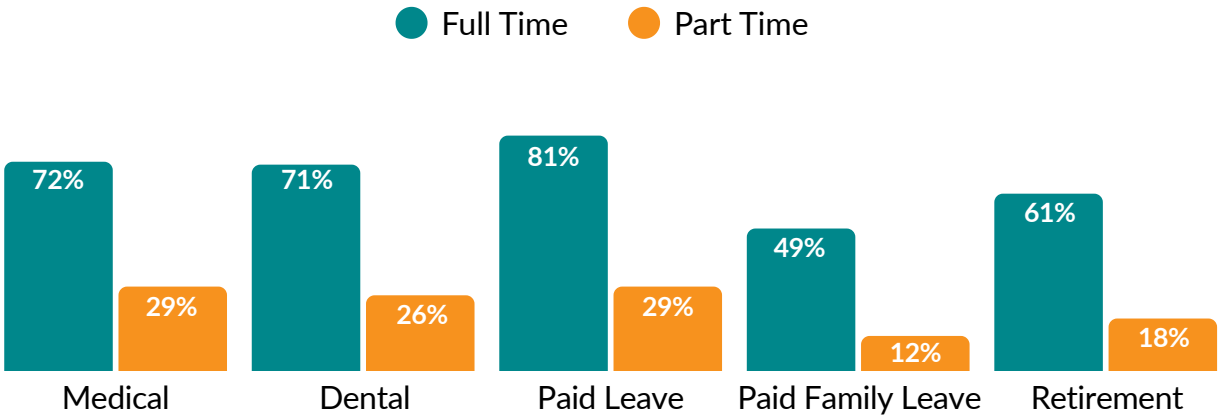
31% were hourly earners



Sentiments Regarding Pay

While **56%** of respondents say they are paid a fair amount for the work they do, **75%** reported improved pay as something they would change about their job.

Benefits Available through Current Employment



SCAN BELOW TO SEE FACTSHEET CITATIONS

POLICY RECOMMENDATIONS TO STRENGTHEN THE OST WORKFORCE

- **Develop and implement policies and programs to ensure staff retention and workforce stability**, such as budget allocations for meaningful OST wages, benefits, and comprehensive training. Strategies include:
  - Increase funding for the BOOST program to $20 million to build on the state's annual investment in community-based out-of-school time programs.
  - Increase federal afterschool and summer funding through 21st Century Community Learning Centers (21st CCLC) and Child Care Development Fund (CCDF).
  - Support the expansion and advancement of school-age child care programs and policies, including paid professional development opportunities for earning school-age credentials, technical assistance, and designated quality improvement funds.
  - Continue to increase state and federal investment in CAPS.
- **Promote and enhance allowable expenditures for staff wellbeing supports** that help improve staff performance and positively affect their overall wellness.
- **Ensure OST staff are explicitly included in statewide mental health and workforce support initiatives**.
- **Allow OST program staff to access subsidized or priority childcare slots**.
- **Establish standard occupational codes** for the afterschool field to be able to track and share data on the field as a whole.
- **Collect comprehensive data** representative of the gaps and needs of Georgia's OST workforce, including part-time staff.

HOW MEDICAID AND PEACHCARE MONEY WORK: A QUICK GUIDE TO ELIGIBILITY, FUNDING, AND COVERAGE

Medicaid and PeachCare for Kids (PeachCare) are Georgia's largest insurer for children, providing primary care, behavioral health, dental, vision, and more.

Georgia Dollars:[1]
$5,016,344,351

Federal Match:[2]
$9,989,540,513

Total Medicaid & PeachCare Budget (FY2024):[3]
$15,005,884,864

DELIVERY SYSTEMS IN GEORGIA

Using the **total combined amount**, Georgia channels funds through three delivery systems that manage the costs, quality, and how services are used.

Fee for Service

Primarily for children who are blind or disabled, including TEFRA and Katie Beckett[4]

- Providers are paid **per service** directly by the state

Georgia Families 360° Managed Care

For children in foster care, receiving adoption assistance, and in certain juvenile justice programs[5]

- Managed by Care Management Organizations (CMOs) and paid **per member per month** by the state

Georgia Families Managed Care

For most children under age 19 who are eligible for Medicaid, as well as newborns whose mothers are enrolled in any Medicaid program[6]

- CMOs receive a monthly payment to manage care/cost by the state

Federal match rate for FY2026: 66.4% (Medicaid)[7] and 76.48% (PeachCare/CHIP).[8]

PeachCare for Kids is Georgia's version of the federal Children's Health Insurance Program.

SCAN BELOW TO SEE FACTSHEET CITATIONS

WHO AND WHAT ARE COVERED BY MEDICAID AND PEACHCARE FOR KIDS

Medicaid

1,698,030 of Georgia's children receive Medicaid (as of July 2025) [9]

Who It Covers: [10]

- Children in families with incomes at or below age-based thresholds
- Children who are blind or disabled
- Newborns born to Medicaid-covered mothers
- Certain children in foster care or juvenile justice programs

Income Limits: [11]

Age	% FPL	Income for family of 4
0-1 years	205%	$65,892
1-5 years	149%	$47,892
6-19 years	133%	$42,756

What It Covers: [12]

- 12 months postpartum benefits
- Primary care
- Preventative screenings
- Specialty care
- Dental & vision
- Mental health services
- Prescription medications
- Hospitals & Emergency Room
- Non-emergency medical transportation

How It Is Funded: [13]

- A combination of federal and state funds
- Exact amount varies year-to-year based on facts like per capita income

PeachCare for Kids®

195,370 of Georgia's children are covered by PeachCare (as of July 2025) [14]

Who It Covers: [15]

- Children in families earning up to **247% FPL**
- Kids whose families earn *too much for Medicaid but too little for private insurance*

PeachCare for Kids is Georgia's version of the federal Children's Health Insurance Program (CHIP).

Income Limits: [16]

Age	% FPL	Income for family of 4
0-18 years	247%	$79,404

What It Covers: [17]

- 12 months postpartum benefits
- Primary care
- Preventive screenings
- Specialist care
- Dental & vision
- Prescription medications
- Mental health care
- Hospitals & Emergency Room

How It Is Funded: [18]

- Federal matching funds are available to subsidize more than 75% of the benefit cost less premiums with the remaining percentage coming from the state
- Percentage of federal matching funds is adjusted annually

WHY DOES THIS ALL MATTER?

- Medicaid and PeachCare insure **half of Georgia's children**.
- Children make up **50% of Medicaid enrollment** but **only about 20% of costs**.
- Stable health coverage supports school readiness, family stability, and healthy development.

SCAN BELOW TO SEE FACTSHEET CITATIONS

GETTING GEORGIA'S CHILDREN COVERED – AND KEEPING THEM COVERED

Georgia has 214,000 uninsured children.[1]

This is the 4th highest number of uninsured children in the nation.[2]

Georgia's highest number in almost a decade.

WHAT IS DRIVING THE INCREASE?

- Incomplete/missing paperwork during the mandatory Medicaid eligibility redeterminations following the end of the COVID-19 disenrollment pause
- Gaps in state-level enrollment systems (e.g., complicated notices, limited real-time enrollment support)
- Misinformation and administrative barriers

Medicaid cuts and marketplace changes are coming soon, which could result in even more kids losing coverage in the months ahead.

MOST EFFECTIVE WAYS TO GET (AND KEEP) KIDS COVERED

Federal Action: 12 Months Continuous Coverage[3]

- Protects kids from losing coverage due to temporary income fluctuations
- Required nationally starting January 2024 in the Consolidated Appropriations Act (2023)

State Action: Express Lane Eligibility (ELE)

- 2021: ELE adopted using SNAP/TANF data (implementation began October 2022)
- 2023: ELE expanded to include data from CAPS, Refugee Cash Assistance, and WIC (began in March 2024)

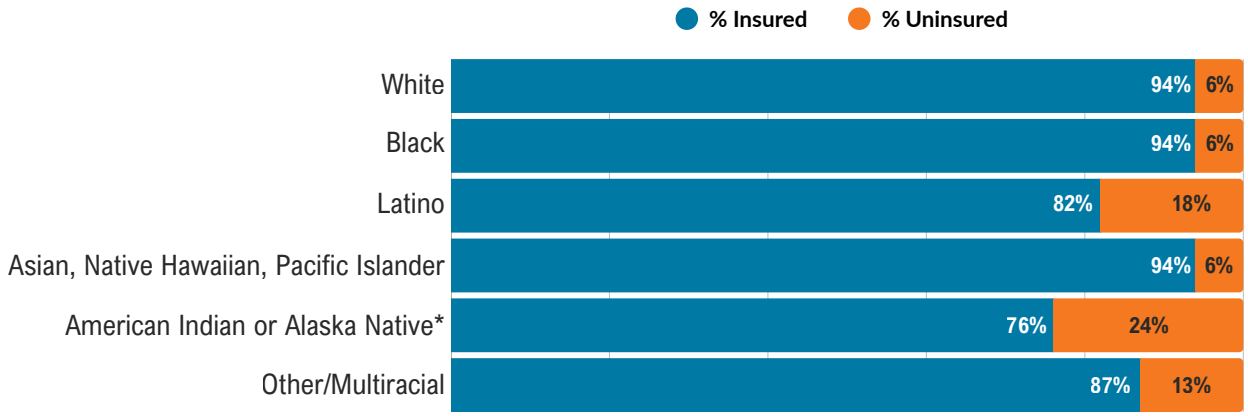
Under ELE, the state can use eligibility data from these programs to automatically enroll or renew eligible children in Medicaid or PeachCare for Kids.

In addition to ELE, using existing state data to confirm eligibility (known as "ex parte" renewals) can greatly cut paperwork for families and the state. The state can use verified data (e.g., from the Georgia Department of Labor, Department of Driver Services, Internal Revenue Service) it already has to process renewals. This would help keep eligible children on Medicaid/PeachCare instead of losing coverage due to a burdensome renewal process.

SCAN BELOW TO SEE FACTSHEET CITATIONS

WHO DOESN'T HAVE HEALTH INSURANCE IN GEORGIA?

Latino children are almost **3x as likely to lack health insurance** as White children in Georgia.



Insurance Status Among Children in Georgia, by Race and Ethnicity, 2024 [3]

**2024 data is not available due to insufficient sampling*

Note: Georgia Medicaid and PeachCare for Kids eligibility rules currently do not include a coverage option for undocumented children.

HOW GEORGIA'S CHILDREN ARE COVERED

PUBLIC COVERAGE *(as of July 2025)* [4]

Medicaid: 1,698,030

PeachCare (CHIP): 195,370

Medicaid and PeachCare provide comprehensive coverage for children in families with low and moderate incomes. Benefits include primary care, preventive services, behavioral health, dental and vision, prescriptions, and more.

PRIVATE COVERAGE *(as of 2023)* [5]

Employer-Sponsored: 1,154,100

Marketplace/Individual Plans: 134,600

Coverage through a parent's job or purchased on the marketplace

UNINSURED *(as of 2025)* [6]

214,000 children in Georgia do not have health insurance

This is Georgia's highest number of uninsured children in almost a decade.

POTENTIAL IMPACTS OF THE ONE BIG BEAUTIFUL BILL ACT [7]

- Fails to extend the the enhanced premium tax credits – **currently relied on by 95% of Georgia's using Georgia Access**
- Eliminates automatic re-enrollment, **making families manually reapply each year**
- Shortens the overall enrollment period, **reducing the time families have to secure coverage**

Learn more: Voices' Healthcare Coverage for Parents and Caregivers factsheet

WHY COVERAGE MATTERS

- ✓ Children receive timely check-ups and developmental screenings.
- ✓ Chronic conditions (asthma, ADHD) are treated, reducing ER visits and school absences
- ✓ Families avoid costly medical bills
- ✓ Providers are reimbursed, keeping clinics stable

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BENEFITS OF SCHOOL-BASED HEALTH CENTERS

School-based health centers (SBHCs) place critically-needed health-related services directly in schools to reduce access to barriers for children, families, and school personnel.[1, 2]

THE NEED FOR SCHOOL-BASED HEALTH CENTERS IN GEORGIA

214,000
children do not have health care coverage[3]

26.7%
of adolescents, ages 12 to 17, haven't had a preventative medical visit in the past year[4]

16.7%
of youth, aged 12-17, who needed mental health treatment or counseling, but did not receive it[5]

What are the benefits of school-based health centers?[6]

More than 100,000 children, families, and school personnel benefit from services at **129** SBHCs in Georgia. There are another 22 SBHCs pending.

National Health Data Supports[7]

Increase in:

- Access to primary, oral, and behavioral health care
- Use of mental health and substance abuse services
- Access to the flu vaccination

Decrease in:

- Emergency room use and hospitalization for children with asthma

Local Data and Implementation in Georgia[8, 9]

- Turner and Lake Forest SBHC implement **Halls to Health**, a program that addresses childhood obesity, student emotional health, and staff wellness
- Tiger Creek and Taliaferro SBHC, and several others, offers services to the entire community, including adults
- Albany Area Primary Care SBHC offers eye exams and glasses to all students within the Dougherty County School System
- Lake Forest, Turner, and Tiger Creek SBHCs provide preventative services and asthma management

National Education Data Supports[10, 11]

Increase in:

- Attendance and GPAs for students utilizing mental health services

Decrease in:

- Drop out rates and school discipline referrals
- Faculty and staff absences due to illness

Local Data and Implementation in Georgia[12, 13, 14]

- Turner SBHC prioritizes state grant funding to reduce barriers to healthy lunches for teachers
- Lake Forest SBHC resulted in a 40% increase in seat time after the first year. The length of time that students were absent due to illness decreased as well
- Health and support services also provided to school staff to increase their attendance and instruction time

National Data Shows Cost Savings[15, 16]

- Emergency room use and hospitalizations
- Pharmacy and transportation costs
- Time away from work for parents
- Pediatric health care for Medicaid, PeachCare for Kids®, and private insurers

Local Data and Implementation in Georgia[17]

- Whitefoord SBHC reported a 50% reduction in average cost per child to Medicaid for children with SBHC access, and a 62% reduction in annual expense per Medicaid-covered child

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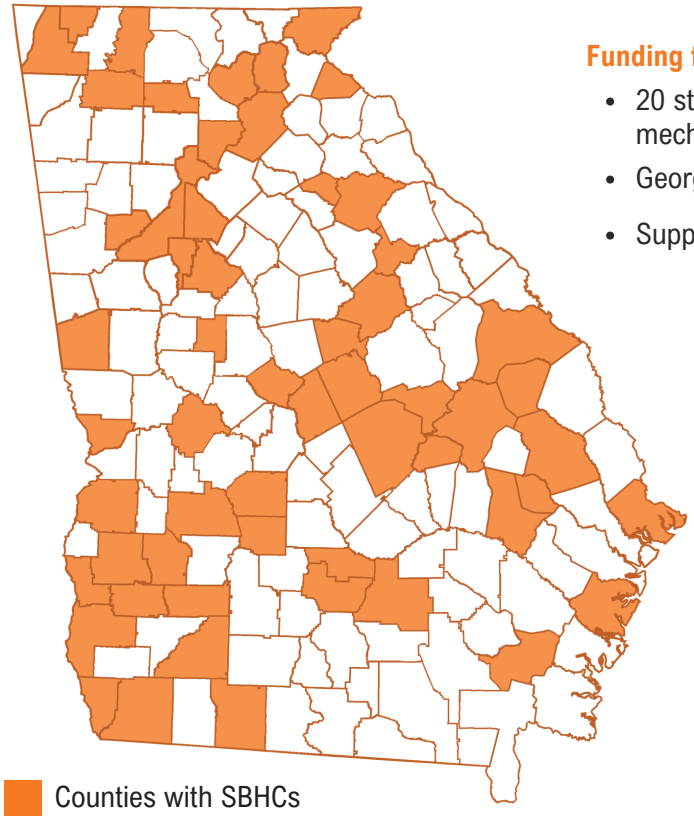
Sustaining School-based Health Centers

School-based health centers can become self-sustaining when startup funds are available. Georgia has allocated $125 million of federal funding to support planning and startup of new SBHCs.



Counties with SBHCs

Funding for SBHCs

- 20 states and Washington, D.C. have an ongoing funding mechanism to support SBHCs.[18]
- Georgia's share of federal SBHC funding
- Support for SBHCs in Georgia includes:
  - Governor's funding resulted in the creation of 15 new SBHCs with 19 additional centers opening during the 25-26 school year
  - National Institutes of Health (NIH) grants study the impact and benefits of SBHCs in suburban and rural areas of Georgia.
  - PARTNERS for Equity in Child and Adolescent Health allocates planning grants to communities in Georgia. 48 have been awarded since 2010.
  - Georgia Department of Education's Whole Child Supports offers SBHC planning grants to expand school-based health services to rural communities. June 2023 Round 1 funding resulted in 8 grantees; to date there are 29 planning grants
  - Medical College of Georgia supports a SBHC in a middle school in Athens, Georgia.

TYPES OF SCHOOL-BASED HEALTH CENTERS

School-based Health Center

These centers offer primary care services through a staffed primary care provider (e.g., nurse practitioner, physician assistant).

Comprehensive School-based Health Center

These centers offer primary care, behavioral health, and other expanded services, including health education, dental, and vision services.

RECOMMENDATIONS TO STRENGTHEN SCHOOL-BASED HEALTH CENTERS

- Continue to increase state and federal funding for medical sponsorship (FQHC and non-FQHC) to support the development and expansion of school-based health services throughout the state, especially in high-need, rural areas.
- Promote the integrated mental health and primary care model into SBHCs.
- Utilize telemedicine as an adjunct to the comprehensive primary care services within the SBHC model (i.e., hub spoke).
- Obtain parent consent to ensure their participation in medical decision-making within the SBHC model.
- Galvanize community support to educate and increase public will for SBHCs.

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SCHOOL-BASED TELEHEALTH IN GEORGIA

A school-based telehealth (SBTH) program uses telecommunications technology to connect children in need of acute or specialty care services to a healthcare provider at a distant site.[1]

WHY DO WE NEED SBTH IN GEORGIA?

More than 212,000
children stay home sick more than 6 days a year [2]

63
counties do not have a pediatrician [3]

92,000
children live in households that do not own a vehicle [4]

WHAT ARE THE BENEFITS OF SCHOOL-BASED TELEHEALTH?

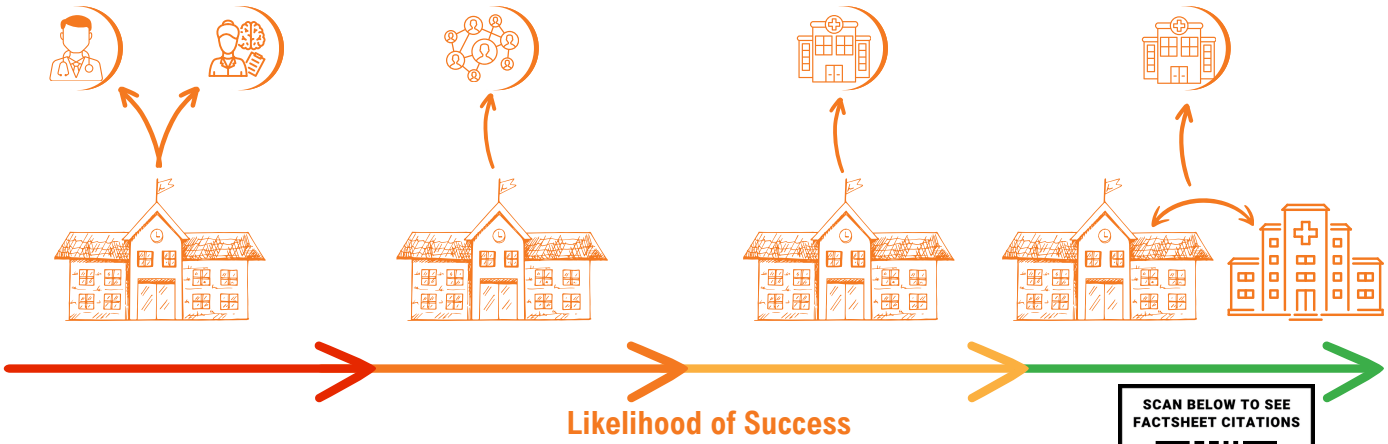
- Increased children and families' access to health education, especially for the management of chronic health conditions (e.g., diabetes, asthma) [5, 6]
- Reduced barriers to healthcare in rural communities [7]
- Reduced student absenteeism due to illness [8]

WHAT ARE THE BARRIERS TO IMPLEMENTATION?

- Engaging and sustaining relationships with healthcare providers or specialists
- Insufficient training or staff capacity
- Lack of continuity of care
- Lack of oversight and access to technical assistance
- Low program enrollment due to parental concerns about privacy and lack of understanding about telehealth

SCHOOL-BASED TELEHEALTH MODELS

*all models require equipment valued at a minimum of $10,000



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TERMS TO KNOW

Certified Community Behavioral Health Clinic (CCBHC): A Certified Community Behavioral Health Clinic (CCBHC) provides comprehensive, 24/7 access to behavioral health and substance use services. It is funded through enhanced Medicaid reimbursement and grants to expand crisis care, care coordination, and integration with physical health.

Federally Qualified Health Center (FQHC): A Federally Qualified Health Center is an outpatient clinic that qualifies for specific reimbursements under Medicare and Medicaid. Health centers provide a comprehensive set of health services including primary care, behavioral health, chronic disease management, preventive care, and other specialty, enabling, and ancillary services, which may include radiology, laboratory services, dental, transportation, translation, and social services.

School-Based Health Center (SBHC): A school-based health center places critically-needed services like medical, behavioral, dental, and vision care directly in schools to reduce access barriers for children, families, and school personnel.

Telehealth: Telehealth refers to a broad scope of remote healthcare services, including nonclinical services, such as provider training, administrative meetings, and continuing medical education, as well as clinical services.

Telemedicine: Telemedicine involves the use of electronic communications and software to provide clinical services to patients without an in-person wait.

POLICY RECOMMENDATIONS

For Policymakers

- Continue to ensure quality, streamlined school access to qualified telehealth providers.
- Increase opportunities for telehealth programs to be implemented within a comprehensive health system, including state funding for comprehensive school-based programs throughout the state.

For Districts and Schools

- If possible, develop a school-based telehealth program within an existing or planned school-based health center.
- Engage and enlist the support of key stakeholders before planning begins.
- Allocate time and resources to continuously market the program and recruit and enroll students.
- Ensure an adequate number of trained personnel to provide services and manage the program's administrative components.
- Ensure all children, regardless of insurance status, are served through the SBTH programs.

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HEALTHCARE COVERAGE FOR PARENTS AND CAREGIVERS

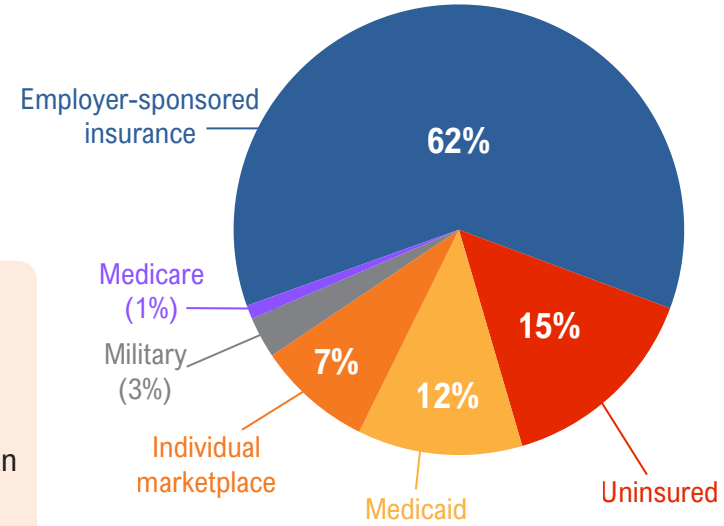
Untreated caregiver physical or behavioral health conditions can result in a traumatic experience for family members, including children and youth. What is more, the cost of healthcare for adults who are uninsured can significantly affect overall household income.

HOW GEORGIA PARENTS/CAREGIVERS ARE (OR ARE NOT) COVERED[1]

Nearly **1 in 6** adults with child dependents, or 319,700 people, lack health care coverage.[2]

Who is uninsured in Georgia?

- **24%** of Hispanic or Latino adults[3]
- **34%** of unemployed adults[4]
- **19%** of working adults with incomes less than 138% FPL ($38,295 for a family of four)[5]



COVERAGE SUBSIDIES AVAILABLE FOR GEORGIA PARENTS AND CAREGIVERS

See p. 3 for definitions of coverage subsidies

Medicaid for Pregnant Women (also known as Right from the Start Medicaid (RSM)) is also available for pregnant women and new moms who have incomes up to 220% FPL.

SCAN BELOW TO SEE FACTSHEET CITATIONS

WHAT RECENT FEDERAL CHANGES MEAN FOR GEORGIA FAMILIES

Recently passed federal legislation could jeopardize health coverage for many children and families in Georgia.[6]

Key Change	Impact on Parents/Caregivers	Effective Date
For Public Insurance (Medicaid/Pathways)		
Reduces retroactive coverage from 3 months to 2 months	Increases financial strain on parents/caregivers by leaving them to cover healthcare costs during gaps in coverage – gaps that last an average of four months before Medicaid reenrollment.	1/1/2027
Work requirements: 1. Extends qualifying activity exemptions to parents with children ages 13 and under 2. Gives states the option to verify that Pathways applicants meet work/ qualifying activity requirements for up to 3 consecutive months before the month of application	1. More parents/caregivers would not have to provide documentation of work or other qualifying activities to maintain coverage. 2. If Georgia implements this option, this creates additional paperwork and increases the risk of being deemed ineligible or experiencing coverage gaps. Those unable to meet the reporting requirements would lose coverage and also be ineligible for premium tax credits (PTCs) in the marketplace.	1/1/2027
Limits coverage to lawful permanent residents and certain individuals protected under special migration agreements between the U.S. and specific countries.	Parents and caregivers who are lawfully present asylees, refugees, and victims of domestic violence & trafficking are no longer eligible for Medicaid coverage.	10/1/2026
For Private Insurance		
No extension of enhanced premium tax credits (ePTCs).	All eligible parents and caregivers will see an increase in premium costs for healthcare coverage.	1/1/2026
Limits coverage to lawful permanent residents and certain individuals protected under special migration agreements between the U.S. and specific countries.	Parents and caregivers who are lawfully present asylees, refugees, and victims of domestic violence & trafficking are no longer eligible for Marketplace coverage.	1/1/2026
Eliminates Marketplace subsidies for immigrants who are ineligible for Medicaid due to 5-year bar with income less than 100% FPL ($32,150/family of 4).[7]	Parents and caregivers who are lawfully present immigrants, including lawful permanent residents will no longer be eligible for premium tax credits that help offset the cost of healthcare coverage.	1/1/2027
Requires verification of eligibility for premium tax credits.	Unable to automatically reenroll in Marketplace plans, and failure to to verify eligibility information results in ineligibility for PTCs for the next plan year.	1/1/2028
Narrows the open enrollment period to November 1-December 15, 2025 (previously November 1, 2025-January 15, 2026). State-based marketplaces, like Georgia, do have the option to extend to December 31, 2025.	Increases risk of coverage gaps due to missing enrollment deadlines.	Effective date: 12/15/2026 but currently in effect by rule.
Eliminates special enrollment period for individuals with income below 150% of the federal poverty level ($48,225/family of 4).[8]	Parents and caregivers with income less than 150% of the federal poverty level are no longer able to enroll in Marketplace coverage year-round.	1/1/2026
Eliminates repayment caps on premium tax credits	Parents/caregivers are required to reimburse the government if they underestimated their income when applying for the premium tax credit.	1/1/2026

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DETAILS ON AVAILABLE COVERAGE SUBSIDIES

Medicaid

Parent/Caretaker Medicaid is for people with child dependents whose incomes are 35% of the federal poverty level, or **$7,836/year for a family of four.**[9] This is the only way for parents/guardians to receive Medicaid if they are not eligible for Georgia Pathways, pregnant, aged, blind, or disabled. Supplemental Security Income (SSIC) is available for adults with certain disabilities.

Georgia Pathways

This program provides coverage for people whose incomes are below 100% of the federal poverty level, or **$32,150/year for a family of four**,[10] and that are ineligible for other types of Medicaid. Individuals are required to report 80 hours per month of qualifying activities.

Subsidized Coverage on the Individual/Small Group Marketplace

Subsidies are available on healthcare.gov for parents/guardians regardless of household income. Prior to the American Rescue Plan and Inflation Reduction Acts, subsides were capped at 400% FPL. The average marketplace premium in Georgia is $493/month.[11]

Employee-Sponsored Coverage

Fewer than half of private-sector employers in Georgia offer employer-sponsored coverage, but most people who have employer-sponsored coverage make more than 400% FPL, or **$128,600/year for a family of four**.[12] Fewer than 20% of people who make less than 100% FPL have employer-sponsored coverage.[13]

Extended Medicaid Coverage for New Moms

In 2022, Georgia extended coverage for new moms under Right from the Start Medicaid for Pregnant Women from six months postpartum to up to 12 months. This extension will improve the health of both mother and baby. Georgia's pregnancy-related death rate is one of the highest in the nation, and **Black women are 2x more likely to die from pregnancy-related complications than White women**.[14]

RECOMMENDATIONS

- Fund community health workers to assist parents/caregivers with application, renewal, and documentation processes across Medicaid and marketplace plans.
- Develop targeted outreach campaigns to address coverage disparities.
- Ensure affordable marketplace coverage remains accessible for parents/caregivers at all income levels, including promoting permanent extension of enhanced premium tax credits (ePTCs).
- Reduce barriers to coverage, including increasing flexibility in the reporting of work requirements, expanding the definition of qualifying activities, and streamlining compliance tools (e.g., mobile-friendly portals).

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ACCESS TO DENTAL CARE IN GEORGIA

Oral health is a critical part of children's overall well-being, yet many children in Georgia face challenges accessing consistent, affordable dental care—challenges that make poor oral health one of the leading causes of school absenteeism.[1]

20% of children in Georgia did not have a dental check-up in the last 12 months.[2]

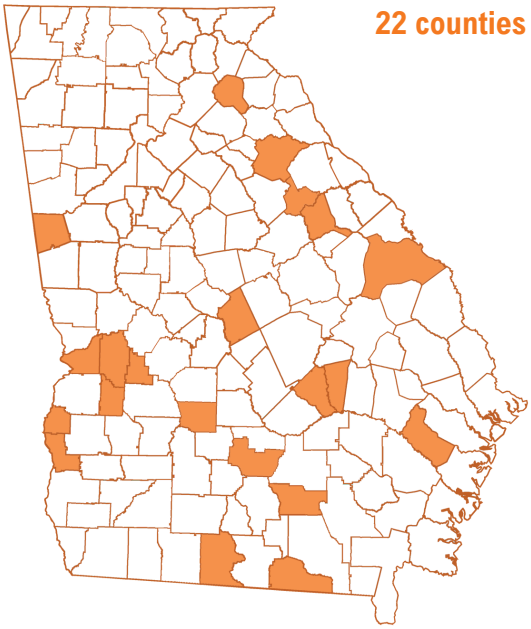
That's more than **481,000** children.

Who is at risk of poor oral health?

- Untreated tooth decay is **50% more common** in children in families with low-incomes compared to children in families with higher incomes.[3]
- Hispanic children have a **higher prevalence** of tooth decay (64%) of tooth decay compared to non-Hispanic children (50%).[4]
- Children in rural communities have a **higher prevalence** of tooth decay (60%) compared to children in urban communities (48%).[5]

Challenges Facing Children and Dentists

Availability of Care



22 counties in Georgia have no dentists.[6]

Dentists: **1 per 2,053** Georgians[7]

Hygienists: **1 per 2,227** Georgians[8]

Georgia has **190** dental care shortage areas.[9]

Federal regulations stipulated that in order to be considered as having a shortage of providers, a designation must have a population-to-provider ratio that meets or exceeds 5,000 to 1 or 4,000 to 1 for areas with unusually high needs.

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Challenges for Those Using Public Insurance (Medicaid and PeachCare for Kids®)

- On average, beneficiaries traveled **20 more miles** for dental care compared to those with private insurance.[10]
- Only **25%** of Georgia dentists accepted public insurance in 2020.[11]
- Children enrolled in fee-for-service Medicaid* were **33% less likely** to receive dental care than those covered by managed care plans. [12]
- Medicaid reimburses only **39.8%** of the fees dentists charge, while private insurance typically covers around **80%**.[13]

Language Barriers Impeding Access to Dental Care

- Medicaid patients are required by federal law to have access to translation services arranged and paid for by the provider. [14], [15], [16]
- **38%** of dental schools in the United States report that students were not adequately prepared to manage limited English-proficient patients.[17]

Benefits of Improved Dental Health

Health

- Improved eating and speaking [18]
- Improved diabetes outcomes [19]
- Reduced dental pain [20]
- Improved pregnancy outcomes, including fewer babies with low birthweights [21]

Cost Savings for Kids, Families, and the State

- Reduction of future dental visits and related costs [22]
- Reduction in emergency department visits for non-traumatic dental problems [23]

Education and Life Outcomes [24], [25]

- Improved school attendance
- Improved academic performance
- Improved self-esteem and employability
- Reduced pain and suffering

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The Importance of Fluoride

Fluoride is a naturally occurring mineral that is proven to protect teeth from decay. Fluoride helps rebuilding tooth enamel and strengthen the tooth's surface.[26]

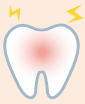
Benefits of Fluoride [27]

Untreated tooth decay can cause **pain**, **school absences**, **difficulty concentrating**, and **poor appearance.**[28] Utilizing fluoride can lead to:

Fewer cavities

Less severe cavities

Less need for fillings and tooth extraction



Less pain and suffering due to tooth decay

Tooth decay and its complications are preventable and early treatment options such as community water fluoridation are safe, effective, and economical.[29]

Multiple studies have consistently found **no scientific evidence** linking community water fluoridation with any potential adverse health outcomes.[30]

Fluoridation **does not** cause: [31]

- An increased risk for cancer
- Down syndrome
- Heart disease
- Osteoporosis and bone fracture
- Immune disorders
- Low intelligence
- Renal disorders
- Alzheimer's disease
- Allergic reactions

Water fluoridation is safe, healthy, and effective.[32, 33]

Community Water Fluoridation

According to the Georgia Dental Hygienists Association, community water fluoridation is "the controlled addition of a fluoride compound to a public water supply to achieve a concentration optimal for dental caries prevention." [34] Research supports that water fluoridation prevents tooth decay by providing frequent and consistent contact with low levels fluoride.[35]

In 2018, due to the decline in tooth decay, the Centers for Disease Control and Prevention (CDC) named Community Water Fluoridation as one of the 10 greatest public health achievements of the 20th century as identified in the public statement, "The Evidence Supporting the Safety and Effectiveness of Community Water Fluoridation." [36]

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Teledentistry

Teledentistry utilizes communications technology to deliver oral care, consultations, and education, as well as the remote provision of dental treatment (screening, diagnosis, consultation, and treatment planning).[37]

Benefits of Teledentistry from the American Dental Association (ADA)

The ADA recognizes teledentistry as an effective way to:

- Extend the reach of dental professionals
- Expand the reach of a dental home
- Increase access to care by reducing distance barriers

Teledentistry allows for a shorter period to obtain specialty consultations and improves workflow efficiencies for patients, providers, and support staff.

Teledentistry has gained popularity in recent years. According to a 2023 report published in The Journal of American Dental Association:[38]

30% of dentists use teledentistry in their practices

63% of teledentistry patients are within **20 miles** of their dentist

Benefits Experienced by Dentists Using Teledentistry[39]

- **63%** reduced in-person patient visits
- **57%** increased access and quality care
- **38%** reduced patient anxiety
- **31%** lower costs for patients
- **31%** patients more receptive to care
- **28%** better care for marginalized communities

Current Policies Affecting Teledentistry in Georgia

- The Georgia Department of Public Health (DPH) established a telemedicine network, available in all 159 counties, which is recognized as a “best practices model of care“ to bring specialized care to the underserved and rural areas of Georgia.
- Georgia allows dentists to provide general supervision of dental hygienists in safety net settings such as Title I schools, preschools, and other settings, which increases access to dental care for Georgia‘s underserved residents.

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POLICY RECOMMENDATIONS

Increase access in shortage areas

- Leverage the telemedicine network to increase utilization of teledentistry.
- Educate and raise awareness about the ability of dental hygienists to practice in settings such as schools and nursing homes.
- Encourage local public health clinics to provide dental services.

Increase access to dentists

- Continue to increase Medicaid reimbursement rates for dental services like exams, cleanings, fluoride, sealants, and treatments of caries (cavities), inclusive of services delivered via teledentistry.
- Reduce administrative barriers that hinder dentists from accepting Medicaid.
- Establish goals to increase dental access for Fee-for-Service member children (e.g., a minimum percent of children receiving services annually).
- Monitor the number of dental providers that are accepting new patients and actively participate in Medicaid Fee-for-Services and CMO dental networks.

Increase access to dental services in schools

- Leverage comprehensive school-based health services as a venue for providing dental care.

Maintain community water fluoridation supplies

- Continue to fluoridate water in accordance with the standards established by the appropriate authority to help prevent tooth decay and promote oral health.

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UNDERSTANDING VACCINES AND THEIR SAFETY

Vaccines save lives! Before vaccines were available, many diseases caused serious illness or death of children. Vaccines have made it possible to greatly reduce, and in some cases even eliminate, these diseases.

HOW VACCINES PROTECT US

A vaccine builds immunity to a disease by imitating an infection which causes the body to create antibodies and defensive white blood cells.[1] The defensive white blood cells remain in the body and fight the disease if the body encounters it in the future.[2]

WHY KIDS NEED VACCINES

- Vaccines protect against **15+** serious, and often life-threatening, diseases [3]
- Vaccines protect everyone, especially those who have weaker immune systems, including newborns, people undergoing cancer treatments, transplant patients, and older adults.[4]

ENSURING VACCINE SAFETY

Hundreds of large-scale studies conducted around the world have consistently shown that: [5]

- Recommended vaccines are safe for children and teens
- Vaccines are **not** associated with autism or developmental delay
- Vaccine ingredients are safe
- Vaccines continue to be monitored to ensure they remain safe and effective

VACCINES DO NOT CAUSE AUTISM

Decades of high-quality, large-scale studies show that vaccines do **NOT** cause autism, including:

Study: Evidence shows no link between vaccines and autism [6]

A large review of studies involving more than 1.25 million children found no link between vaccines and autism. This includes no connection between autism and the MMR vaccine or the ingredient thimerosal (a form of mercury).

Study: Research shows no association between vaccine ingredients and autism risk [7]

Researchers compared vaccine ingredients received by 321 children with autism and 752 children without autism at several ages in early life. They found no association between autism diagnoses and the amount of vaccine components—either over time or in a single day—that children received.

Study: Vaccinating on schedule does not affect long-term development [8]

Researchers studied more than 1,000 children to see if getting vaccines on time in the first year of life affected learning or behavior years later. They found no negative effects—in fact, children who were vaccinated on time often performed better on many developmental and cognitive tests.

SCAN BELOW TO SEE FACTSHEET CITATIONS

COMMON VACCINES AVAILABLE TO CHILDREN

The American Academy of Pediatrics' (AAP) Recommended Child and Adolescent Immunization Schedule provides up-to-date, trusted guidance on when children and teens should receive each vaccine.[9] Before a vaccine is recommended for the AAP's schedule, it must undergo rigorous testing, be proven safe, remain closely monitored, and be licensed by the Food and Drug Administration (FDA).[10] *Please note:* This factsheet was finalized on November 30, 2025. As of that date, **bolded** vaccines appeared on both the AAP's immunization schedule and the Centers for Disease Control and Prevention's immunization schedule.[11]

Diphtheria*
Hepatitis A*
Hepatitis B*
Hib*
Human Papillomavirus (HPV)
Influenza (Flu)
Measles*
Meningococcal* (Meningitis)
Mumps*
Pertussis* (Whooping cough)
Pneumococcal Disease*
Polio*
Respiratory Syncytial Virus (RSV)
Rotavirus
Rubella*
1vCOV-mRNA, 1vVOC-aPS (COVID-19)
Tetanus*
Tuberculosis
Varicella* (Chickenpox)

*Vaccines that are required for school or childcare attendance in Georgia.[12]

VACCINE-PREVENTABLE DISEASES AND THEIR SYMPTOMS

Diphtheria

- Can cause difficulty swallowing and breathing and lead to heart failure, paralysis, or even death [13]
- Most commonly spread from person to person through coughing or sneezing [14]
- Vaccine was developed in the early 1920s and widely used by the 1930s[15]
- Fatality rate for children under age 5 is 20%[16]

While diphtheria was one a major cause of illness and death among children, it is now rare in the United States. **Between 2004-2011, no cases of diphtheria were reported**; two cases were reported in 2019, the latest year for which data are available.[17]

Hepatitis A

- Liver infection caused by Hepatitis A virus[18]
- Can be contracted from contaminated food, drink, stool, or sexual contact[19]
- Vaccine developed in 1995[20]

Since universal childhood vaccination was recommended in 2006, **hepatitis A cases in the U.S. dropped by 95%**.[21]

SCAN BELOW TO SEE FACTSHEET CITATIONS

VACCINE-PREVENTABLE DISEASES AND THEIR SYMPTOMS, CONTINUED

Hepatitis B

- Liver infection caused by Hepatitis B virus[22]
- Spreads when blood and other bodily fluids of an infected person enter an uninfected person[23]
- Can be contracted through sexual contact, mother-to-child during pregnancy, sharing needles, and needle sticks[24]
- Vaccine initially developed in 1981, replaced with an updated version in 1986[25]

Hepatitis B vaccine is **more than 90% effective** when the full vaccine series is completed.[26]

Hib (Haemophilus influenzae type b)

- Bacteria that infects the lining of the brain and spinal cord (meningitis) and swelling of the epiglottis in the back of the throat (epiglottitis)[27]
- Harms the immune system, causes brain damage and hearing loss, and is sometimes fatal[28]
- Vaccine first licensed in 1985; an improved version was introduced in 1987[29]

Prior to Hib vaccine development, about 20,000 children younger than five developed severe Hib disease every year and about 1,000 died. **By 2006, the number of reported cases was just 29.**[30]

Human Papillomavirus (HPV)

- Spread primarily through skin-to-skin contact (e.g., sexual contact, cuts, abrasions, or even a small tear in skin)[31]
- Most infections go away on their own, some can cause certain types of cancer in both men and women[32]
- The AAP recommends getting the HPV vaccine starting when your child is between the ages of 9 and 12 years[33]
- Nearly all unvaccinated, sexually active individuals will get HPV at some point in their lives[34]
- Vaccine was originally licensed in 2006, with later versions approved in 2009 and 2014[35]

HPV vaccines have been show to be effective in preventing precancerous changes in men and women caused by high-risk cancer-causing HPV strains.[36]

Influenza (Flu)

- Respiratory illness caused by a virus[37]
- Pneumonia is the most commonly seen complication of influenza infection[38]
- At least 260 children died from influenza during the 2024-2025 season[39]
- Vaccine licensed for all civilians in the U.S. during 1945[40]

The influenza vaccine **reduces flu-related hospitalizations for children by about 50%.**[41]

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VACCINE-PREVENTABLE DISEASES AND THEIR SYMPTOMS, CONTINUED

Measles

- Highly contagious; 9 out of 10 people catch it if exposed [42]
- Can be contracted through airborne particles, which can stay active for up to 2 hours in the air or on objects [43]
- Especially serious for young children [44]
- Vaccine first available in 1963, and became a part of the combined measles, mumps, rubella program in 1971 [45]
- Measles was declared eliminated in the U.S. in 2000, however outbreaks have resurged as vaccine hesitancy drives down immunization rates. [46]
    - In 2024, just 87% of Georgia kindergarteners had completed the measles, mumps, and rubella (MMR) vaccine series. [47]
    - **As of November 2025, the U.S. had more than 1,400 cases and 2 pediatric deaths due to measles.** [48]

The two-dose MMR vaccine provides **97% protection** against measles and contributes to herd immunity when at least 95% of the population is immunized. [49]

Meningococcal (Meningitis)

- Bacteria cause meningococcal meningitis; the bacteria infect the lining around the brain and spinal cord (meningitis) and bloodstream (septicemia) [50]
- Spreading occurs by sharing respiratory and throat secretions (e.g., saliva or spit) [51]
- While anyone can get bacterial meningitis, teens, young adults, and those living in crowded settings (i.e., dorms) are at a higher risk [52]
- Meningococcal vaccines have evolved over time; the current vaccine that was licensed in 2005 provides stronger and longer-lasting protection [53]

Research shows the meningitis vaccine is **83.7-100% effective**. [54]

Mumps

- Contagious disease with most common outbreaks occurring among groups of people who have prolonged, close contact (e.g., sharing eating and drinking utensils, kissing, heavy breathing, sports, close quarters) [55]
- Symptoms include salivary gland swelling, fever, and aches and fatigue [56]
- Vaccine licensed in the U.S. in 1967 and became a part of the combined measles, mumps, rubella program in 1989. [57]
- By 1999, only one in a million kids got sick with mumps. However, vaccine rates have declined since then and now there are 3,000-6,000 cases a year. [58]

In the United States, cases of mumps **dropped by 99%** since the introduction of the vaccine in 1967. [59]

SCAN BELOW TO SEE FACTSHEET CITATIONS

VACCINE-PREVENTABLE DISEASES AND THEIR SYMPTOMS

Pertussis (Whooping Cough)

- Highly contagious and sometimes deadly for infants; as of November 2025, **4 infants had died of pertussis**[60]
- Known for uncontrollable, violent coughing which makes it difficult to breathe[61]
- Pertussis vaccine initially developed in 1914 followed by a combined diphtheria-tetanus-pertussis vaccine in 1948; in 1991, the diphtheria-tetanus-acellular pertussis (DTaP) vaccine is licensed[62]
- In 2024, the U.S. reported a total of 35,435 cases of pertussis, a more than **six-fold increase** reported in 2023.[63]

The pertussis vaccine is **98% effective** for children for a year after the full vaccine series is complete, and remains **70% effective** for five years after the series is completed.[64]

Pneumococcal Disease

- Bacterial disease that results in ear and sinus infections, pneumonia, and sometimes meningitis[65]
- Especially dangerous for children and can affect the brain and spinal cord[66]
- Every year, pneumococcal bacteria cause more than 4,800 cases of invasive pneumococcal disease in children younger than age 5; about 5% die from the infection[67]
- Vaccine first used in U.S. in 1977; most recent vaccine was licensed in 2010[68]

The pneumococcal disease vaccination was added to the recommended childhood vaccination schedule in 2000. Since then, invasive pneumococcal disease in children has **dropped by nearly 80%** in the United States.[69]

Polio

- A virus which lives in the infected individual's throat and intestines but can enter the brain and spinal cord and result in paralysis or death[70]
- Spreads from person to person via contact with an infected person's feces; a less common spread can occur through sneezing or coughing[71]
- Can be contracted through contaminated food and unsanitary water[72]
- Vaccine was developed in 1955[73]

Introduction of polio vaccine led **99% reduction** in cases across the world.[74]

Respiratory Syncytial Virus (RSV)

- Common respiratory virus causing cold-like symptoms[75]
- Spreads through coughing, sneezing or even talking[76]
- Infants and older adults are at risk for severe cases and hospitalization; the most common complication is respiratory failure[77]
- Two to three out of every 100 infants with RSV will be hospitalized[78]
- Vaccines for pregnant women can protect infants and young children from severe RSV[79]

Infant RSV vaccination has been shown to be **80-90% effective** in preventing infants from being hospitalized[80]

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VACCINE-PREVENTABLE DISEASES AND THEIR SYMPTOMS

Rubella

- Spreads through sneezing and coughing 67 AAP [81]
- Symptoms include low-grade fever, respiratory problems, and a rash of pink or light red spots that typically begin on the fact and spread downward; rash appears two to three weeks after exposure to the virus [82]
- Especially dangerous to pregnant women and fetuses 69 AAP [83]
- Fetuses infected with rubella can be born with Congenital Rubella Syndrome, resulting in deafness, blindness, and intellectual disabilities; infection can also result in neonatal deaths and spontaneous miscarriage [84]
- Vaccine first available in 1969 and became a part of the combined measles, mumps, rubella program in 1971; an improved rubella vaccine replaced the original in the MMR in 1979 and rubella was declared eliminated in the U.S. in 2005 [85]

The rubella vaccine (MMR) is about **95% effective** in preventing the rubella disease.[86]

SARS-COV-2 (COVID-19)

- Highly contagious respiratory disease caused by the SARS-CoV-2 virus; discovered in 2019 [87]
- Symptoms similar to a cold, the flu, or pneumonia: fever, cough, shortness of breath, sore throat [88]
- Many people have mild symptoms, but some can become severely ill (approximately 1.2 million U.S. deaths as of June 24); certain health conditions raise the risk of serious illness [89]
- Vaccine made available to the public in December 2020; The COVID-19 vaccine was developed rapidly in response to the pandemic, building on decades of research and clinical trials that began in 1984.[90]

Studies show the SARS-COV-2 vaccine is **39% effective against COVID-19-associated hospitalizations** and **64% effective against COVID-19-associated deaths**.[91]

Tetanus

- Serious, and potentially fatal, infection caused by a toxin made by the bacteria [92]
- Bacteria is found in soil and can be contracted through wounds and burns; more likely to occur in a deep puncture wound [93]
- Causes muscle stiffness and spasms, paralysis, and breathing problems; also known as "lockjaw," which comes from the tightening of the muscles around the jaw [94]
- Treatment usually requires hospitalization [95]
- Vaccine first introduced in 1938; combined with diphtheria vaccine in mid-1940s; FDA approved DTaP in 1991 [96]

Tetanus is very rare, especially in immunized individuals, which suggests an **efficacy rate of nearly 100%**; immunity wanes over time, so boosters are recommended every 10 years.[97]

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VACCINE-PREVENTABLE DISEASES AND THEIR SYMPTOMS

Tuberculosis

- Bacteria spread through the air (i.e., coughing, sneezing, speaking, singing) from one person to another[98]
- Bacteria can linger in droplets in poorly ventilated spaces for hours[99]
- Symptoms can include a cough lasting three weeks or longer, chest pain, and coughing up blood[100]
- Treatment is extensive: four antibiotics taken for 6 months[101]

The United States is considered low-risk for tuberculosis in children; **no universal recommendation to vaccinate against tuberculosis currently exists**. Vaccination is typically reserved for healthcare workers exposed to drug-resistent tuberculosis.[102]

Varicella (Chickenpox)

- Highly contagious disease that spreads via coughing, sneezing, or exposure to the fluid from blisters[103]
- Causes a very itchy, blister-like rash and fever[104]
- Can be serious, leading to bloodstream infections, lung infections, and encephalitis[105]
- Vaccine licensed for use in the U.S. in 1995[106]

Since the introduction of the varicella vaccine in 1995, infections have **dropped by 97%**. A single dose **reduces the risk of chickenpox between 70-90%**. Two doses reduce the risk even further.[107]

Why haven't I heard of some of these diseases?

Because vaccines work!

Many of these diseases have been wiped out or are exceedingly rare, thanks to vaccines!

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BENEFITS OF PHYSICAL ACTIVITY

Physical activity, both structured (e.g., physical education) and unstructured (e.g., recess, free play), boosts children's physical and mental health, academic achievement, and emotional wellbeing.[1, 2]

FACTS ON GEORGIA'S YOUTH

Among youth ages 10-17:

- **15.1%** are overweight[3]
- **17.2%** are obese[4]

Approximately **63%** middle and high school students do not meet the recommended 60 minutes of physical activity per day.[5]

PHYSICAL ACTIVITY RECOMMENDATIONS, BY AGE

0-1 year:[6]

Daily play with adult (e.g., peek-a-boo, tummy time)

1-3 years:[7]

- 30 minutes of *structured play* (e.g., obstacle courses, guided games)
- 60+ minutes of *unstructured play* (e.g., recess, free play)

6-17 years:[8]

60+ minutes of daily physical activity each day (e.g., recess, sports practice, walking)

BENEFITS OF PHYSICAL ACTIVITY AND PLAY

Structured and unstructured physical activity impact the following areas:

Learning and Academic Performance

- Higher grades and standardized test scores[9]
- Better memory and vocabulary recall[10]
- Improved performance for students below grade level[11]

Social and Emotional Development

- Increases opportunity for development of social, intrapersonal, and communication skills, especially for young children[12, 13]
- Boosts brain function tied to focus, memory, and positive mood[14]
- Promotes self-regulation and coping techniques among young children[15, 16]

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MORE BENEFITS OF PHYSICAL ACTIVITY AND PLAY

Mental and Behavioral Health

- Reduces depression, stress, and psychological distress[17]
- Improves positive self-image, life satisfaction, and psychological well-being[18]

Classroom Engagement and Productivity

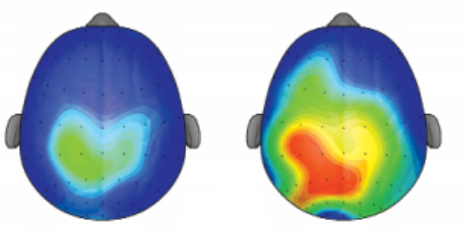
- Helps kids stay focused and on-task[19]
- Decreases disruptive behaviors[20]
- Strengthens executive function (e.g., planning, organization, flexibility)[21]

Physical Health and Fitness

- Improves motor skills and coordination[22]
- Builds strong bones and muscles[23]
- Reduces the risk of chronic disease (e.g., heart disease, Type 2 diabetes)[24]

Cognitive and Brain Health

Average composite of 20 students' brains taking the same test after sitting quietly or taking a 20 minute walk



Sitting Quietly **Walking**

Reprinted with permission of Dr. C.H. Hillman[25]

KEY TERMS

Body Mass Index (BMI): a ratio of weight to heigh used to determine weight status[26]

Obese: BMI above the 95th percentile[27]

Overweight: BMI between 85th-95th percentile[28]

Structured Play: adult-guided with goals (e.g., P.E., skill games)[29]

Unstructured Play: child-led, creative, open-ended play (e.g., recess)[30]

POLICY RECOMMENDATIONS

- Require that K-5 students receive a minimum of 30 minutes of unstructured activity (e.g., recess) and 6-8 students receive a minimum of 20 minutes of unstructured activity per day
- Ensure that neither physical activity nor recess opportunities are withheld for disciplinary reasons
- Ensure physical activity during recess is not used as punishment (e.g., walking laps instead of free play)
- Design built environment utilizing elements that encourage physical activity for youth and adults
- Increase access to afterschool and summer learning programs that support health and active lifestyles through opportunities for formal and informal physical activity and recreation

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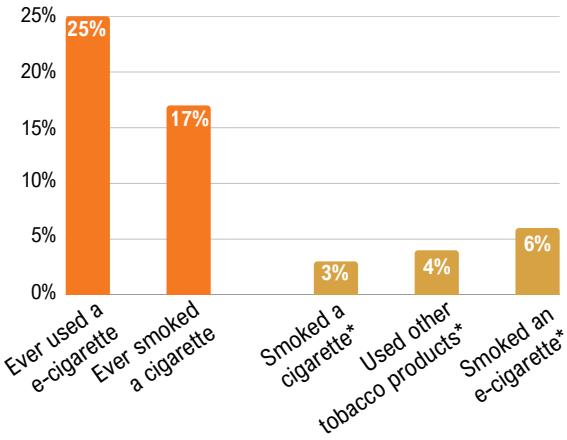
YOUTH E-CIGARETTE AND TOBACCO USE IN GEORGIA

E-cigarettes are the most widely used tobacco product among U.S. youth. All tobacco products, including e-cigarettes, pose serious health risks, particularly for children and teens.[1]

Georgia's Youth and Nicotine Use

Vaping remains widespread among Georgia's youth, with nearly **one in four** high school students reporting having ever used e-cigarettes.[2]

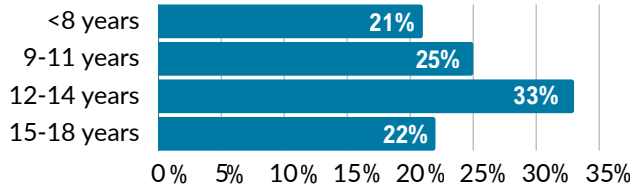
Nicotine Product Use Among Georgia High School Students[3, 4]



*Within the last 30 days

Youth Exposure to Nicotine: From Convenience Stores to Social Media

- **84%** buy e-cigarettes from gas stations or convenience stores [5]
- **32%** get products from friends; **31%** buy them directly[6]
- **74%** of students who use social media reported encountering posts or content related to e-cigarettes [7]



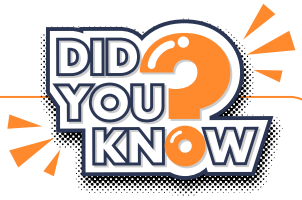
Age at which 6-12th graders first used cigarettes[8]

What are e-Cigarettes?

E-cigarettes are electronic devices that heat a liquid to produce an aerosol containing nicotine, flavorings, and other chemicals.

Also known as: [9, 10]

- e-cigs
- e-hookahs
- mods
- vape pens
- vapes
- carts
- tank systems
- electronic delivery systems
- JUULing



Vape aerosol can contain ultrafine particles and toxicants that irritate and injure lung tissue.[11]

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PERCEPTION VS. REALITY

Many Georgia teens underestimate the risks of vaping. Misconceptions about safety, addiction, and social acceptance continue to fuel nicotine use among youth.

Youth Perceptions	v. Reality
1 in 4 believed e-cigarettes are more acceptable in society than cigarettes[12]	Georgia law now treats vaping the same as smoking. The 2023 amendment to the Smoke-Free Air Act extends existing restrictions to e-cigarettes, affirming vaping is not viewed as a more acceptable alternative in public spaces.
26.6% believed e-cigarettes are less addictive than cigarettes[13]	Young people who use e-cigarettes and smokeless tobacco (chew or dip) are **more likely** to smoke cigarettes in the future.[15]
43% believed there is little to no risk in smoking one or more packs of cigarettes a day [14]	Nicotine use during adolescence can harm brain regions responsible for attention, learning, mood and impulse control,[16] with research showing lasting reductions in brain structure and cognitive performance among youth who start smoking in late childhood.[17]

POLICY RECOMMENDATIONS

- Increase the excise tax on tobacco products from 37 cents (the lowest in the nation) to the national average of $1.91.
- Ban flavored e-cigarette products, including disposable devices and refillable pods.
- Fund, increase, and improve public anti-smoking and anti-vaping campaigns, including messaging about the drivers of substance misuse among youth (e.g., peer pressure, family environment/parental approval).
- Encourage stronger regulations on advertising and social media exposure to tobacco/nicotine use.

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OVERVIEW OF FEDERAL CHILD FOOD AND NUTRITION PROGRAMS

When given access to adequate nutrition, the impact is clear: children are healthier and perform better in school.[1] However, children who do not eat enough healthy food often perform poorly in school and are more likely to experience mental health challenges.[2] These children are also at greater risks for health issues later in life, like diabetes, high blood pressure, hypertension, heart disease, arthritis, and some types of cancer.[3]

Food insecurity affects approximately

496,110

of Georgia's children under the age of 18.[4]

Programs Designed to Support Health and Adequate Child Nutrition

Program Description	Enrollment in Georgia
Child and Adult Care Food Program (CACFP) Reimburses for nutritious meals. Child care programs, afterschool care programs, child care homes, emergency shelters, and adult care centers can be CACFP eligible.[5]	**130,208** average daily attendance[12]
National School Lunch Program (NSLP) Provide nutritionally balanced, free or reduced-cost (based on a sliding scale) lunches to children in public and nonprofit private schools, and residential child care institutions.[6]	**1,129,375** total participation[13]
School Breakfast Program (SBP) Provides cash subsidies to public or nonprofit private schools and residential child care institutions to provide meals that meet federal nutrition criteria. Meals are provided to eligible children for free or at a reduced cost.[7]	**650,185** average daily attendance[14]
Seamless Summer Option (SSO) Provides the same meal service that is available during the regular school year to hungry kids in the community during the summer. This program is provided through either the NSLP or SBP.[8]	**124,471** average daily participation[15]
Summer Food Service Program (SFSP) Reimburses for healthy meals and snacks served to children from areas with low-income during summer months when school is not in session.[9]	**52,518** average daily attendance[16]
Supplemental Nutrition Assistance Program (SNAP) Provides a nutrition-designated electronic benefit card to supplement food budgets of individuals or families with low-income.[10]	**417,226** households with children[17]
Women, Infants, and Children (WIC) Provides supplemental food assistance, health care referrals, and nutrition education for pregnant, postpartum, and breastfeeding women with low-incomes, as well as infants and children up to age five.[11]	**231,480** total participation[18]

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CHILD FOOD AND NUTRITION PROGRAMS: HOUSEHOLD AND ACADEMIC SETTINGS

Food insecurity affects approximately 496,110 of Georgia's children under the ages of 18.[1] When given access to adequate nutrition, the impact is clear: children are healthier and perform better in school.[2] On the other hand, children who do not eat enough healthy food often perform poorly in school, are more likely to experience mental health problems, and are at greater risks for health issues later in life.[3]

The federal government funds seven food and nutrition programs which support children and adults within academic settings, afterschool programs, care facilities, and at home. Such programs have proven to support child health and development, all while addressing long-standing inequities (e.g., food insecurity, disparate chronic health outcomes).[4, 5]

What should children and youth be eating?

The *Dietary Guidelines for Americans, 2020–2025**, published by the U.S. Department of Agriculture, offer recommendations** on healthy eating and drinking habits to support nutrient needs, enhance overall health, and reduce the risk of chronic diseases.[6] The guidance is organized by age group.[7]

Ages	Vegetables (Cup/Day)	Fruit (Cup/Day)	Grains (Cup/Day)	Protein (Cup/Day)	Dairy (Cup/Day)
2 to 8 years	1 to 2.5	1 to 2	3 to 6	2 to 5.5	2 to 3
9 to 13 years	1 to 3.5	1.5 to 2	5 to 9	4 to 6.5	3
14 to 18 years	2.5 to 4	1.5 to 2.5	6 to 10	5 to 7	3

**This factsheet was prepared before the release of the 2026–2030 Dietary Guidelines for Americans. Information reflects the most current guidance available at the time of publication.*
***Recommendations vary on each child and their individual caloric intake.*

How do nutritious foods affect your body?

Nutritious foods support:

- Immune system responses[8]
- Eyesight[9]
- Cognitive development[10]
- Bone health[11]

Nutritious foods protect against:[12]

- Dental cavities
- Heart disease
- Chronic illness (e.g., type 2 diabetes, obesity)
- Iron deficiency

What are the benefits of nutrition education?[13, 14]

- Nurturing eating habits and behaviors
- Supporting individuals in informed decision-making about food and beverage consumption
- Empowering individuals by increasing nutrition and health knowledge

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Programs Designed to Support Child Nutrition at Home

Two federally-funded feeding programs provide food purchasing benefits as well as nutrition education to participating households.

Eligibility Requirements	Georgia Enrollment

Supplemental Nutrition Assistance Program (SNAP)

417,226
households with children[17]

Individual Demographics[15]

- Resident of the state of Georgia
- Lived in the United States for at least 5 years, or
- Receives disability-related assistance or benefits, or
- Children under age 18

Income[16]

- Lives at or below 130% of the federal poverty (FPL) income guidelines, depending on household status and deduction calculations

Food Benefits

Monthly monetary benefit loaded on the SNAP/EBT card to purchase fresh fruits, vegetables, and frozen, canned, and shelf-stable items[18]

Health and Nutrition Resources

Nutrition education (i.e., information on healthy eating, safe food, staying active, stretching food dollars, etc.)[19]

Women, Infants, and Children (WIC)

231,480
total participants [23]

- Pregnant, breastfeeding, and non-breastfeeding postpartum women
- Infants and children up to age 5 [20]

Income[21]

- Lives at or below 185% of FPL
- Participating in another assistance program may make an applicant automatically income-eligible for WIC (e.g., SNAP, Medicaid)

Nutrition Risk [22]

- Applicants must be determined to be at "nutritional risk" by a health professional or a trained health official

Food Benefits

- Nutritionally balanced food packages[24]
- WIC Farmers Market Nutrition Program benefits [25]

Health and Nutrition Resources

- Breastfeeding supports[26]
- Healthcare referrals [27]
- Nutrition education [28]
- Immunization screenings [29]

SCAN BELOW TO SEE FACTSHEET CITATIONS

Programs Designed to Support Health and Adequate Child Nutrition in Early Education, School, and Afterschool Programs

Five federally-funded feeding programs provide nutritionally balanced meals and snacks to children within early care and education programs, schools, and afterschool programs. Eligibility for participation is based on income, from 130% of FPL (free) to 185% of the FPL (reduced-cost).

Program and Description	Georgia Enrollment
Child and Adult Care Food Program (CACFP) Reimburses for nutritious meals and snacks, which align with dietary meal guidelines. Child care programs, afterschool care programs, child care homes, emergency shelters, and adult care centers can be CACFP eligible.[30]	**130,208** average daily attendance [35]
National School Lunch Program (NSLP) Provide nutritionally balanced, free or reduced-cost (based on a sliding scale) lunches, which align with dietary meal guidelines to children in public and nonprofit private schools, and residential child care institutions.[31]	**1,129,375** total participation [36]
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POLICY RECOMMENDATIONS

For Programs Supporting Household Nutrition Programs:

State Only:

- Strategically engage community organizations and benefit enrollment staff to understand and eliminate barriers to SNAP and WIC
- Ensure state agencies are fully leveraging data to ease enrollment for all eligible households (e.g., use Medicaid or SNAP data to facilitate WIC enrollment)
- Explore and enact opportunities to leverage virtual tools to support physicians in WIC program operations (e.g., electronic prescriptions, referral systems, electronic health data contracts)
- Explore an extension of the WIC Farmers Market Nutrition Program (FMNP) farmers' market season

State and Federal:

- Increase culturally and linguistically inclusive resources within SNAP and WIC
- Ensure SNAP and WIC programming and enrollment supports are incorporated in DPH's Home Visiting Pilot

Federal Only:

- Increase culturally inclusive foods within WIC food packages
- Expand the WIC child eligibility from age 5 to age 6
- Extend the WIC-certification timeline from 1 to 2 years
- Explore and incorporate online purchasing WIC-eligible foods

For Programs Supporting Early Education, School, and Afterschool Nutrition Programs:

State Only:

- Ensure state agencies are fully leveraging data to ease enrollment for eligible students (e.g., Direct Certification, which is using Medicaid data to facilitate NSLP enrollment)
- Leverage available data to strategically recruit CACFP-eligible programs (e.g., low-income, low food access areas)

State and Federal:

- Provide funding for transportation grants to fund innovative approaches and mobile meal trucks to increase access to summer meals
- Promote local food procurement by connecting food systems to child care programs and simplifying procurement processes for CACFP operators

Federal Only:

- Allow all CACFP programs to be reimbursed for an additional meal (e.g., snack or dinner), as was previously allowed
- Increase nutritious food access for Head Start, family child care homes, and afterschool programs by allowing them to receive a higher reimbursement rate (an additional 10 cents for eligible meals and snacks)
- Eliminate the two-tier system for family child care homes in CACFP, which would provide consistent and adequate reimbursement rates
- Streamline CACFP program requirements, reduce paperwork, and maximize technology to improve program access (e.g., streamline CACFP and SFSP applications, virtual monitoring)

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CRISIS IN CHILD AND ADOLESCENT BEHAVIORAL HEALTH

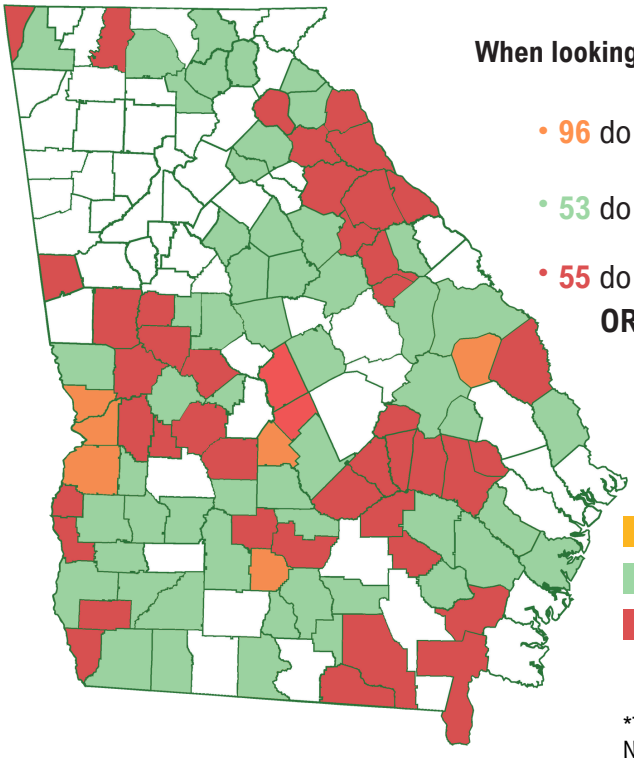
Children diagnosed with ADHD, autism, or developmental delays are twice as likely to experience chronic absenteeism as their peers without these conditions.[1] Undiagnosed, untreated, or inadequately treated conditions can lead to poor immediate and long-term outcomes, including significant impacts on a child's education.

THE YOUTH BEHAVIORAL HEALTH LANDSCAPE IN GEORGIA

Georgia Kids in Crisis

- In Georgia, **suicide is the 2nd leading cause of death** among youth ages 10-17.[2]
- **57%** of children ages 3-17 struggle to, or are not able to, access needed mental health treatment or counseling.[3]
- **70% of youth** in Department of Juvenile Justice secure facilities have a diagnosed disruptive, impulse-control, or conduct disorder.[4]

Accessing Behavioral Health Services in Georgia



When looking at Georgia's counties:

- **96** do not have a licensed psychiatrist
- **53** do not have a licensed social worker
- **55** do not have a licensed psychiatrist **OR** a licensed social worker

Counties without a licensed psychiatrist[5]

Counties without a licensed social worker[6*]

Counties without a licensed psychiatrist[7] OR licensed social worker

*The most recent available data for this indicator is from 2019. No updated dataset has been released as of the publication date.

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THE ROLE SCHOOLS PLAY IN BEHAVIORAL HEALTH

Schools often serve as the primary point of access to behavioral health services and supports.

	What We Have:	What We Need:	Georgia Law
School Counselors	1:374 students [8]	1:250 students [9]	1:1,450 students [10]
School Social Workers	1:1,911 students [11]	1:250 students [12]	No requirement
School Psychologists	1:2,150 students [13]	1:500 students [14]	No requirement
School Nurses	1:1,041 students [15]	1:750 students* [16]	No requirement

**Note: The National Association of School Nurses (NASN) recommends school nurse-to-student ratios as a guideline, but simple ratios alone do not capture the full scope of nursing services needed to meet student health needs. Evidence supports using an updated, evidence-informed workload analysis to determine safe and effective staffing.*[17]

WHY WE NEED BEHAVIORAL HEALTH SERVICES

Untreated behavioral health conditions in children and adolescents can lead to:[18]

- Drug and alcohol abuse
- Low educational attainment
- Violence or risky behavior
- Lower rates of employment in adulthood
- Poor physical health (immediate and long-term)

POLICY RECOMMENDATIONS

- Sustain and expand support for the Georgia Apex Program to continue advances in school-based mental health.
- Ensure full implementation of the Behavioral Health Care Workforce Database and develop strategies to address identified provider shortages and diversify the workforce.
- Allocate more funding to strengthen crisis support and intervention services, including continued implementation of 988 and mobile crisis services for children and adolescents.
- Strengthen and equitably implement HB 268 by establishing minimum behavioral health credentials for school mental health roles, ensuring all mandated trainings are evidence-based and trauma-informed, prioritizing resources for high-need districts, protecting student privacy, and requiring transparent reporting on outcomes.
- Regularly collect, update, and publicly share behavioral health workforce data.

WHAT'S NEXT?

We need to fully implement Georgia's comprehensive three-year System of Care State Plan** for child and adolescent health and support the work of Behavioral Health Innovation and Reform Commission to develop policy which can improve children's behavioral health outcomes.

**Read Georgia's System of Care State Plan at:
https://tinyurl.com/MindworksSP2024-2026

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GEORGIA APEX PROGRAM

The Georgia Apex Program (Apex), funded by the Georgia Department of Behavioral Health and Developmental Disabilities, is a statewide, school-based mental health initiative that embeds community mental health providers directly in schools to expand access for children and youth. Apex strengthens district partnerships and delivers a full continuum or supports, from universal prevention to intensive intervention, offered in-person and via telehealth during the school year, breaks, and summer.

What are the goals of the Georgia Apex Program?

- Early detection of student mental health needs
- Increase access to clinical care and prevention
- Sustained coordination of school-community partnerships

How urgent is the crisis in Georgia?

Of the 751,785 6th through 12th graders that responded to the 2024 Georgia Student Health Survey:[1]

370,573 (49%)
reported feeling **depressed, sad, or withdrawn**

38,329 (5%)
reported they had **attempted** suicide

Suicide remains a leading cause of death for Georgia youth under the age of 18.[2]

Why invest in school-based mental health?

School-based mental programs, like Apex, address needs of students meeting them where they are and intervening before a crisis escalates.[3]

Growth of the Apex Program from 2015 to 2025[4, 5]

	2015	2025
Schools	104	808
Services	19,465	231,531
Students	4,372	16,121

That's a nearly 677% growth rate in the number of schools with Apex from years 1 to 9!

APEX STATS, 2023-2024[6]

16,121
students served

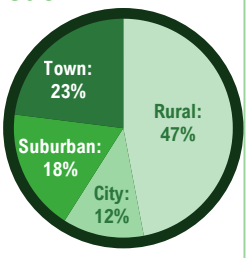
231,531
services delivered

808 (37%)
schools participated

133 (73%)
districts participated

Geographic Reach:

124 (78%)
counties served



Funding & Payer Source:

79% of services were billed to Medicaid or CMOs, maximizing Georgia's return on investment.

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SBMH Programs Support the ABCs of Student Success

Research shows that SBMH programs like Apex strengthen the key pillars of learning environments: **Attendance, Behavior,** and **Climate**. The following are results that have been observed in schools implementing SBMH programs:

Attendance

- **20–60% fewer absences** *(national study)* [7]
- Significantly improved attendance observed in Apex schools with an embedded therapist *(Apex study)* [8]

Behavior

- **60% reduction in suspensions and disciplinary referrals** *(national study)* [9]
- **Notably fewer student discipline incidents** compared to non-Apex schools *(Apex study)* [10]

Climate

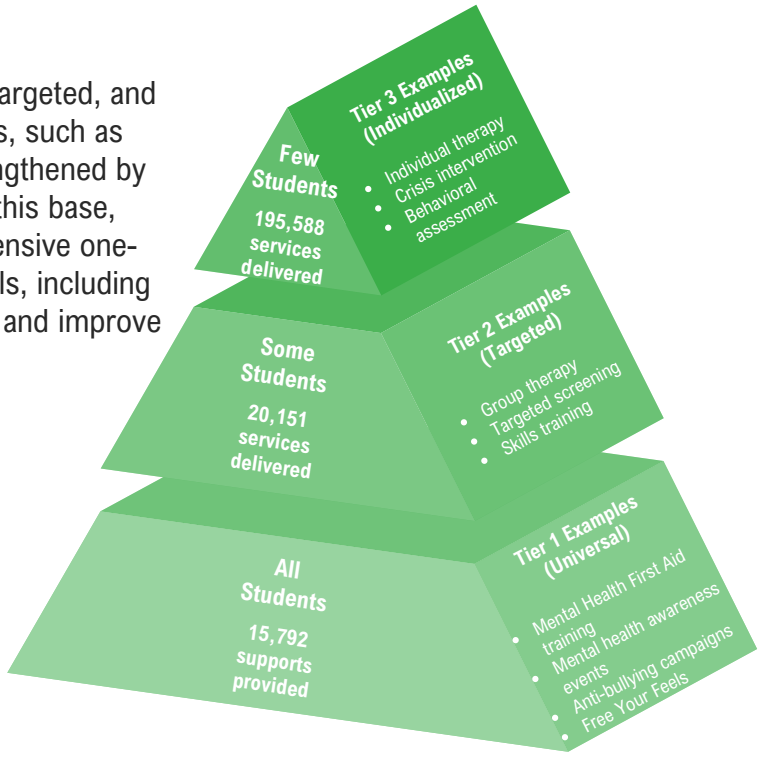
- **Increased feelings of safety** *(national study)* [11]
- **Stronger student-staff relationships** *(national study)* [12]
- **Higher student engagement** *(national study)* [13]
- **Greater improvement in School Climate Star Ratings** than non-Apex schools *(Apex study)* [14]

Youth are **SIX TIMES** more likely to complete treatment in school settings, making Georgia's continued investment a smart, high-impact way to expand access.

Apex fosters safe, supportive, and enriching learning environments.

Multi-tiered System of Supports [15]

Apex's three-tiered model delivers universal, targeted, and individualized supports. School-wide programs, such as PBIS, create a strong foundation and are strengthened by a diverse of school support staff. Building on this base, Apex delivers targeted group services and intensive one-on-one interventions from trained professionals, including social workers, to advance student well-being and improve school climate.



Data is from 2023-2024

How to bring Apex to more schools:

Providers:

- Become an in-network mental health provider with the Georgia Department of Behavioral Health and Developmental Disabilities or be chosen through the RFP process. Funding is determined by demonstrated need.

Schools:

- Partner with an in-network community-based or funded provider and direct the selection of schools for implementation.

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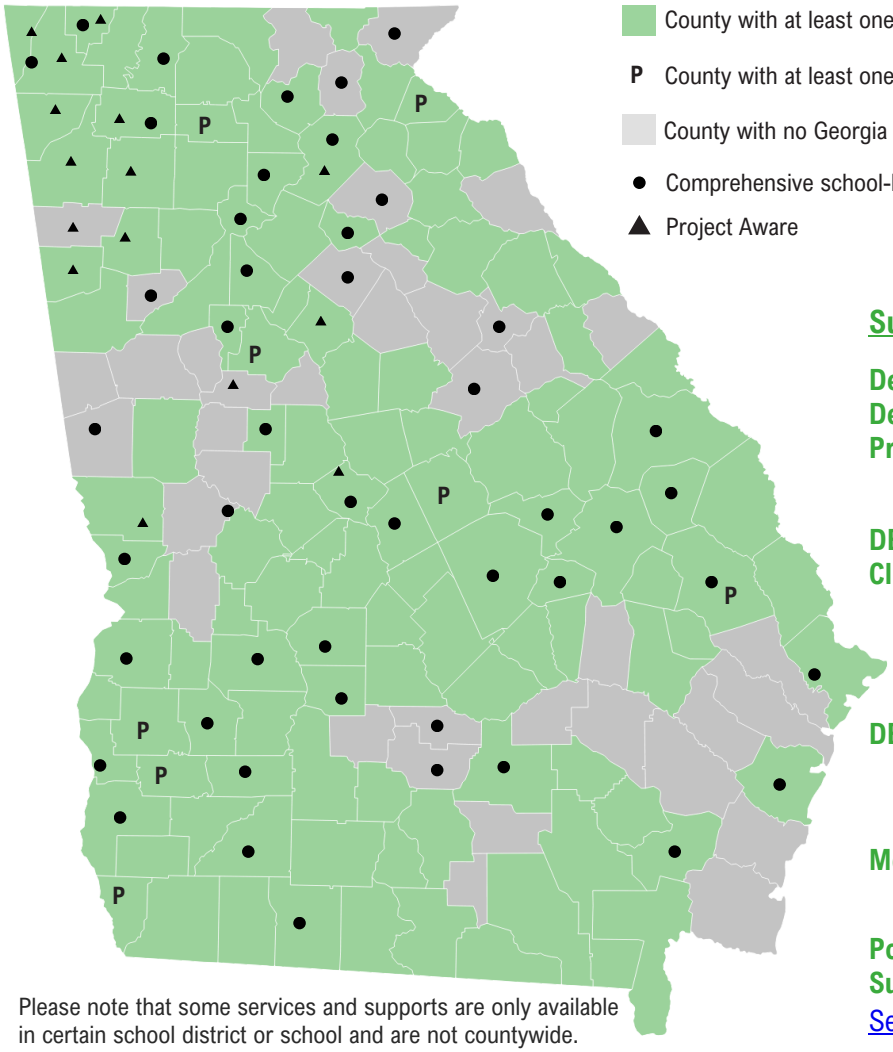
SCHOOL-BASED MENTAL HEALTH PROGRAMS

School-based mental health programs are well-positioned to provide a continuum of behavioral health care to students and their families. The following provides an overview of select school-based mental health programs.



County with at least one school operating a Georgia Apex Program

P County with at least one school with a pending Georgia Apex Program

County with no Georgia Apex Program

● Comprehensive school-based health centers (SBHC)

▲ Project Aware

Please note that some services and supports are only available in certain school district or school and are not countywide.

Supportive Initiatives

Department of Behavioral Health and Developmental Disabilities' (DBHDD) Prevention Clubhouses:

Gwinnett, Terrell, Troup

DBHDD Mental Health Resiliency Clubhouses:

Bartow, Butts, Dougherty, Douglas, Fulton, Gwinnett, Laurens, Newton, Oconee, Rabun, Sumter, Thomas, Ware

DBHDD Recovery Support Clubhouses:

Bulloch, Chatham, Douglas, Floyd, Fulton, Gwinnett, Hall, Muscogee

Medical Mobile Units:

Chatham, DeKalb, Fulton

Positive Behavioral Interventions and Supports (PBIS):

See Voices' PBIS factsheet here

As of November 2025, the Georgia Department of Education (GaDOE) and Regional Educational Service Agencies (RESAs) had coordinated **1,290 Mental Health Awareness Trainings (MHAT)** for more than **34,000 educators and school staff***, including:[1]

- **Trauma 101**
- **Brain 101**
- **Trauma to Resilience**
- **Secondary Traumatic Stress**
- **Psychological Safety**

*This data only reflects requests requests submitted through the MHAT catalog and does not include mental health trainings delivered independently by GaDOE, RESAs, local school districts, or school personnel.

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SCHOOL-BASED ACCESS

Georgia Apex Program

Increases school-based behavioral health capacity through partnerships between community-based providers and local schools and school districts. Both develop partnerships with local schools to provide behavioral health services. Funding: DBHDD state funds [2]

Project Aware

Builds capacity of state and local educational agencies to increase awareness of mental and substance issues through students screenings and school staff trainings. Grantees will assist in developing a statewide framework to provide training to school and community professionals to identify students with mental health needs and connect youth and families to community resources.[3] (Project Aware is currently partnering with the Northeast Georgia RESA serving 13 counties for grant period 2023-2028. Additionally, schools in Bibb, Hall, and Houston counties have also received awards for grant period 2020-2025.)

Youth Mental Health First Aid

Provides individuals who interact with youth with skills for helping an adolescent who is experiencing a mental health or addiction challenge or is in crisis.[4]

Sources of Strength

Targets strengthening multiple sources of support, changing social norms and school culture. This program is designed to prevent suicide, violence, bullying, and substance abuse by encouraging connections between peers and adults.[5]

School-based Health Centers (SBHCs)

Improves childrens' access to health services. 117 SBHCs provide mental and behavioral health services through on-site services in partnership with community providers. Funding: Foundation grants for start-up costs, insurance billing for sustainability,[6] and the Georgia Department of Education. [7]

Positive Behavioral Interventions and Supports (PBIS)

Facilitates positive school climate and timely identification of behavioral health needs for students. A network of 1,400+ schools and programs representing 62% of Georgia local educational agencies continue implementation with fidelity. Funding: GaDOE funds PBIS specialists in each RESA [8, 9, 10]

TELEMEDICINE & TELEHEALTH

School-based Telehealth (SBTH)

Provides children and families with access to needed primary, acute, and specialty care on a school campus through telecommunication technologies.

Georgia Partnership for Telehealth

172 schools had telehealth equipment, as of September 2022, to be used for behavioral health services through the GPTH network. Funding: GPTH grant; school budget for staff time; Medicaid [11]

OUT-OF-SCHOOL TIME

DBHDD-Supported Clubhouses

DBHDD Mental Health Resiliency Support Clubhouses: 16 clubhouses statewide, supported by the Office of Children, Young Adults & Family, to provide supportive services (e.g., educational, social, and employment support geared to engage youth and assist them in managing behaviors and symptoms [12]

Prevention Clubhouses: 3 clubhouses statewide, supported by the Office of Behavioral Health Prevention, that were designed to provide prevention services to high-risk youth ages 12-17 to address socio-economic ills and risk factors they fact in their communities at home[13]

Recovery Support Clubhouses: 9 clubhouses, supported by the Office of Recovery Transformation for youth and young adults aged 13 to 17 years with substance used challenges. The Recovery Support Clubhouses utilize a comprehensive substance use recovery support model designed to engage adolescents and their families in their recovery.[14]

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SCHOOL-BASED MENTAL HEALTH PROGRAMS: HOW THEY WORK AND SUCCEED

School-based mental health programs increase much-needed access to mental health support by eliminating barriers to care such as transportation, provider availability and proximity, and cost.

WHY DO WE NEED SCHOOL-BASED MENTAL HEALTH PROGRAMS IN GEORGIA?

73,495

Georgia students in grades 6-12 reported seriously considering attempting suicide[1]

56%

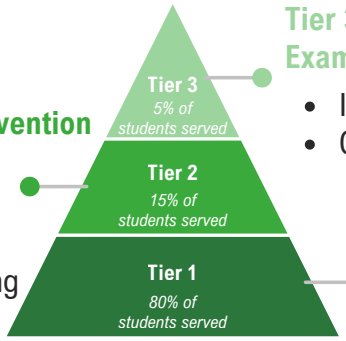
of children ages 3-17 had difficulty accessing or were unable to access needed mental health treatment and counseling [2]

1 in 4

children ages 3-17 has a diagnosed mental, emotional, developmental, or behavioral condition [3]

A MULTI-TIERED APPROACH

Comprehensive mental health services are most effective when provided through a multi-tiered system of supports (MTSS). **MTSS encompasses the continuum of need, enabling schools to promote mental wellness for all students, identify and address problems before they escalate or become chronic, and provide increasingly intensive, data-driven services for individual students as needed.**



Tier 3 Intensive Treatment Examples Include:

- Individual therapy
- Crisis management
- Behavior assessment

Tier 2 Targeted Intervention Examples Include:

- Individual therapy
- Group therapy
- Social skills training

Tier 1 Universal Prevention Examples Include:

- Suicide prevention training
- Youth Mental Health First Aid for school faculty
- Parent/teacher workshops
- Trauma training
- Test anxiety outreach
- Mental health awareness events (e.g., fun run)

Comprehensive SBMH systems address the full array of services and supports, including **universal prevention**, **targeted intervention**, and **intensive treatment**.

Tier 1 can be delivered by a **diverse group of student support professionals** (any school staff). **Tier 2** can be delivered by **counselors, social workers, or mental health providers**. **Tier 3** is limited to **licensed clinicians (or those seeking licensure and receiving supervision) only**.

Factors that Promote Program Success [4]

- Family-school-community collaboration
- Implementation of evidence-based and emerging best practices
- Needs assessment and resource mapping
- Well-trained and consistent staff, and specialized instructional support personnel

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CHALLENGES EXPERIENCED BY PROVIDERS

- Limited qualified workforce that will accept the salary*
  **Salaries are typically lower than other jobs in the field*
- Clinician burnout (e.g., heavy caseloads and secondary trauma)
- Stigma around mental health treatment
- Blurred roles in schools and extra demands on clinicians' time**
  ***This hinders billable time, which is important for program sustainability*
- Lack of transportation for afterschool/summer services
- Limited parental involvement

POLICY RECOMMENDATIONS

For State Agencies and Leadership:

- Continue to fund and expand the Georgia Apex Program, a statewide comprehensive SBBH model funded by the Georgia Department of Behavioral Health and Developmental Disabilities
- Allocate funding in the budget to continue improving the ratios of school counselors, social workers, and psychologists in K-12 congruent with national standards
- Extend telemedicine reimbursement provisions to support increasing access (including summer services) and family engagement
- Collect and share school-based mental health program outcomes annually
- Promote the integrated mental health and primary care model into school-based health centers
- Allocate additional funding to increase DBHDD and Medicaid Behavioral Health provider rates
- Ensure all provider types can be reimbursed by the appropriate payor (i.e., Medicaid or private insurance) for services delivered in school settings
- Leverage telehealth to increase access to SBBH supports and services, particularly in rural school districts

For Providers:

- Increase peer-to-peer support opportunities for youth and families (e.g., Sources of Strength, establishing family federation chapters)
- Support clinicians to ease the burden and prevent burnout (e.g., secondary trauma supports, billing programs to minimize administrative burdens)
- Promote free clinical supervision toward licensure and incentives, like federal loan forgiveness
- Partner with afterschool and summer learning programs
- Partner with Regional Education Service Agencies (RESAs), School Climate Specialists, and school Positive Behavioral Interventions and Supports (PBIS) coordinators

For Schools:

- Work with providers to submit community plans to draw down federal and philanthropic funding
- Leverage district- and school-level funds to support program costs
- Include providers in school meetings and groups (e.g., staff meetings, student support teams) and leverage providers for teacher trainings and professional development

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BEHAVIORAL HEALTH IN AFTERSCHOOL AND SUMMER LEARNING PROGRAMS

Afterschool and summer learning programs provide critical opportunities to support children's behavioral health, helping them build resilience, manage stress, and thrive both in and out of the classroom.

WHY DO WE NEED BEHAVIORAL HEALTH SERVICES AND SUPPORTS?

26%
of Georgia's youth, ages 3 to 17 years old, have a diagnosed mental, emotional, developmental, or behavioral problem [1]

3rd
leading cause of death among youth ages 10-17 is suicide [2]

56%
of Georgia's children, ages 3-17 struggle to, or were unable to, access needed mental health treatment or counseling [3]

AFTERSCHOOL AND SUMMER LEARNING PROGRAMS OFFER:

- Supportive environments and incorporate healthy habits into routine [4]
- Protective factors that improve youth outcomes and mitigate the effects of risk factors [5, 6]
- Positive behavioral factors like positive decision-making skills, self-control, and self-awareness [7]

of Georgia's school-aged children participated in afterschool programs in 2020 [8]

In 2023, **more than 275** government-funded afterschool and summer learning programs operated nearly **1,600 sites** in 112 of Georgia's 159 counties.[9, 10, 11, 12] These programs serve elementary, middle, and high school-aged students.

WHAT SUCCESSFUL COLLABORATIONS LOOK LIKE

Programs with knowledge of local community resources and an understanding of the basics of mental health reported* greater success in integrating behavioral health into programming.

- Robust community engagement with key stakeholders
- Training opportunities
- Collaboration on funding opportunities
- Referral pathways between programs and behavioral health providers
- Sharing resources like time, expertise, and facilities

CHALLENGES EXPERIENCED BY PROVIDERS

- Funding
- Accessing mental health training
- Knowledge of local community resources in referral pathways

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SELECT POLICY RECOMMENDATIONS

- **Community-based behavioral health providers** should partner with afterschool and summer learning programs to provide behavioral health supports and services.
- **State agencies** should offer existing training opportunities, curricula, and learning platforms to afterschool and youth development professionals.
- **State agencies and philanthropic funders** should create incentive grants for afterschool and summer learning programs to use evidence-based behavioral health curricula, training, and programming.
- **Georgia's Department of Behavioral Health and Developmental Disabilities (DBHDD) and Department of Education (GaDOE)** should encourage Georgia Apex program participants to create partnerships with summer learning programs to use their facilities and extend services to youth during the summer.

For a complete list of recommendations, explore the 2023 Out-of-School Time Behavioral Health Landscape Survey Results at https://adoble.ly/3xSTbdm.

FALL 2023 OUT-OF-SCHOOL TIME BEHAVIORAL HEALTH LANDSCAPE SURVEY

The 2023 Out-of-School Time Behavioral Health Landscape Survey was conducted by the Georgia Statewide Afterschool Network (GSAN) and Voices for Georgia's Children, and was funded by the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD).

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GEORGIA'S BEHAVIORAL HEALTH WORKFORCE: WHAT'S WORKING AND WHAT'S NEXT

Georgia has made significant progress in strengthening its child and adolescent behavioral health workforce through cross-agency collaboration, legislative action, and strategic investments.

Progress at a Glance

Georgia continues to strengthen its behavioral health workforce to ensure kids and families can access care when and where they need it. Below are select examples of recent progress:

Licensing & Oversight

- **Expanded the Behavioral Health Reform and Innovation Commission (BHRIC):** added subcommittees for Intellectual and Developmental Disabilities (IDD) and Addictive Diseases
- **Reduced provider shortages:** joined interstate compacts so licensed physicians and psychologists can serve Georgia patients, including via telehealth
- **Simplified clinical experience requirements:** for associate and licensed marriage and family therapists

K-12 Education Supports

- **Growing future workforce:** created a graduate training pipeline through Georgia Apex
- **Increased school supports:** added requirement for GaDOE to fund Student Advocacy Specialists to coordinate behavioral health services and train school staff
- **Increased school psychologist services:** allowed credentialed psychologists to provide academic and behavioral supports across state lines

Sustaining & Development

Sustaining the Workforce:

- **Passed Mental Health Parity Act:**
  - Guarantees equal coverage for behavioral and physical health
  - Increases oversight of Care Management Organizations (CMOs)
  - Expands support for children with complex needs (MATCH team)
  - Boosts co-responder training and creates new loan programs
  - Evaluates reimbursement rates and medical necessity denials
- **Increased Accountability:** more than $20+ million in fines assessed for parity violations
- **Integrated Care Expansion:** Georgia is adopting the Certified Community Behavioral Health Clinic model to combine primary and mental health care under one roof.

Developing the Workforce by Allocating Funds to:

- **Recruit & Retain Early Intervention Providers** through Babies Can't Wait
- **Hire More School Counselors** to meet the 1:450 student-to-counselor ratio
- **Expand Medical Education** with new fellowships and residency programs in child psychiatry and primary care
- **Increase School Social Workers** to meet the recommended 1:250 ratio
- **Implement Behavioral Health Provider Rate Increases** approved by CMS

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Gaps in Georgia's Behavioral Health Workforce

95 counties do not have a psychiatrist[1]

52% of youth ages 3-17 had difficulty getting the mental health treatment or counseling they needed[2]

66% of youth with major depression reported not receiving mental health services [3]

5M+ residents live in a designated Mental Health Professional Shortage Area [4]

Select Challenges Facing the Child and Adolescent Behavioral Health Workforce

Low Pay, High Turnover

*30% to 60% of behavioral health providers leave their jobs every year due to **low wages**, **heavy paperwork**, and **burnout** [5, 6, 7]*

Extremely Low Medicaid Reimbursement Rates

*Behavioral health providers are often paid **far below market rates**, making it difficult for community-based and rural programs to recruit and retain qualified staff*[8]

Training Gaps

*New graduates often lack **hands-on experience** and confidence using evidence-based therapies or handling real-world administrative tasks*

Limited Scope of Practice

*Psychiatric nurses in Georgia face **tighter restrictions** than peers in other states, limited access to care, especially in rural communities*

Safety on the Job

*Social workers and behavioral health staff face **high rates of workplace violence**, which reduces morale, quality of care, and staff retention*[9]

Select Challenges Facing Georgia's Children and Families

Access Still Out of Reach

Even with the progress Georgia has made, many families **still struggle** to find or afford behavioral health care for their children.

What are key obstacles experienced by families?

- Cost and insurance gaps
- Stigma and negative perceptions
- Lack of in-network providers
- Transportation and scheduling barriers
- Complex systems that are hard to navigate
- Caregivers unable to take time off work

A Workforce for Every Community

Georgia's behavioral health workforce doesn't yet reflect the **state's growing diversity**. Families who clear access barriers often face a shortage of providers who share their language or cultural background.

Why does this matter?

- **16%** of Georgians speak a language other than English at home.[10]
- The state's **foreign-born population has risen nearly 40 percent** since 1990, now totaling more than 10%.[11]

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POLICY RECOMMENDATIONS

Scope and Practice Environment

- Continue to encourage the practice of combining primary health and mental health care in one setting and ensure payer reimbursement for such integrated care.
- Streamline and enforce insurer provider certification, prior authorization, and billing practices.
- Expand authorization and capacity of psychiatric nurses to include additional prescriptive abilities and the ability to practice independently.

Education and Training

- Expand and standardize training that supports the behavioral health workforce in serving varied communities.
- Develop a Registered Behavior Technician (RBT) program within the Technical College System of Georgia to help meet the state's need for a larger autism and behavioral health workforce.
- Continue to intentionally encourage, recruit, and support diverse and rural students to pursue mental and behavioral health careers (e.g., Georgia Department of Education's Health Occupations Students of America (HOSA), and Career, Technical, & Agricultural Education (CTAE) Clusters and Pathways).

Support

- Prioritize identifying ways to integrate foreign-trained health professionals into the work plans of the Secretary of State Office (e.g., licensing boards) and the Georgia Board of Healthcare Workforce, including a licensure pathway, allowing temporary licenses, and comprehensive data collection on available providers.
- Conduct a national scan to identify evidence-based practices for provider recruitment and retention.
- Create a tax incentive program to support behavioral health providers that supervise emerging professionals. This program could mirror the Georgia Preceptor Tax Incentive Program for physicians.
- Leverage the Care Management Organization procurement process to explore and implement metrics that support increased care coordination and address social determinants of health.

Voices' In-Depth Child and Adolescent Behavioral Health Workforce Resources

- An Analysis of Georgia's Child and Adolescent Behavioral Health Workforce
- Sustaining Georgia's Child and Adolescent Workforce through Supervision
- Licensing Barriers for Foreign-trained Behavioral Health Professionals
- Whole Child Primer, 4th Edition

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Mindworks Georgia serves as the state director-level, multiagency working group of the Behavioral Health Coordinating Council and is responsible for developing and implementing the system of care framework in Georgia. Also known as the Interagency Directors Team (IDT), Mindworks' Workforce Development Committee contributed to the development of this factsheet.

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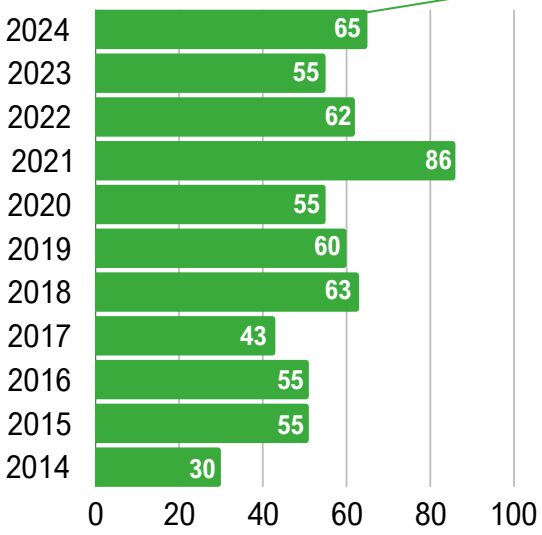
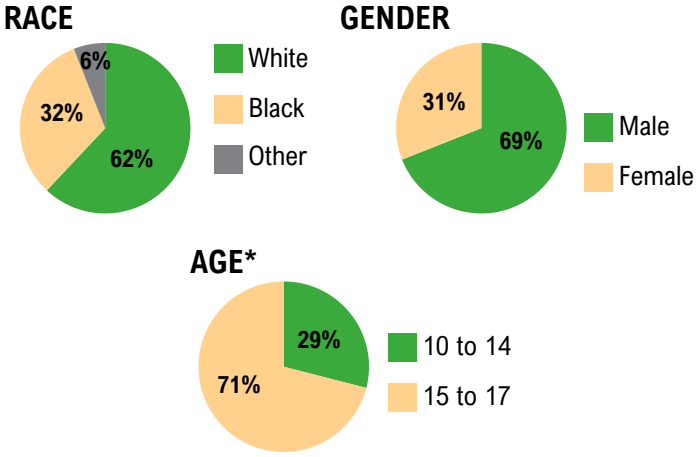
YOUTH SUICIDE IN GEORGIA

Suicide was the **third** leading cause of death for Georgia children aged 5-17 in 2023.[1]



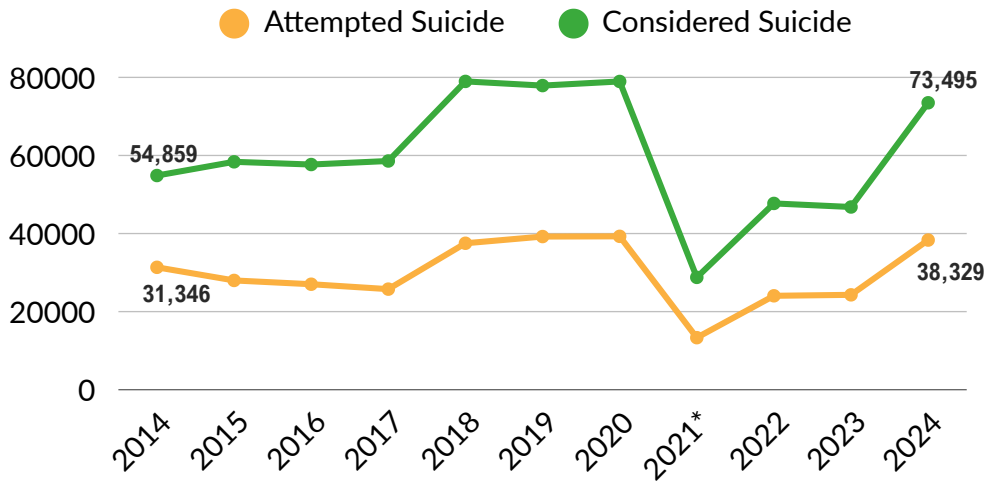
BREAKING DOWN THE 2024 DATA[2]



*There were no deaths for the 5-9 age range.

The number of children, aged 5-17 in Georgia, who visited emergency rooms for reasons related to suicide more than doubled between 2010 and 2024.[3]

YOUTH VOICE: WHAT GEORGIA STUDENTS SAY ABOUT SUICIDE[4]



In 2024:

116,513
students reported having seriously considered harming themselves

70,881
students reported having harmed themselves

**Responses to the Student Health Survey declined following 2021, with 418,705 responses recorded in 2022 compared to 725,229 in 2020. However, in 2024, participation returned to pre-pandemic levels, with 713,456 responses submitted. *The Georgia Student Health Survey was not administered during the 2020-2021 school year. Instead, the GaDOE developed a brief Student Wellness Survey to highlight non-academic barriers to learning.*

If you or someone you know is struggling with anxiety, depression or suicidal ideation, call 988, the National Suicide and Crisis Lifeline.

SCAN BELOW TO SEE FACTSHEET CITATIONS

WARNING SIGNS OF SUICIDAL BEHAVIOR

There are many warning signs that can signal someone is at risk for suicide. The risk is higher if the behavior is new or has increased, or if the changed behavior is related to a painful event, loss, or change. The risk is also greater with the presence of multiple warning signs. Warning signs include: [5]

- Talking about being hopeless or wanting to die
- Expressing feelings of being trapped or in unbearable pain
- Increased use of alcohol or drugs
- Looking up ways to end their life online
- Withdrawing from previously enjoyed activities
- Changes in sleep patterns
- Saying goodbye, visiting unexpectedly, and giving away possessions
- Sudden aggression
- Mood changes like depression or anxiety
- Unexpected calmness or sudden sense of relief after distress

PROTECTIVE FACTORS TO PREVENT SUICIDE

There are a range of protective factors at the individual, relationship, and community levels that can buffer individuals from suicidal thoughts and behaviors. [6]

Individual Protective Factors:

- Effective coping and problem-solving skills
- Reasons for living (i.e., family, friends, pets, etc.)
- Strong sense of cultural identity

Relationship Protective Factors:

- Support from partners, friends, and family
- Feeling connected to others

Individual Protective Factors:

- Feeling connected to school, community, and other social institutions
- Availability of consistent and high quality physical and behavioral healthcare

COMPREHENSIVE PREVENTION STRATEGIES AND EXAMPLES [7]

Identify and assist persons at risk

Examples: training for community leaders, suicide screening, teaching warning signs, referral to professional help (e.g., 988 Suicide and Crisis Lifeline, My GCAL line and app)

Ensure access to effective treatment

Examples: safety planning, evidence-based treatment, and reducing financial, cultural, and logistical barriers to care

Reduce access to means of suicide

Examples: educating families, distributing gun safety locks, changing medication packaging, installing barriers on bridges

Promote social connectedness and support

Examples: social programs for specific population groups, promote healthy peer norms, and engage community members in shared activities

Support safe care transitions and organizational linkages

Examples: formal referral protocols, interagency agreements, cross-training, follow-up contacts, rapid referrals, and patient/family education

Respond effectively to individuals in crisis

Examples: mobile crisis teams, walk-in crisis clinics, hospital-based psychiatric emergency services, and peer-support programs

Provide coping and problem solving skills

Examples: skills training, including parenting programs and education programs that support resilience

Provide immediate and long-term support after a suicide

Examples: protocols to respond effectively and compassionately after a suicide, supports for people bereaved by suicide

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SUBSTANCE USE AND BEYOND: UNDERSTANDING YOUTH RISK BEHAVIORS IN GEORGIA

Substance use and behavioral health challenges continue to shape the well-being of Georgia's youth. Insights from the 2024 Georgia Student Health Survey (GSHS) reveal the patterns, risks, and realities facing Georgia's 6th through 12th graders today, from alcohol and vaping to disordered eating and gambling.

What Substances Georgia's Youth are Using

Alcohol, marijuana, and vaping products top the list of substances used by Georgia's youth.[1] In the 30 days before they took the GSHS, thousands of Georgia middle and high school students reported substance use:[2]

- **43,873 (6%)** drank **alcohol**
- **35,136 (5%)** smoked **marijuana**
- **38,996 (5%)** **vaped nicotine products**

What is a substance use disorder?

A substance use disorder (SUD) occurs when repeated substance use leads to significant impairment and disrupts school, relationships, or health.[3]

Common Substances and Their Effects

Substance	*Type*	*How It's Consumed*	*Health Impact*
Alcohol	Depressant	In beverages	Impairs brain function; weakens immune system; increases risk of cancer, heart and liver disease, and risky behavior[4, 5]
Cocaine	Stimulant	Snorted, smoked, or injected	Increases heart rate and alertness; raises risk of anxiety, psychosis, and infectious disease[6, 7]
Marijuana*	Psychoactive	Smoked or eaten	Affects memory, coordination, and learning; linked to anxiety and impaired mental health[8, 9]
Opioids	Pain relievers, depressants, & stimulants	Swallowed or injected	Slows breathing; causes drowsiness, nausea, and confusion; can be fatal in overdose[10, 11]
Tobacco	Stimulant	Smoked, snorted, chewed, or vaporized	Damages lungs and heart; increases risk of chronic disease and cancer[12, 13]

**Legislation passed in 2017 and 2018 that expanded the conditions for which cannabis oil can be prescribed to include post-traumatic stress disorder (PTSD), intractable pain, Tourette's syndrome, Autism Spectrum Disorder, Epidermolysis bullosa, Alzheimer's disease, human immunodeficiency syndrome, autoimmune disease, and peripheral neuropathy.*

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Non-substance Disorders Affecting Georgia's Youth

In the 30 days prior to taking the GSHS, **1 in 5** Georgia students reported disordered eating behaviors.[14]

- **123,477 (20%)** 6th through 12th graders reported forced vomiting, using laxatives, or avoiding food in order to lose weight. Of those who reported this behavior,
  - **27%** were **female**
  - **12%** were **male**

What is a non-substance disorder?

Non-substance disorders are behavioral addictions. Compulsions like gambling or disordered eating can cause serious emotional, social, and physical harm.[15]

Common Non-Substance Disorders and Their Effects

Disorder	*What It Is*	*Health Impact*
Pathological Gambling	Persistent, uncontrollable betting that disrupts school, finances, and/or relationships	Loss of money or basic needs, increased stress, damaged relationships, higher risk for crime or substance use
Disordered Eating	Severe disturbances in eating behavior or body image (e.g., anorexia-nervosa, bulimia-nervosa, binge-eating).[16] Common behaviors include extreme restriction of food, binge-purge cycles, fasting, excessive exercise, or use of diuretics and laxatives to restrict absorption.[17]	Malnutrition, heart issues, and potentially life-threatening complications[18]

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OPIOID MISUSE IN GEORGIA

Opioids are a class of drugs that act in the nervous system to produce feelings of pleasure and pain relief.[1]

THREE CATEGORIES OF OPIOIDS[2]

1 *Prescription Opioids*

- Prescribed for moderate to severe pain
- Can be addictive and dangerous if misused
- Known as: oxycodone (OxyContin), hydrocodone (Vicodin), morphine, and methadone

2 *Fentanyl*

- Powerful synthetic pain reliever
- Prescribed for severe pain (like advanced cancer)
- Illegally made fentanyl is driving a surge in overdoses

3 *Heroin*

- Illegal opioid with no medical use in the United States
- Highly addictive
- Use has increased across the country among both genders, most age groups, and all income levels

WHAT IS ADDICTION?[3]

Addiction (termed "substance dependence" by the American Psychiatric Association) is defined as a **brain disease** that leads to compulsive substance use despite harmful consequences.

IMPACT OF OPIOID MISUSE ON CHILDREN AND YOUTH

Opioid misuse and addiction can profoundly affect children and adolescents. When parents misuse opioids, children may face serious challenges, from health complications at birth to inadequate supervision and other experiences that threaten their immediate and long-term wellbeing.[4] For young people themselves, opioid misuse can quickly lead to addiction, disrupting brain development, hindering academic success, and even shortening life expectancy.[5]

Parental Opioid Misuse

Neonatal Abstinence Syndrome, or NAS, occurs when a newborn experiences withdrawal symptoms after being exposed to drugs in the womb. This can include both prescription medications or illegal substances.[6]

762 confirmed cases of NAS in Georgia in 2017*, and **20%** were attributed to opioids.[7]

More than **1 in 3** infants with NAS were born to mothers 25-29 years of age.[8]

Parental substance abuse was a factor in **41.5%** of children entering the foster care system in FY2023.[9]

Youth Opioid Misuse

During the 2024-2025 school year, among middle and high school students, who completed the Georgia Student Health Survey:

26,937 students reported taking a prescription drug painkiller that was not prescribed for them within the last 30 days.[10]

19,870 students reported using heroin within the last 30 days.[11]

**2017 is the latest publicly available data*

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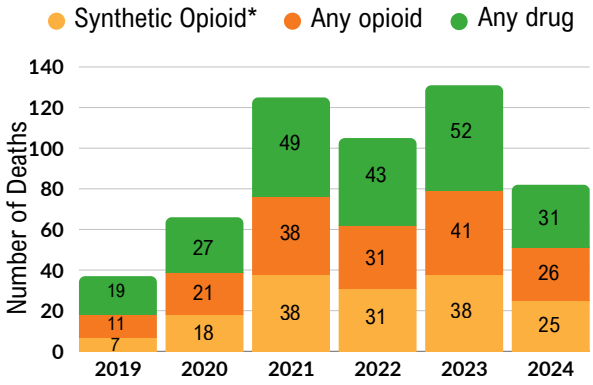
OPIOID DEATHS AMONG ADOLESCENTS(10-19 YEAR OLDS) IN GEORGIA

- In 2024, **84%** of all overdose deaths among adolescents involved opioids.[12]

From 2019-2024, Georgia saw: [13]

- a **136%** increase in opioid overdose deaths
- an **257%** increase in overdoses involving synthetic opioids (e.g., Fentanyl)
- Fentanyl overdoses rise to **78% for adolescents**, compared to 53% for adults.

Overdose Deaths Among Adolescents, by Drug Type, Georgia, 2019-2024 [14]



**Synthetic Opioids (e.g., Fentanyl) other than Methadone*

SELECT EXAMPLES OF GEORGIA'S RESPONSE

Naloxone Access:

Pharmacists statewide can dispense naloxone (Narcan), a life-saving overdose reversal drug [15]

State Coordination

Georgia's **Opioid and Substance Misuse Unit** leads workgroups on prevention, treatment, data, and enforcement [16]

Youth Initiative

The Criminal Justice Coordinating Council funds programs to improve data collection, overdose prevention training, and youth treatment services[17]

Settlement Funds

Georgia secured $636 million from a national opioid settlement to support prevention and recovery efforts to be paid out over 18 years.[18] As of January 2024, Georgia had received $118.9 million.[19]

POLICY RECOMMENDATIONS

- Increase promotion of the state's Good Samaritan law.
- Leverage opioid abatement funds to support youth-focused and youth-informed prevention, treatment and harm-reduction efforts.
- Fund and increase Naloxone awareness campaigns and training.
- Continue to fund, provide training to, and expand the reach of family treatment courts to provide dependency diversion programs for parents, caregivers, and youth.
- Continue to invest in peer supports for mental health and/or substance use recovery and support services (e.g.,, Certified Peer Specialists - Mental Health, -Forensic Peer Mentors, -Whole Health and Wellness Coach, -Youth, and -Addictive Disease).

Infant-Toddler Courts, which use a collaborative, trauma-informed model, have demonstrated success in reducing foster care placements, supporting family reunification, and strengthening long-term outcomes for young children and their caregivers.[20]

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AUTISM SPECTRUM DISORDER

Autism and Autism Spectrum Disorder (ASD) are used interchangeably to describe a group of complex disorders of brain development that impact how people communicate, interact, and behave.[1]

DIAGNOSING AUTISM SPECTRUM DISORDER

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is the primary tool for diagnosis of ASD. In order for a child to be diagnosed with ASD, the DSM-5 requires that they demonstrate a combination of: [2]

Persistent deficits in social communications and interactions:

- Ability to engage in social interactions between two or more people
- Nonverbal communicative behaviors used for social interaction
- Developing, maintaining, and understanding relationships

AND

Restricted and repetitive patterns of behaviors, interest, and activities:

- Repetitive motor movements, use of objects, or speech
- Insistence on sameness; inflexible adherence to routines
- Highly restricted, abnormally intense, and fixated interests
- Hyper- or hypoactivity to sensory input; unusual interest in sensory aspect of environment

WHY EARLY INTERVENTION MATTERS

Behaviors associated with ASD can be evident in children prior to two years old, however most signs and symptoms begin to appear between 2-3 years old.[3]

- Early intervention services are most effective when provided in a child's first years of life.[4]
- Early diagnosis and treatment lead to long-term improvements in skills and symptom management.[5]
- Families face barriers to accessing these services, including:

Shortage of qualified, well-trained professionals

Limited transportation options

Gaps in healthcare coverage

AUTISM AND CO-OCCURRING CONDITIONS

Autism is often associated with other intellectual delays or structural/language disorders. Additionally, many individuals with autism also experience symptoms of another mental health diagnosis. For example, 70% of individual with autism may have one additional mental diagnosis, and 40% may experience two or more combined mental diagnoses. Some common co-occurring diagnoses include: ADHD, anxiety, depression, development and coordination disorders, and learning disorders.[6]

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AUTISM SPECTRUM DISORDER IN GEORGIA

66,966 children, ages 3-17, were diagnosed with autism in 2022.[7]

Factors related to apparent increase in prevalence:[8]

- Improved diagnosis criteria
- Environmental influences, such as parental age at conception, prematurity, and birth weight
- Increased awareness and earlier screenings

BEHAVIORAL ANALYSTS IN GEORGIA[9]

Applied Behavior Analysis is an evidence-based therapy used for people with autism and other developmental disorders that addresses language and communication, attention and memory, and behavior concerns.[10]

Certification	Doctoral (BCBA)	Master/Graduate (BCBA)	Bachelor (BCaBA)	RBT	Total
Statewide Count	101	1,911	86	11,625	**13,723**

BCBA: Board Certified Behavior Analyst
BCaBA: Board Certified Assistant Behavior Analyst
RBT: Registered Behavior Technician

RECOMMENDATIONS

- Develop a Registered Behavior Technician (RBT) program within the Technical College System of Georgia to help meet the state's need for a larger autism and behavioral health workforce.
- Ensure billing codes, professional development opportunities, and wellness practices support the sustainability, and expansion of, a qualified autism workforce (e.g., BCBA, BCaBA, RBT, other therapists, and qualified healthcare professionals).
- Increase funding and support to expand respite care facilities and services for children and youth with behavioral health conditions, including autism, serious emotional disturbance, and substance use disorders.
- Promote early autism identification and classroom inclusion information such as signs and symptom education materials, developmentally appropriate curriculum, resources, and agency and community supports for new and existing childcare workforce members to better serve infants and young children aged zero through four and their caregivers.
- Review and strengthen policies, procedures, state licensing provisions and quality monitoring of residential treatment for children and youth with behavioral health conditions, including serious emotional disturbance, substance use disorders, and autism.
- Expand funding to support classrooms in educating children, youth, and young adults with different cognitive, physical, and developmental abilities.
- Ensure adequate behavioral health and developmental disability training for school staff, public safety officers, and other additional discipline-related fields.

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DYSLEXIA IN GEORGIA

Dyslexia is a learning disability that affects language skills.[1] Children with dyslexia often struggle with reading, spelling, writing, and speaking words correctly.[2]

Dyslexia is not related to intelligence.[3] Many students have dyslexia but need extra assistance in school.[4]

DYSLEXIA AND GEORGIA'S KIDS

- More than **80,000** Georgia students are diagnosed with a specific learning disorder like dyslexia. [5]
- About **1 in 3** special education students in Georgia have this type of disability. [6]
- Many kids with dyslexia also have attention-deficit/hyperactivity disorder (ADHD) or social challenges. [7]

SOME CHARACTERISTICS OF DYSLEXIA[8]

In Young Children:

- Can't easily rhyme words
- Trouble with letter sounds
- Can't identify first, middle, and last sounds in words
- Struggles to write their own name

When Reading:

- Has trouble sounding out simple words like "cat" or "map"
- Mixes up letters that look alike
- Skips or adds words when reading
- Doesn't understand what they read

When Writing:

- Many spelling errors
- Forgets capitalization and punctuation
- Messy handwriting with poor spacing

GEORGIA LAWS AIMED AT EARLY IDENTIFICATION AND INTERVENTION

Senate Bill 48 (2019) [9]

Georgia's first dyslexia law

- Required schools to screen kindergarteners beginning in 2024
- Helped train teachers about dyslexia

House Bill 307 (2025) [10, 11]

Subsequent legislation to implement additional support

- Develops individualized reading support plans for students who are experiencing difficulties
- Mandates triannual reading assessments
- Ensures parents are informed if their child requires reading support
- Adopts evidence-based instructional methods for teaching reading
- Prohibits the use of ineffective reading strategies

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HOW GEORGIA'S INTERVENTIONS ARE HELPING STUDENTS WITH DYSLEXIA

- Applies clear criteria to determine which students need support
- Conducts early screenings to detect reading difficulties
- Offers tiered levels of support tailored to each student's needs
- Trains teachers to effectively support students with dyslexia

WHAT WE NEED TO DO NEXT

Identify kids with dyslexia before they start preschool

Train new teachers about dyslexia

Use proven reading programs in schools

Train teachers on spotting dyslexia

Assess programmatic success

RECOMMENDATIONS

- Provide training for ALL new teachers through the schools of education, relating to identifying dyslexia/reading problems and knowing how to teach students reading skills.
- Embrace the Cox Campus' "Read Right from the Start" program that provides instruction to existing teachers and educators on how to teach reading.
- Expand early screening by building the expertise of healthcare and other child-serving professionals.

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BABIES CAN'T WAIT

Why is early intervention important?

The brain develops rapidly from birth to age three. **Early intervention during this period can catch developmental delays before they become lifelong challenges.**

What is Babies Can't Wait?

DPH GEORGIA DEPARTMENT OF PUBLIC HEALTH babies can't wait

Babies Can't Wait (BCW) is Georgia's early intervention program available to **children ages zero to three years old with developmental delays and/or certain diagnosed conditions that have a high probability of resulting in delays.**[1] Housed in the Georgia Department of Public Health, Babies Can't Wait (BCW) brings together a team of specialists that deliver early intervention services, connect families to community resources, and offer training and referrals tailored to each child's needs.[2]

Who is served by BCW?

17,538

children were served in federal fiscal year 2023.[3]

An increasing number of children are referred and determined eligible each year.[4]

Demand for early intervention likely exceeds BCW's current capacity to serve children.

What services are available?[5]

- ✓ Evaluations and assessments
- ✓ Family training, counseling, and home visits
- ✓ Occupational therapy
- ✓ Physical therapy
- ✓ Psychological services
- ✓ Respite services
- ✓ Service coordination
- ✓ Special instruction
- ✓ Speech-language therapy
- ✓ Behavioral intervention
- ✓ Autism services

Anyone can refer a child to the program including, but not limited to:[6]

Parents | Childcare Providers | Doctors

Families can receive a free developmental evaluation to determine eligibility for services and supports.[7]

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Funding and Financing

How is the program funded?

Federal funding is provided from the Office of Special Education Programs, Individuals with Disabilities Education Act. Babies Can't Wait also receives state funds, including a recent investment of more than $550k to support the hiring and retention of Service Coordinators and Special Instructors. [8]

Who pays for services? [9]

- Services are first billed to the child's health insurance (Medicaid/private insurance, where applicable, and with parent permission)
- For what isn't covered, a sliding fee is determined, based on income and family size
- BCW serves as a payor of last resort, if needed

What are the steps to receive early intervention services? [10]

1. Referrals can be made by anyone including but not limited to a pediatrician, care provider, or a parent/guardian for assessment. Assessment of children must start within 45 days of referral.

2. Intake is conducted by BCW Service Coordinators (SC) and/or BCW Intake Service Coordinators (ISC) to assess potential delays or diagnoses. Early Intervention Coordinators (EIC) and Service Coordinators ensure that children receive assessments and services in a timely fashion and align with the care plan; they also ensure that timely and complete data is collected.

3. The Individualized Family Services Plan (IFSP) team, which includes parent(s)/guardian(s), service provider(s), Service Coordinator(s), and anyone the family deems necessary, create an IFSP based on the child's needs.

4. Children and families receive services for conditions based on their IFSP up until their 3rd birthday. Services are provided by BCW local agency staff and contracted providers (Physical Therapists, Occupational Therapists, Speech Language Pathologists, Special Instructors, and other BCW contracted providers.)

5. The child's progress is evaluated every six (6) months or as needed based on the needs of the child and the concerns of the IFSP team. BCW Service Coordinators work with providers and families to determine if additional services are recommended.

6. Transition plans can begin when a child is 24 months, but no later than 33 months. BCW Service Coordinators help families develop a plan to determine which next step will support the child's developmental needs after they have exited the BCW program. Options for next steps include preschool intervention programs, Head Start, child care, private therapy services, private preschool, or other community activities such as library story hours or Mommy & Me groups. [11]

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Effectiveness of Babies Can't Wait [12]

- **97.3%** received timely services
- **89.5%** received an initial evaluation, assessment, and initial Individualized Family Services Plan (IFSP) meeting within 45 days
- **96.2%** had IFSP developed with transition steps and services within timeline
- **100%** of Local Education Authorities (LEAs) were notified of a toddler's potential eligibility for Part B within timeline
- **96.2%** had a transition conference conducted within the required timeline
- **95.1%** received services in a home or community setting
- **83.7%** who entered early intervention below age expectations in the use of appropriate behavior to meet their needs substantially increased their behavior growth by age three or time of program exit

Challenges to the Success of the Babies Can't Wait Program

Babies Can't Wait operates in all 18 public health districts. However, contractor shortages, especially in rural areas, limit the program's ability to meet the needs of enrolled children. **Understaffing ultimately results in children/families receiving delayed services or not receiving the recommended services.**

RECOMMENDATIONS TO STRENGTHEN BABIES CAN'T WAIT

- Work closely with local agency staff, stakeholders, and community partners to continue assessing and addressing staff/program recruitment and retention issues.
- Streamline coordination and follow-up coordination/communication between referral source (e.g., physician) and program staff across the state.
- Continue to recruit providers to serve in all districts at numbers that meet the demand for services.
- Continue to offer telehealth as a platform for providing services to parents/caregivers where possible.
- Continue to explore whether there are early intervention services provided by the state which could be billed to Medicaid and/or private insurance (e.g., provider-to-provider consultations to coordinate services). If feasible, this would allow greater flexibility for IDEA Part C grant funds to support case management.

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Babies Can't Wait is a federally regulated program under the Individuals with Disabilities Education Act, specifically, Part C of the law. The program is to be a statewide, coordinated, multidisciplinary interagency system that provides early intervention services for infants and toddlers, and coordinates developmental, educational, and community supports for those children. However, eligibility criteria may vary state to state.

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CHILDHOOD EXPERIENCES AND RESILIENCE

Adverse Childhood Experiences (ACEs) are potentially traumatic events in childhood that can have lasting negative impacts on physical and mental health, academic achievement, and overall well-being. Positive Childhood Experiences (PCEs) can help counteract the effects of ACEs by fostering resilience, which is the ability to recover and thrive despite challenges.

ADVERSE CHILDHOOD EXPERIENCES

Prevalence in Georgia

Data from the Georgia Behavioral Risk Factor Surveillance System (BRFSS) shows **16.4%** of Georgia adults experienced at least 4 of the following ACEs:[1, 2, 3, 4]

- **Abuse**: emotional, physical, sexual
- **Neglect**: physical, emotional
- **Bullying**
- **Community violence**
- **Discrimination**
- **Household challenges**: substance abuse, mental illness, domestic violence
- **Loss**: parental separation, divorce, death
- **Natural disasters**

Impact on Health & Life

ACEs increase the risk of:[5, 6]

- Poor physical and mental health
- Substance abuse
- Depression
- Risky behavior
- Difficulty concentrating or making decisions
- Poor academic achievement
- Employment problems

MITIGATING THE IMPACT OF ACES

Resilience is the ability to recover from challenges and can help reduce the lasting effects of ACEs. Caregivers play a key role in building this resilience by creating safe, supportive environments, and modeling healthy behaviors, such as:

- Model healthy coping and relationships
- Respond with patience and care
- Strengthen social connections
- Meet basic needs
- Understand child development
- Teach social and emotional skills

POSITIVE CHILDHOOD EXPERIENCES

Positive Childhood Experiences (PCEs) help mitigate the harm of abuse and help build resilience. The Healthy Outcomes from Positive Experiences, or HOPE, framework has four building blocks:[7]

- **Relationships:** supportive peers and adults
- **Engagement:** social or civic activities
- **Environment:** safe, equitable, and stable environments, at school and home
- **Opportunities:** play, sports, arts, music

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POLICY RECOMMENDATIONS

These recommendations strengthen protective factors for families and place a strong support system for every child at the core of any policy response to ACEs and toxic stress.

Early Care and Learning

- Create an environment where the effects of toxic stress are buffered with appropriate supports.

Early Intervention

- Increase access to health care and home visiting support, including screening, diagnosis, and intervention.

Parental Health & Education

- Educate parents on building resiliency and protective factors to mitigate adverse experiences.
- Address parental mental and behavioral health to minimize, or even prevent, a child's exposure to traumatic environments.

Afterschool and Summer Learning Programs

- Increase funding and prevalence for quality afterschool and summer learning programs like the Boys and Girls Clubs and YMCAs to increase access and ensure affordability.

Foster Youth Care

- Maximize implementation of the federal Family First Prevention Services Act.
- Develop procedures that enable continuity of behavioral health and primary care while youth are in foster care and after they're transitioning out of the system.

Juvenile Justice and School Discipline

- Train school resources officers and public safety officers who engage with children in child development and trauma awareness.

Workforce and Systems Development

- Train caregivers and child-serving professionals on the effects of trauma and stress on children and youth to ensure they respond appropriately to behaviors and initiate effective interventions.
- Educate professionals on building resiliency and protective factors to mitigate adverse experiences.

Stable Housing

- Improve Georgia's renter protection laws to reduce incidents of unsafe housing and eviction.

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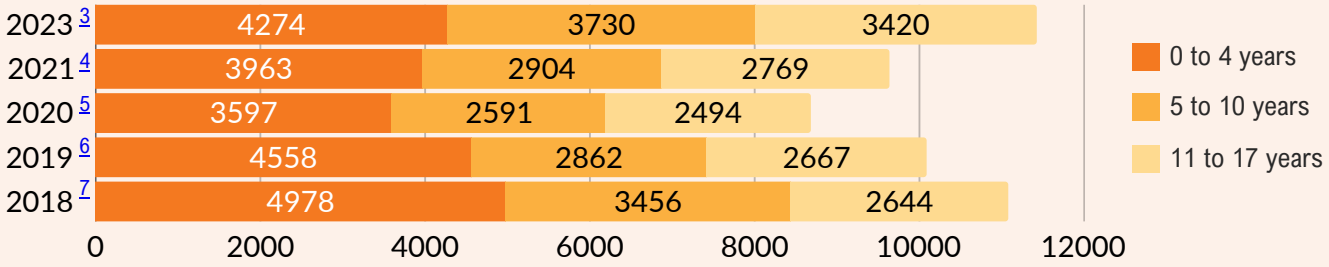
CHILD MALTREATMENT: EFFECTS ON THE BRAIN

Brain development is impacted by both genetics and experiences. As children grow, their brain develop basic functions first (e.g., breathing), before progressing to more sophisticated function (e.g., complex thought).[1]

WHAT IS CHILD MALTREATMENT?

Child maltreatment includes all types of abuse and neglect of a child under the age of 18 by a parent, caregiver, or other person in a child-serving role. There are four common types of abuse: **physical**, **sexual**, **emotional**, and **neglect**.[2]

SUBSTANTIATED CHILD VICTIMS OF MALTREATMENT IN GEORGIA, BY AGE



**2022 data was not published.*

THE IMPACT OF MALTREATMENT[8]

- Triggers lasting fear responses, even without real threats
- Disrupts emotional and stress regulation
- Delays developmental milestones
- Impairs executive functions such as memory, attention, and impulse control
- Reduces responsiveness to positive feedback or rewards
- Makes social interactions more challenging

OTHER FACTORS IMPACTING DEVELOPMENT

Responding to Stress

The timing and intensity of stress shape its impact on the brain:

- **Positive:** brief, moderate challenges that are a normal part of life[9]
- **Tolerable:** more severe, longer-lasting stress that can be managed IF buffered by supportive adults[10]
- **Toxic stress:** strong, frequent, prolonged stress that overwhelms the system and disrupts healthy development[11]

Sensitive Periods

Windows of time in development when certain parts of the brain may be more susceptible to certain experiences (e.g., strong attachments to caregivers formed during infancy)[12]

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POLICY AND PRACTICE RECOMMENDATIONS

- Expand evidence-based afterschool, out-of-school, and summer programs
- Decrease family violence through the adoption and promotion of evidence-based practices and approaches
- Increase access to evidence-based or research-informed programs for parenting skills and support that help parents/caregivers understand all stages of their child's development
- Increase access to family support services in emergency rooms and urgent care facilities
- Promote access and expand comprehensive and specialized supports for families of children with disabilities
- Promote policies that ensure at-risk families receive evidence-based parenting education
- Promote strategies to ensure families can quickly recover from natural disasters and public-health crises
- Promote the development of transition plans for state-placed children and youth (e.g., Department of Juvenile Justice, Division of Family and Children Services), and engage families in the planning process
- Promote, link, and support information and referral systems
- Shape social norms around positive parenting and family help-seeking in times of need (e.g., public awareness campaigns)

*Trauma-induced changes to the brain can result in varying degrees of **cognitive impairment** and **emotional dysregulation** that can lead to a host of problems, including difficulty with attention and focus, learning disabilities, low self-esteem, impaired social skills, and sleep disturbances.*

-Child Welfare Information Gateway, Supporting Brain Development in Traumatized Children and Youth

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FAMILY FIRST PREVENTION SERVICES ACT

The Family First Prevention Services Act (FFPSA) changes the child welfare system by allowing states to use federal funds under Title IV of the Social Security Act to support families and prevent foster care placements. Georgia began phased implementation of FFPSA in Fall 2021[1] and the state's Title IV-E Prevention Plan was approved in October 2022.[2]

FAMILY FIRST SERVICES IN GEORGIA

Evidence-based Programs:[3, 4, 5]

Multisystemic Therapy (MST) and Functional Family Therapy (FFT) are evidence-based treatments that address behaviors of youth at-risk for out-of-home placement

Locations:[6]

MST: Chatham and Richmond counties

FFT: Dekalb and Cherokee counties

Expansion plans:[7]

May 2025: RFP released for Healthy Families America and Parents as Teachers programs

Funding:

All FFPSA services are currently **state-funded** pilot programs (as of August 2025)

EVIDENCE-BASED PROGRAMS INCLUDED IN GEORGIA'S PREVENTION PLAN

Program	Who It Serves	Program Goal
Healthy Families America	Expectant families and families with children up to 2 years of age at risk for abuse, neglect, or other adverse experiences	Strengthen parent-child relationships, promote health development, and enhance family functioning
Parents as Teachers	Expectant families or parents of children up to kindergarten entry (around age 5)	Support positive parenting skills through home visits and evidence-based education
Brief Strategic Family Therapy (BSFT)	Families with children/adolescents (6-17) at risk for problem behaviors such as substance use, bullying, or truancy	Restructure family interactions to reduce risky behaviors and improve family functioning
Multisystemic Therapy (MST)	Youth aged 12-17 with serious emotional or behavioral needs and their families	Reduce criminal behavior and prevent out-of-home placements through intensive family- and community-based treatment
Functional Family Therapy (FFT)	Children aged 11-18 with disruptive or externalizing behaviors, including conduct disorders and substance use	Improve family functioning and reduce problem behaviors through structured family interventions

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FOSTER CARE PREVENTION AND SERVICE PROGRAMS

Who is eligible?[8]

- Children at imminent risk of entering foster care (children who receive ongoing family preservation services)
- Expectant and parenting youth in foster care
- Children/youth post permanency and their caregivers
- Eligibility is **not** dependent on family income

What services and programs are eligible for reimbursement for Title IV-E funds?[9]

- Mental health services
- Substance abuse prevention and treatment services
- In-home parenting programs

How does a state obtain funding for services or program?

- State must maintain a **written** prevention plan for each eligible child and collect data on programs and services administered.
- Services or programs must be trauma-informed and evidence-based.
- Services or programs must be based on promising, supported, or well-supported practices.

Half of the cost of prevention services, training, and related administrative tasks can be covered by Title IV-E funds.

CONGREGATE CARE

FFPSA limits foster care payments for group homes for up to two weeks only. Although FFPSA limits federal reimbursement for foster care maintenance payments for group homes, the limitations do not currently impact the ability to place youth in group homes if it is determined to be the most appropriate placement. [10]

Qualified Residential Treatment Programs (QRTP)* must meet the following requirements: [11]

- Use a trauma-informed treatment model
- Have a registered or licensed nursing and clinical staff onsite
- Facilitate family outreach and participation
- Document family integration into the treatment process
- Provide discharge planning and family-based supports for at least 6 months after discharge
- Meet the treatment needs of children as determined by an assessment within 30 days of placement
- Be licensed and accredited by one of the following:
  - Commission on Accreditation of Rehabilitation Facilities
  - Joint Commission on Accreditation of Healthcare Organizations
  - Council on Accreditation
  - Other nonprofit accrediting organization approved by the Secretary

*Georgia is currently piloting a QRTP model at Murphy-Harpst in Polk County which is completely state funded.[12]

Note: States may be prohibited from claiming federal financial participation for Medicaid services delivered to children while they reside in a QRTP that has more than 16 beds due to the "institution for mental disease" exclusion.[13]

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CROSSOVER YOUTH

A "crossover youth" is a child who is "at risk of or is fluctuating between the child welfare and juvenile justice systems." These youth are also sometimes referred to as "dual-system involved youth."[1]

Just because a child enters the child welfare system does not mean they will become involved in the juvenile justice system. However, long standing research shows that "a history of child abuse, neglect, and child welfare system involvement increases the likelihood of aggression, violence, delinquency, and justice system involvement."[2, 3]

Nationwide, at least half of youth entering the juvenile justice system have a history of child welfare intervention.[4]

HOW DOES A CHILD BECOME A CROSSOVER YOUTH?[5]

	Starting Point		Occurence		Result
PATHWAY 1	Youth has an open child welfare case.	»	Youth is arrested	»	Youth enters the delinquency system.
PATHWAY 2	Youth is arrested.	»	Youth has a previously closed child welfare case.	»	Referral is made to child welfare.
PATHWAY 3	Youth is arrested; no previous contact with child welfare.	»	Upon investigation, maltreatment is discovered.	»	Referral is made to child welfare.
PATHWAY 4	Youth is arrested, adjudicated, and in a correctional placement	»	Time in correctional placement ends, but there is no safe home to return to.	»	Referral is made to child welfare.

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HOW GEORGIA IS SERVING CROSSOVER YOUTH

To effectively serve crossover youth, the child welfare system and the juvenile justice system must collaborate on the delivery of services and assistance to families and limit the amount of time youth spend in out-of-home placements.[6]

Georgia's efforts to service crossover youth include:

- Creating the Children in Need of Services (CHINS) classification and detention alternatives to provide community services and divert youth away from further court involvement.[7]
- Using Local Interagency Planning Teams (LIPTs) and Multi-Agency Treatment for Children (MATCH) to bring together multiple agencies and court staff to address the treatment of youth with complex needs.
- Appointing Court Appointed Special Advocates (CASAs) who are often assigned to more complex juvenile court cases, including crossover youth.[8]
- Implementing provisions from Senate Bill 401 (passed in 2024) which mandates the statewide collection and reporting of dependency case data, which will help with the early identification of crossover youth and track outcomes.

CHALLENGES FACING GEORGIA

While these are important steps for addressing the needs of crossover youth, the lack of a statewide protocol for cross-agency information sharing and limitations on existing databases present opportunities for improvement.

For additional information on Crossover Youth, see Punishment to Potential: A Landscape of Georgia's Juvenile Justice System.

RECOMMENDATIONS

- Mandate better and more consistent identification of crossover youth, and evaluation of integrated systems approaches to improving their outcomes.
- Integrate agency data systems to share robust and timely information and data between the DJJ, individual juvenile courts, and other child-serving agencies to better identify needs, prevention strategies, and outcomes.
- Encourage and enforce cooperation and coordination among the various agencies and courts that administer, oversee, and support the juvenile justice system.
- Create a designated funding stream for LIPTs.
- Expand community-based alternatives by increasing the availability of diversion programs across all counties, developing partnerships with community organizations to provide comprehensive services, and establishing methods to measure the effectiveness of these alternatives.

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SCHOOL SAFETY AND VIOLENCE PREVENTION IN GEORGIA

Ensuring school safety means protecting the physical and mental health of everyone in our schools.[1] This requires teamwork among students, parents, teachers, and law enforcement to prevent violence and support recovery.[2]

GEORGIA'S GROWING SCHOOL SAFETY CRISIS

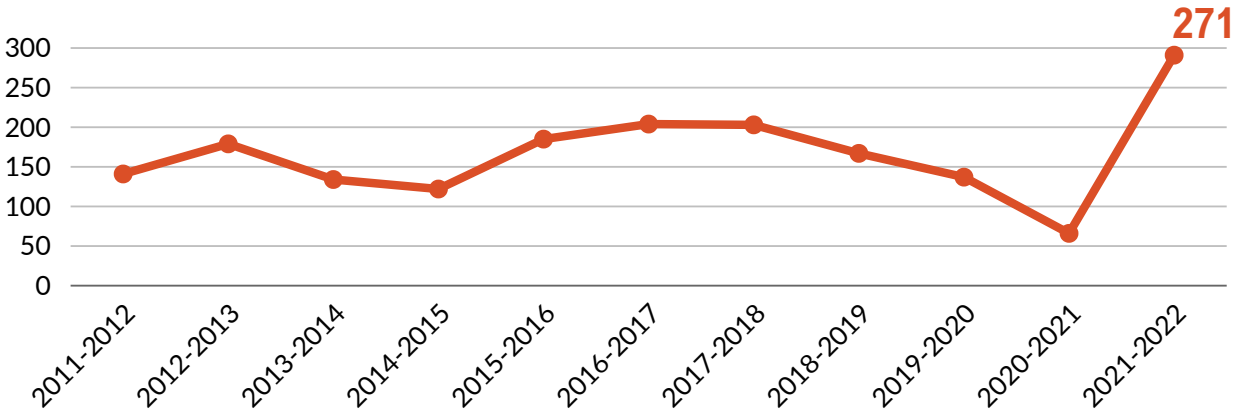
Between 2020-2024, there were

41 school shooting incidents in Georgia.[3]

31 were wounded[4]

8 were killed[5]

The number of students who brought a firearm to school reached a ten-year high in 2021-2022: [6]



WHAT STUDENTS AND PARENTS ARE EXPERIENCING

What Teens Say: [7]

- **54%** say students "fight a lot" at their school
- **85%** feel unsafe at school in the last 30 days
- **20%** say they've been bullied or threatened in the last 30 days
- **24%** do not know an adult at school they could talk to if they need help
- **13%** do not know what to do if there is an emergency at school

What Parents Say: [8]

- **60%** believe schools are less safe than they were 10 years ago
- Only **25%** of parents say they aren't worried about their children's safety at school
- **One-third** of parents reported their child's school had gone into lockdown during the 2024-2025 school year

SCAN BELOW TO SEE FACTSHEET CITATIONS

UNDERSTANDING SCHOOL VIOLENCE

What is it? [9]

 Bullying

 Sexual violence

 School shootings

 Fighting

What causes it?

Research identifies five primary predictors of school violence, ranked by strength and evidence: [10]

1. Delinquent or antisocial behavior: Early patterns of rule-breaking, aggression, or antisocial actions appearing before age 12
2. Behavioral and attention challenges: Untreated or unrecognized difficulties with focus and self-regulation, which can lead to impulsive or risky behavior
3. Child maltreatment: Experiences of abuse or neglect that increase the likelihood of later violent behavior
4. Peer rejection: Social isolation and lack of positive peer connections, which can increase vulnerability
5. Moral disengagement: Separating one's actions from moral standards, allowing harmful behavior to occur without guilt

Impact on Youth

Youth who experience violence tend to have: [11]

- Worse academic and psychosocial outcomes
- Higher rates of behavioral and mental health problems
- Increased likelihood of academic difficulties and future violence
- Higher rates of school absenteeism and dropout

WHAT ISN'T WORKING

Research consistently shows that the following traditional security measures alone have **limited effectiveness** in preventing school violence: [12], [13]

 Security officers and guards

 Excessive security measures that create a prison-like atmosphere

 Metal detectors and similar measures

 Punitive disciplinary approaches that escalate rather than reduce problems

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COMPREHENSIVE PREVENTION STRATEGIES: A BETTER APPROACH

Most school violence is predictable and preventable. Effective prevention requires comprehensive approaches addressing individual, social-contextual, and environmental factors. [14, 15]

Individual Interventions

- Mental health screening with appropriate follow-up
- Targeted support for ADHD and behavioral challenges
- Evidence-based programs addressing antisocial behavior
- Social skills & peer integration initiatives
- Moral reasoning and ethnical decision-making curriculum

Social-Contextual Interventions

- Family-focused prevention strategies like the Strengthening Families Program
- Peer-based interventions including mediation and bystander training
- Community partnerships with comprehensive violence prevention approaches
- Coordinated care systems between schools and community providers

School Environment Strategies

- Comprehensive school climate assessment and improvement
- Focus on fostering positive student-teacher relationships
- Evidence-based threat assessment protocols
- Safe reporting mechanisms for students
- Alternatives to traditional security measures
- Restorative justice practices that repair harm while maintaining accountability
- Trauma-informed approaches throughout the school

GEORGIA'S CURRENT SCHOOL SAFETY INITIATIVES

Georgia has implemented several school safety initiatives, including: [16]

- **School Safety Plans:** required for all schools to address responses to violence and emergencies
- **School Safety Hotline:** anonymous reporting system for unsafe situations
- **Center for School Safety:** online clearinghouse for resources and training
- **School Climate Star Rating:** 1-5 star rating system to assess school climate
- **K-12 Student Discipline Dashboard:** discipline data racking system
- **Georgia Tiered-System of Supports for Students:** evidence-based interventions and screenings
- **School Social Work:** professionals trained to address barriers to learning
- **Georgia School Climate Survey:** anonymous survey to identify safety issues

While these initiatives provide a foundation, implementation challenges remain, as evidenced by the 13% of Georgia students who report not knowing what to do during a school emergency.[17]

For a complete list of Georgia's School Safety efforts, see https://www.gadoe.org/wholechild/Pages/default.aspx

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POLICY RECOMMENDATIONS

For Policymakers:

- Build support for comprehensive school safety legislation requiring evidence-based components in safety plans
- Expand dedicated school mental health funding streams (including Georgia Apex program, Project AWARE, and Mental Health First Aid Training)
- Develop improved cross-agency information sharing protocols
- Fund adequate staffing levels for school-employed mental health professionals (counselors, psychologists, social workers)
- Develop improved cross-agency information sharing protocols

For School Districts:

- Shift resources from physical security to relationship-based approaches
- Implement evidence-based prevention curricula at all grade levels
- Provide school safety and trauma-informed training for all grade levels
- Ensure appropriate school mental health professional to student ratios
- Utilize school health and discipline data to address school climate and ensure that policies are clear and consistently applied
- Establish school-community violence prevention coalitions
- Create family resource centers in high-need communities

For Community Partners

- Support school-based mental health services expansion to provide access to mental health supports for all students
- Implement/strengthen community-based mentoring program
- Create safe storage campaigns for firearms with free lock distribution
- Develop coordinated care systems between schools and community providers

MOVING FORWARD TOGETHER

The safety of Georgia's students requires a unified approach that moves beyond reactive security measures to address the root causes of violence. By implementing evidence-based prevention strategies across individual, social, and environmental domains, Georgia can create truly secure schools where students can focus on learning rather than fear.

Our children deserve comprehensive safety approaches that protect both their physical and psychological well-being. The time for action is now.

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FAMILY VIOLENCE IN GEORGIA

In Georgia, family violence is considered abuse or neglect that a child or adult experiences from a family member, or from someone with whom they have an intimate relationship.

THE SCOPE OF THE PROBLEM IN GEORGIA

The statistics paint a sobering picture of family violence in the state.

4 in 10
women face partner violence at some point in their life[1]

3 in 10
men face partner violence at some point in their life[2]

110,000
crisis calls were made to help centers in 2024[3]

42,000+
family violence cases were reported in 2024[4]

8 out of 10
of deadly family violence cases involved a firearm[5]

27,000+
children received help from family violence programs in recent years[6]

159
adults and children were killed by domestic violence in 2024[7]

4,000+
people were unable to get space in a shelter when they needed it[8]

HOW FAMILY VIOLENCE HURTS PEOPLE[9]

Physically

- Injuries
- Broken bones
- Lasting health problems

Mentally

- Sleep problems
- Eating changes
- Depression
- Anxiety
- Thoughts of suicide
- Drug or alcohol use

Emotionally

- Hopelessness
- Low self-worth
- Trust issues

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BARRIERS TO SAFETY, STABILITY, AND JUSTICE [10]

For People Seeking Help:

No affordable housing

Fear of more violence

Shame and blame from others

Hard to find and use services

Gaps in Helping Services:

Not enough shelter space

Few low-cost housing options

Services don't fit all cultures or languages

Not enough mental health help

Less help in rural areas

Problems with the Legal System:

Different courts make different rules

Hard to prove what happened

Hard to enforce protection orders

Court process can cause more trauma

HOW FAMILY VIOLENCE IMPACTS CHILDREN [11]

Children who witness or experience violence can suffer long-term emotional and psychological harm. They need support from professionals trained to address their unique needs and should remain connected to their safe, supportive parent whenever possible. Schools can play a critical role by offering a safe environment where children can access help and begin to heal.

5 WAYS TO HELP [12]

1. **More money** for shelters, housing, and treatment.
2. **Teach about healthy relationships** starting in early childhood.
3. **Spread the word** about family violence and where to get help
4. **Better training** for all workers who help families in crisis.
5. **Better teamwork** between all agencies that help families.

STOPPING THE CYCLE [13]

Family violence often happens because of money problems, mental health issues, substance abuse, family, and community beliefs that make violence seem normal or make people afraid to ask for help.

To prevent family violence, we need early education, public awareness, community leaders speaking up, and better support for families in need.

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HOMELESSNESS AND CHILDREN IN GEORGIA

In Georgia, someone is considered homeless if they don't have access—or are not expected to have access—to safe, clean, and affordable long-term housing.[1] This includes people staying in places not meant for living, like cars or abandoned buildings, or those staying in temporary shelters.

HOW MANY CHILDREN EXPERIENCE HOMELESSNESS?

Infants and Toddlers:

13,691 children under age 3 were estimated to experience homelessness in 2022-2023, with approximately 461 served in an early childhood development program [2]

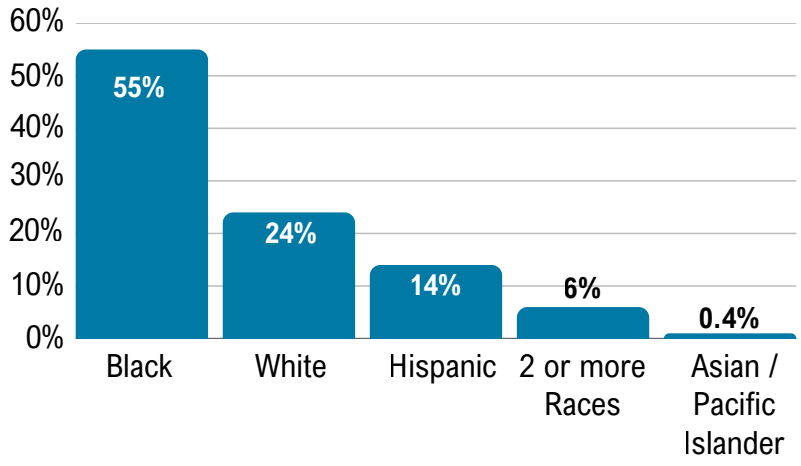
Pre-k through 12th Grade:

40,136 students identified as experiencing homelessness in the 2022-2023 school year [3]

WHERE ARE UNSTABLY HOUSED CHILDREN LIVING (PRE-K THROUGH 12TH GRADE)?[4]

- **70%** reported as being doubled up, i.e., staying with extended family or friends
- **22%** reported staying in extended stay hotels/motels
- **5%** reported staying in a shelter
- **2%** reported being unsheltered

WHO IS HOMELESS IN GEORGIA? [5]



Homeless Students, by Race and Ethnicity

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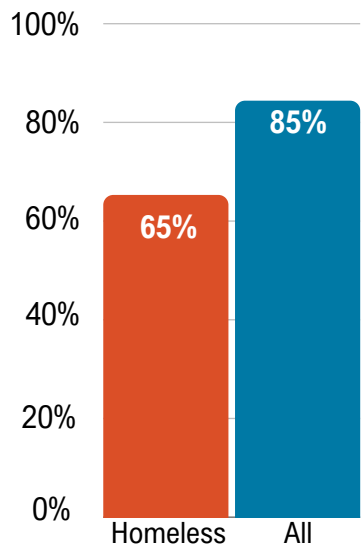
IMPACT OF CHILD AND YOUTH HOMELESSNESS ON EDUCATION

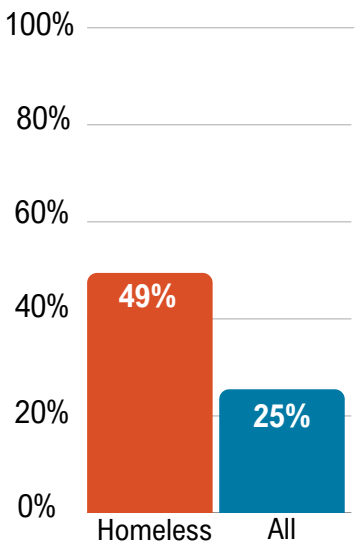
Students experiencing homelessness are more likely to: [6]

- be suspended
- miss school
- have poor academic performance
- drop out of school

High School Graduation Rate [7]



Chronic Absentee Rate [8]



RISK FACTORS FOR CHILD AND YOUTH HOMELESSNESS: [9, 10, 11]

- Family conflict/abuse/substance use
- Race (Black and Hispanic youth have a higher risk than their peers)
- LGBTQ+
- Youth pregnancy/ young parents
- Youth who do not complete high school
- Poverty/housing instability
- Involvement with foster care or juvenile justice systems, including transition-aged youth

HOUSING INSECURITY IN GEORGIA

Housing insecurity directly impacts children. According to the U.S. Census Household Pulse Survey taken at the end of October 2024, **21%** of adults in Georgia households with children say that they are likely to be evicted from their house in the next two months [12]

In Georgia, **2,728** people in families with children and **578** unaccompanied youth were counted as homeless in a 2024 Housing and Urban Development point in time survey. [13]

In FY23, approximately 19% of foster care placements cite inadequate housing as a reason for removal of a child from the home. [14]

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MCKINNEY-VENTO HOMELESS ASSISTANCE ACT

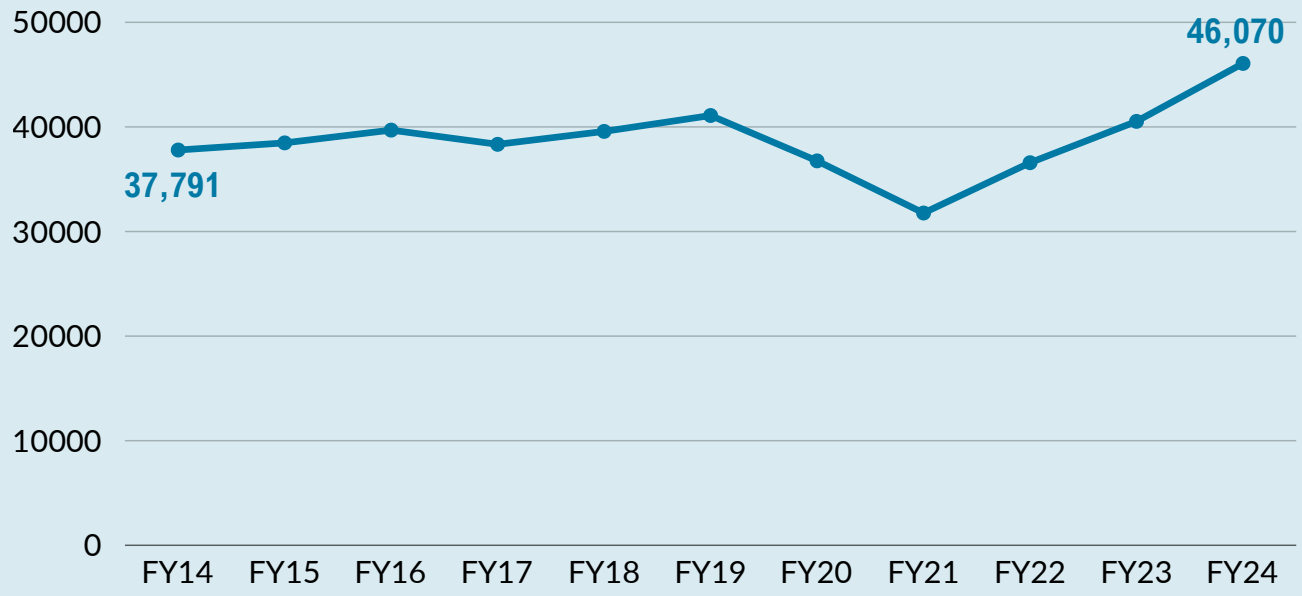
As the primary piece of federal legislation focused on **addressing the needs of homeless people in the United States**, the McKinney-Vento Homeless Assistance Act's definition of "homeless children and youth" means children and youth who lack a fixed, regular, and adequate nighttime residence, including those who are:[15]

- sharing the housing of others due to loss of housing, economic hardship, or a similar reason;
- staying in motels, trailer parks, or camp grounds due to the lack of an adequate alternative;
- staying in shelters or transitional housing; or,
- sleeping in cars, parks, abandoned buildings, substandard housing, or similar settings.

McKinney-Vento Education for Homeless Children and Youth Program

The section of the McKinney-Vento Homeless Assistance Act dealing with **problems faced by homeless youth with enrolling, attending, and succeeding in school.** The program requires state education agencies ensure each homeless child has equal access to the same free and appropriate public education as their peers.

McKinney-Vento Count of Homeless Students in Georgia [16]



In FY25, the Georgia Department of Education subgranted more than $3 million for homelessness initiatives in 51 school districts. [17]

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POLICY RECOMMENDATIONS

- Increase the availability and fair distribution of quality and affordable housing, and support policies, including expanding the definition of housing instability and providing rent and mortgage subsidies, to protect families and children from unsafe housing, hardship or baseless evictions, and untenable fees and penalties.
- Evaluate the effectiveness of the Family Unification Program (FUP) vouchers for families whose lack of adequate housing is the primary factor for removal of children or is delaying the reunification of children currently in foster care.
- Support policies that facilitate housing opportunities for people with past evictions, criminal histories, and mental or behavioral health conditions.
- Increase local school system (via the Regional Education Service Agencies (RESAs)) outreach to expand funding for McKinney-Vento Education for Homeless Children and Youth programs.
- Develop clear guidelines to better help youth who have matriculated out of or who have aged out of K-12 education and who are experiencing or have experienced homelessness.
- Create and fund community-based resources, such as drop-in centers and job-training, to prevent youth who age out of foster care and unaccompanied youth from becoming homeless.

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CHILD SEXUAL ABUSE

Child sexual abuse is the exploitation of a child for the sexual gratification of an adult or caregiver. Sexual abuse includes both touching and non-touching offenses.[1]

PREVALENCE OF SEXUAL ABUSE OF CHILDREN

Child sexual abuse is often underreported.[2] As such, the following data points likely underestimate the frequency of sexual abuse.

1 in 4 girls experience sexual abuse.[3]

1 in 20 boys experience sexual abuse.[4]

Of the children removed from their home in 2024,* **6%** were removed for reasons of sexual abuse.[5]

*A child may be removed for more than one reason.

TYPES OF OFFENSES

Touching Offenses:

- Fondling
- Sodomy
- Rape
- Intercourse
- Masterbation

Non-touching Offenses:

- Child pornography
- Indecent exposure

WHO ARE THE VICTIMS?

90% of children know their abuser.[6]

Certain groups of children and youth are more at risk of being sexually abused:[7, 8, 9]

Females

LGTBQ+ youth

Youth with physical, emotional, or cognitive disabilities

Children living in single parent households

Children who have been sexually abused are more likely to:[10, 11, 12]

- Show physical aggression
- Experience behavioral health problems
- Attempt suicide
- Engage in delinquent behavior
- Abuse alcohol or other drugs
- Become pregnant

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WHO ARE THE PERPETRATORS?

Among child victims of sexual abuse, more than **half** are abused by family members.[13]

People who sexually abuse children look just like everyone else. Abusers can be neighbors, religious leaders, teachers, family members, or anyone who interacts with children. Child sexual abuse frequently goes unreported, as many victims DO NOT tell an adult about what happened. Children may feel guilty or responsible for the abuse, worry they will not be believed, and are concerned about how it will affect their relationships with their families and how they are perceived by their peers. [14]

DID YOU KNOW?

- LGTBQ individuals are **not** more likely to sexually abuse children than someone who is heterosexual.[15]
- Although men are consistently shown to commit the majority of child sexual abuse, **women are also abusers**.[16]
- In 2018, Georgia **mandated** age-appropriate sexual abuse and assault awareness education for all students K-9th grade.[17]
- Georgia's Child Sexual Abuse and Exploitation Prevention **Technical Assistance Resource Guide (TARG)** outlines sexual abuse prevention strategies. [18]

LABELING YOUTH AS SEXUAL PREDATORS

- Juveniles represent **one-fourth** of all sex offenders and **one-third** of known offenders against other juveniles. [19]
- **40% to 80%** of juvenile sex offenders have themselves been victims of sexual abuse. These children are often responding to their own trauma. [20]
- Juvenile sex offenders are unlikely to commit another sex offense later in life. [21] Studies universally confirm that juvenile sex offense recidivism is relatively low with an estimated rate of 7%.[22]

HOW CAN I HELP?

- Encourage community members to learn how they can prevent child sexual abuse. Learn more at GeorgiaCenterForChildAdvocacy.org.
- Educate adults, youth, and children about the harm caused by treating others as sexual objects.
- Develop relationships with your local state and federal representatives, and educate them about sexual abuse and exploitation.

If you suspect that a child is being abused, call the Division of Family and Children Services at 1-855-GACHILD immediately to report your concerns.

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CHILDHOOD LEAD POISONING

Even small amounts of lead can permanently harm a child's brain development. In 2024, 116,227 of Georgia's children were screened for lead. Of those, 3,450 children had lead levels measuring 3.5 µg/dL or more.[1]

WHAT IS LEAD EXPOSURE AND POISONING?

Lead exposure happens when a child swallows or breathes in lead or lead dust.[2] Once inside the body, lead quickly enters the bloodstream. There is no safe amount of lead in a child's blood.

Lead poisoning is defined as 3.5 µg/dL (micrograms per deciliter).[3]

WHAT HAPPENS WHEN CHILDREN ARE EXPOSED TO LEAD?

Children's bodies absorb lead more easily, affecting the brain and other physical development in organs and the nervous system.[4] Children under age 6 are at the greatest risk of lead poisoning.[5] Even low levels of lead can result in: [6]

- Speech, language, and behavior problems
- Learning disabilities and Attention-Deficit/Hyperactivity Disorder (ADHD)
- Lower IQ
- Nervous system damage

Exposure to elevated blood lead levels can cause serious health problems, including seizures, coma, intellectual and developmental disabilities, and even death. Treatment is costly and can worsen existing health conditions.[7] Prenatal exposure increases the risk of miscarriage, premature birth, and can cause lasting damage to a baby's brain, kidneys, and nervous system.[8]

THE SCOPE OF THE PROBLEM IN GEORGIA

Of Georgia's 159 counties, **16** were identified as locations where children may have a higher risk of being exposed to lead: Bibb, Chatham, Clayton, Cobb, Colquitt, DeKalb, Dougherty, Floyd, Fulton, Gwinnett, Hall Houston, Laurens, Muscogee, Richmond, and Troup.[9]

According to 2021 Georgia Department of Public Health (DPH) data, childhood lead poisoning is more prevalent in Asian, Black, and Multiracial children than White children.[10]

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WHERE IS LEAD FOUND?

Water
Drinking water can be contaminated when it passes through older lead pipes, newer brass pipes, or copper pipes that are joined with lead solder.[11]

Soil
Lead-based exterior paint flakes can pollute yards, playgrounds, industrial sources, or other sites. Lead is naturally occurring and can be found in high concentrations in some areas.[12]

Toys and Other Items
May be present in those imported from other countries.[13]

Paint
Older dwellings (those built prior to 1978) are more likely to contain lead-based paint. The use of lead in residential paints was banned in 1978.[14]

Herbal or Folk Remedies
Greta, azarcon, and other traditional medicines from India, China, Bhutan, and others can contain lead.[15]

Small Metal Objects
Can be swallowed by children.[16]

PROGRESS FOR GEORGIA'S KIDS

In 2022, Georgia signed into law stronger protections for children who may be exposed to lead.[17, 18] The legislation supports GaDPH in:

- hiring additional lead inspectors statewide to investigate cases of lead exposure;
- educating families on exposure reduction; and,
- engaging with property owners to reduce and eliminate lead sources.

The Clean Water for Georgia Kids Program supports schools and early care and education (ECE) programs through testing, communications, and providing low-cost recommendations on how to remove lead from drinking and cooking water. The program is funded by the Environmental Protection Agency and is free to participants.

PROTECTING YOUR FAMILY FROM LEAD POISONING

- ☑ Have your child tested
- ☑ Clean regularly
- ☑ Test your water
- ☑ Check your home for hazards
- ☑ Remove shoes or wipe off soil before entering the house

POLICY RECOMMENDATIONS

- Secure funding to support early childhood education (ECE) programs in removing and replacing lead pipes, fixtures, and other sources of contamination.
- Update Georgia law to require blood lead level monitoring and mitigation for women of childbearing age and for children under six. *(DPH)*
- Create a multi-year plan for testing and removing lead in drinking water and built environments at schools, childcare centers, and other places where children spend time.* Explore federal, state, and private funding options to cover costs.
- Expand partnerships to increase the number of sites offering blood lead testing (e.g., clinics, labs, and other points of care). *(DPH)*
- Work with Care Management Organizations (CMOs) to increase well-child visits and ensure required Medicaid lead screenings are completed.** Confirm that Medicaid/DCH is accurately monitoring and reporting these screenings. *(DCH)*
- Investigate and address environments where children have blood lead levels at or above the CDC action level, with a priority on children under age three. *(DPH, GEPD)*

*Consider leveraging the Georgia Lead Poisoning Prevention Act of 1994 to develop lead testing and mitigation strategies for drinking water.[19]

**Medicaid (federal) requires that every state provides at least 80% of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) recipients with timely medical screenings, including lead screening for under age 6.[20] Federal data show that from 2015 to 2019, Medicaid lead screening rates steadily declined in Georgia (from approximately 108,000 to 96,000 for ages 0-6.[21] Note: Medicaid reported that this data was incorrectly reported so numbers will vary.

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SWIMMING POOL SAFETY

Drowning is the seventh leading cause of death for children ages birth to 17 years old in Georgia.[1] In 2024, 31 children in that age group drowned,[2] and there were 161 emergency room visit for drowning and submersion.[3]

WATER-RELATED INJURIES IN THE U.S.

While the biggest threat to children around unexpected, unsupervised access to water is drowning, every year thousands of children are treated in the emergency room for non-fatal water-related injuries.[4]

Estimated Number of Emergency Room-Treated Non-fatal Pool or Spa Injuries, 2022-2024 [5]

	Younger than 5	5-14 years	Total <15 years
Average	**4,600**	**1,700**	**6,300**
2024	4,300	1,900	6,200
2023	4,900	1,300	6,200
2022	4,500	1,900	6,400

Source: U.S. Consumer Product Safety Commission: National Electronic Injury Surveillance System

Most drownings of children ages 1 to 4 happen in swimming pools.

SWIMMING POOL RULES AND REGULATIONS

The Georgia Department of Public Health (DPH) is responsible for ensuring public swimming pools are clean, healthy, and safe. In addition to **adult supervision**, there are laws in place regarding fencing, pool drains, and clean water that are critical to pool safety.

Public Pool Barriers[6]

- All outdoor swimming pools and spas must be enclosed by a barrier (e.g., fence, safety cover, wall, building wall, or a combination) that prevents entry to the pool area when the pool is closed.
- Top of the barrier should be at least 4 feet high.
- Pedestrian access gates should be self-closing and self-latching; other gates should have a self-latching device.

Public Pool Drains[7]

- All pools must have at least two main drain suction outlets.
- Suction outlets must have a cover that has been tested by a nationally recognized testing laboratory and comply with the current standards.
- The main drain must be visible through the water from the pool edge.
- All drain covers and grates must meet appropriate standards.

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WHY ARE POOL INSPECTIONS IMPORTANT?

Germs that cause water illnesses can be spread in recreational settings when swallowing water that has been contaminated with **fecal matter**.[8]

Because of this, children under 4 years of age, and those not toilet-trained, are required to wear a swim diaper in a public swimming pool.[9] **HOWEVER IT IS IMPORTANT TO KNOW:** Swim diapers are not leak proof. Diarrhea-causing germs may be delayed from leaking into the water for a few minutes, but these germs still contaminate the water.[10] Appropriate levels of disinfectants kill most germs within minutes, but some can survive for days.[11]

Germ [12]	Symptoms Can Include:	Time It Takes to Kill or Inactive Germs in Chlorinated Water[17]
E.coli O157:H7 Bacterium	Watery or bloody diarrhea, fever, abdominal cramps, nausea, vomiting[13]	Less than 1 minute
Hepatitis A virus	Fever, dark urine or clay-colored stools, diarrhea, feeling tired, abdominal pain, loss of appetite, jaundice[14]	About 16 minutes
Giardia parasite	Diarrhea, gas, greasy stools that tend to float, stomach or abdominal cramps, upset stomach or nausea/vomiting, dehydration (loss of fluids)[15]	About 45 minutes
Crypto parasite	Watery diarrhea, stomach cramps or pain, dehydration, nausea, vomiting, fever, weight loss [16]	About 10.6 days

*1 part per million (ppm) free chlorine at pH 7.5 or less and a temperature of 77°F (25°C) or higher. Source: CDC

SWIMMING POOLS IN GEORGIA

To ensure minimum standards are met, DPH regularly inspects public swimming pools. Public swimming pools must have: [18]

- A clearly labeled emergency shut-off valve
- A trained operator perform a minimum of two weekly visits and document conditions
- Regular collection of water samples to test

DPH'S 7 PREVENTION STEPS FOR HEALTHY AND SAFE SWIMMING

- Closely supervise children in the water
- Don't swim when you have diarrhea
- Shower before you enter the pool
- Don't swallow the water you swim in
- Don't urinate in the water and always report fecal matter
- Don't swim if pool drain covers are missing, broke, or can't clearly be seen
- Report hazards to your local health department or environmental health office

SCAN BELOW TO SEE FACTSHEET CITATIONS

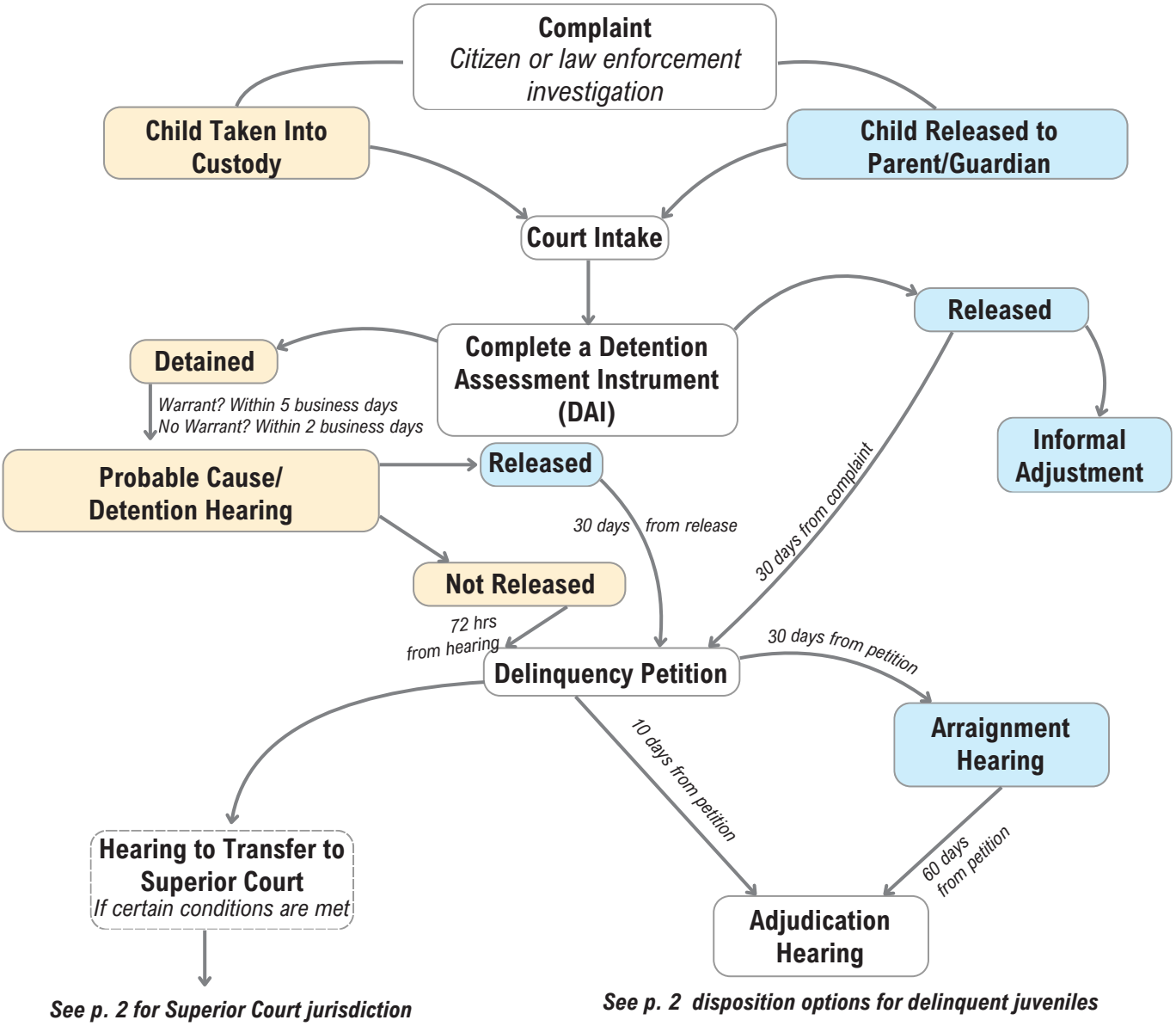
A GUIDE TO DELINQUENCY IN GEORGIA'S JUVENILE JUSTICE PROCESS

A child may come in contact with the juvenile justice system through a delinquency, dependency, or a Child in Need of Services (CHINS) complaint.

Who is considered a juvenile in Georgia's court system?

Georgia classifies youth as juveniles if they are under the age of 17 when they commit an offense. **It is one of five states that processes all 17-year-olds as adults.***

HOW THE DELINQUENCY PROCESS WORKS



See p. 2 for Superior Court jurisdiction

See p. 2 disposition options for delinquent juveniles

Key: Judicial Procedure | In DJJ custody | In parent's custody | Superior Court

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If Transferred to Superior Court	If Adjudicated "Not Dependent"	If Adjudicated "Dependent"***
Superior Court	**Disposition Hearing**	**Disposition Hearing**
Superior Court has jurisdiction over a child if indicted in Superior Court or transferred from Juvenile Court. *Prior to indictment, the district attorney can decline prosecution in Superior Court and cause the petition to be filed in juvenile court.* **Superior Court has jurisdiction over juveniles charged with the following felonies:** • **Murder (1st and 2nd degree)** • **Rape** • **Armed Robbery with a firearm** • **Aggravated child molestation** • **Aggravated sodomy** • **Aggravated sexual battery** • **Aggravated assault upon a public safety officer with a firearm** • **Aggravated battery upon a public safety officer** • **Voluntary manslaughter** • **Terroristic Act Upon a School**	**Disposition Options** *A judge can order a combination of these options.* • **Placement in facility:** Judge may place child in an institution, camp, or other facility operated under the direction of the court or other local public authority only if such child was adjudicated for a felony or a misdemeanor with a prior felony at at three prior adjudications • **Commitment to DJJ**:** for up to 2 years, DJJ has discretion on placement, but youth are typically placed in YDC • **Probation**:** child remains with parent/guardian at home. Probation officer is assigned to supervise while in the community. • **Other:** mandatory school attendance or completion, community service, counseling, suspension or prohibit issuance of driver's license, or treatment/rehabilitation	**Placed in DFCS Custody** *Dependent child may also be subject to delinquency disposition options.* When a child is adjudicated as a dependent child and placed in DFCS custody: 1. The court must conduct a preliminary protective hearing within 72 hours; 2. All parties to the delinquency case must provide certain documents in their custody relating to the child/parent/guardian to DFCS; and 3. Court shall order the production to DFCS of any assessment, evaluation, or report not in the possession of the parties. See OCGA § 15-11-6(13) for Permanency Planning for Delinquent and Dependent Children

* More information: Raising the Age in Georgia factsheet

** In any case in which DJJ or a county operated probation office believes a child to be dependent, it shall make a report to the Statewide Child Protective Services Communication Center and notify the DFCS office in the disposition county.

SCAN BELOW TO SEE FACTSHEET CITATIONS

TERMS TO KNOW

Adjudication Hearing: Fact-finding proceeding to determine whether the facts alleged in the petition or other pleadings are true. This is the juvenile court equivalent to a trial in civil cases. Standard of proof is beyond a reasonable doubt. (GA Code § 15-11-181; GA Code § 15-11-441; GA Code § 15-11-582)

Community-based risk reduction program: Programming designed to identify children and families at risk of future court-involvement for the purpose of developing and implementing intervention actions or plans and providing services and resources. (GA Code § 15-11-38)

Dependency Petition: A legal document that alleges that a child is abused, neglected, or abandoned which may be filed by the Division of Family and Children Services, a child's guardian ad litem, or any other person who has knowledge of the facts alleged. (GA Code § 15-11-3(5))

Detention Assessment Instrument (DAI): A standardized and validated tool, required prior to detention, that measures the youth's risk to reoffend and risk to flee before court proceedings occur. The DAI was implemented in 2000 to provide greater structure and consistency, focus the use of detention resources on high risk youth, reduce inappropriate detention by identifying youth who can be safely released, and establish a basis for DJJ to monitor detention assessment operations. The DAI is completed by DJJ or court intake staff at the time a youth is arrested or picked up by law enforcement. (GA Code § 15-11-505)

Disposition Hearing: Proceeding to determine which placement is best suited to the protection and physical, mental, and moral welfare of a child adjudicated dependent, delinquent, or "child in need of services". In Delinquency and CHINS cases, the disposition proceeding will also determine if the child is in need of treatment, rehabilitation, or supervision and may include community service and/or restitution. (GA Code § 15-11-210; GA Code § 15-11-600; GA Code § 15-11-442)

Guardian ad Litem: Officer of the court who is appointed to represent the best interest of the child in abuse and neglect proceedings, custody proceedings, and sometimes in delinquency or unruly proceedings. May be an attorney or layperson. Often referred to as "G.A.L." (GA Code § 15-11-2(35))

Informal Adjustment: An informal adjustment is the disposition of a case other than by formal adjudication and disposition. (GA Code § 15-11-2(39)) It often involves referral to a community-based risk reduction program.

Juvenile Justice Reform Act of 2013: A comprehensive update to Georgia's juvenile justice statute, which resulted in improved responses to young offenders. This data-driven approach has reduced recidivism, saved taxpayer dollars, improved public safety, and helped misbehaving youth get back on track to success.

Post-Disposition: Treatment that is received after the case has been disposed.

SCAN BELOW TO SEE FACTSHEET CITATIONS

TERMS TO KNOW, CONTINUED

Predisposition Investigation: A predisposition investigation, or PDI, is ordered by the court to obtain more information from a youth and family in order to determine what services or assistance is needed to help a youth move forward and stay out of the juvenile justice system. (GA Code § 15-11-590) During this time, a Guardian ad Litem may be appointed to represent the best interest of the child.

Probation: Probation is a court-ordered supervision program for young people who have committed a delinquent or CHINS act. Instead of being sent to a locked facility, the juvenile is allowed to stay at home under the supervision of a probation officer, but must follow specific rules set by the court. (GA Code § 15-11-601)

Regional Youth Detention Center (RYDC): Regional Youth Detention Centers provide temporary, secure care and supervision to youth who have been charged with offenses or who have been adjudicated delinquent and are awaiting placement. In addition, youth who have been committed to the custody of DJJ are sometimes placed in an RYDC while awaiting treatment in a community program or a long-term facility

Transfer Hearing: A hearing in juvenile court to determine whether jurisdiction over a juvenile case should remain in juvenile court or be transferred to adult court. In Georgia, these are commonly referred to as "440 cases" which encompass the most serious offenses such as murder, rape, aggravated assault, etc. (GA Code § 15-11-561)

Youth Development Campus (YDC): A Youth Development Campus provides secure care, supervision and treatment services to youth who have been committed to Department of Juvenile Justice custody for short- and long-term programs. Every YDC provides education, vocational programming, health and mental health treatment, food services, resident counseling, substance abuse treatment/ counseling, and family visitation.

SCAN BELOW TO SEE FACTSHEET CITATIONS

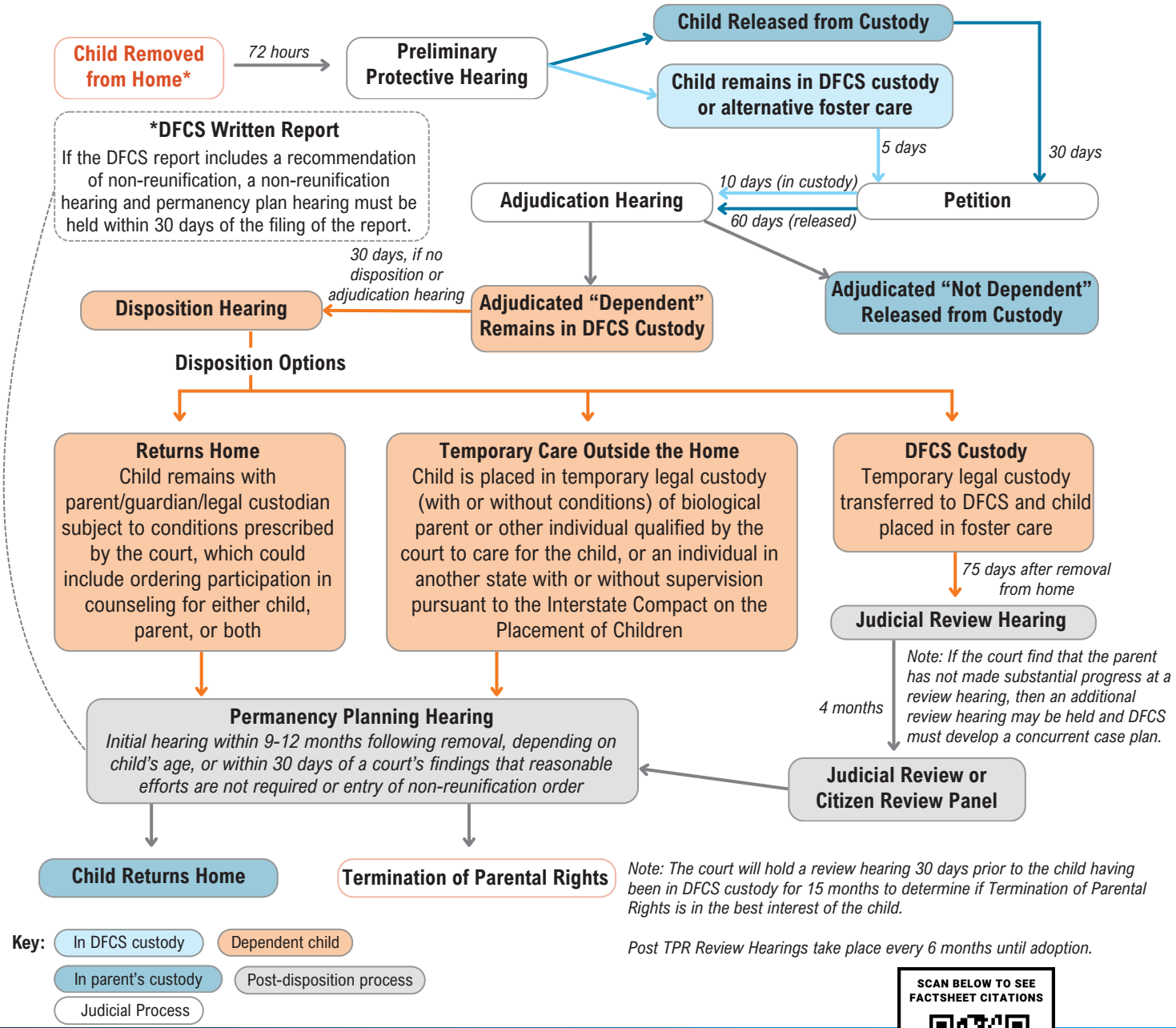
A GUIDE TO DEPENDENCY IN GEORGIA'S JUVENILE JUSTICE PROCESS

A child may come in contact with the juvenile justice system through a delinquency, dependency, or a Child in Need of Services (CHINS) complaint.

WHO IS CONSIDERED A DEPENDENT?

A dependent child is one whose physical or mental health and welfare is substantially at risk of harm from abuse, neglect, or exploitation, and who may be further threatened by the conduct of others, such as a parent, caregiver, or other person inside the home. (GA Code § 15-11-100)

HOW THE PROCESS WORKS: A DEPENDENT CHILD IN DFCS CUSTODY



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TERMS TO KNOW

Adjudication Hearing: Fact-finding proceeding to determine whether the facts alleged in the petition or other pleadings are true. This is the juvenile court equivalent to a trial in civil cases. Standard of proof in delinquency is beyond a reasonable doubt. (OCGA § 15-11-181; GA Code § 15-11-441; GA Code § 15-11-582)

Dependency Petition: A legal document that alleges that a child is abused, neglected, or abandoned. A Dependency Petition can be filed by DFCS, a guardian ad litem, or any other person who has knowledge of the facts alleged. (GA Code § 15-11-150)

DFCS Written Report: Within 30 days from the date that the child is removed from the home, DFCS must submit a written report which includes details of the reasons for removal, the reunification plan, and the reasons for non-reunification (GA Code § 15-11-200)

Disposition Hearing: Proceeding to determine which placement is best suited to the protection and physical, mental, and moral welfare of a child adjudicated dependent, delinquent, or "child in need of services". In Delinquency and CHINS cases, the disposition proceeding will also determine if the child is in need of treatment, rehabilitation, or supervision and may include community service and/or restitution. (GA Code § 15-11-210; GA Code § 15-11-600; GA Code § 15-11-442)

Guardian ad Litem: for an alleged dependent child's best interest throughout the dependency process. The Guardian ad Litem attends all court hearings and provides written reports to the court and the parties, including recommendations regarding the placement of such child. (GA Code §§ 15-11-104 - 15-11-105)

Judicial Review Hearing: Within 75 days of a child being adjudicated as a dependent child, the court shall hold a review hearing to determine:

1. Whether a child adjudicated as a dependent child continues to be a dependent child;
2. Whether the existing case plan is still the best case plan for such child;
3. The extend of compliance with the case plan by all participants;
4. The appropriateness of any recommended changes to such child's placement;
5. Whether appropriate progress is being made on the permanency plan;
6. Whether all legally required services are being provided to a child adjudicated as a dependent child, his or her foster parents if there are foster parents, and his or her parent, guardian, or legal custodian;
7. Whether visitation is appropriate and, if so, approve and establish a reasonable visitation schedule;
8. Whether, for a child adjudicated as a dependent child who is 14 years of age or older, the services needed to assist such child to make a transition from foster care to independent living are being provided; and,
9. Whether reasonable efforts continue to be made to prevent or eliminate the necessity of such child's removal from his or her home and to reunify the family after removal of a child adjudicated as a dependent child, unless reasonable efforts were not required. (GA Code §15-11-216)

Permanency Planning Hearing: Proceeding to determine permanent goal/plan for child. Subsequent permanency planning hearings are held every 6 months.

Preliminary Protective Hearing: If a child is removed from the home, the court shall hold a preliminary protective hearing within 72 hours of removal to determine whether or not the child will remain in DFCS custody or be returned to the home. (GA Code § 15-11-145)

Termination of Parental Rights: An order divesting a parent and his or her child of all legal rights, powers, privileges, immunities, duties, and obligations with respect to each other; based on legal grounds or length of time in foster care (exceptions apply); clear and convincing evidence standard. (GA Code § 15-11-261)

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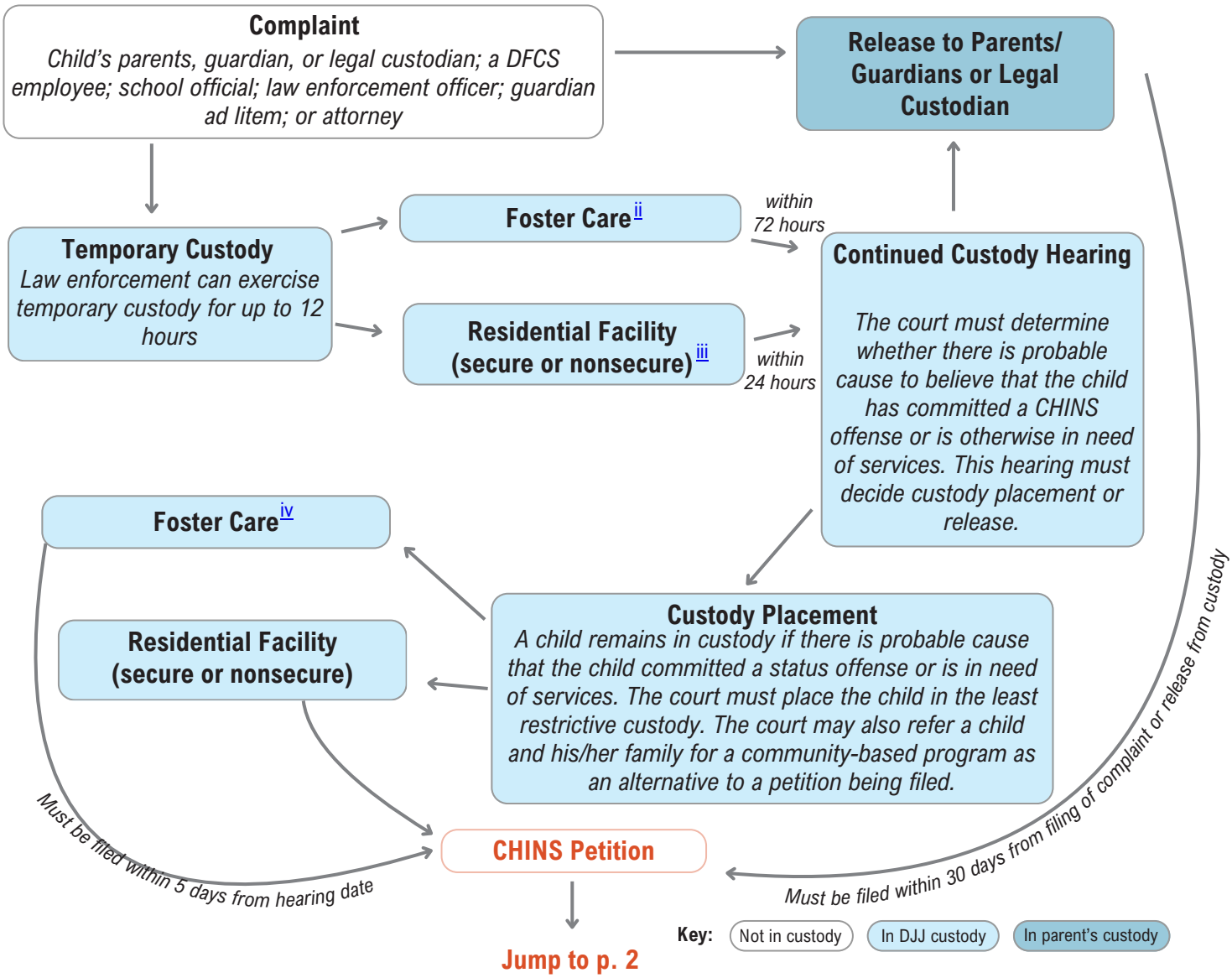
A GUIDE TO A CHILD IN NEED OF SERVICES IN GEORGIA'S JUVENILE JUSTICE PROCESS

A child may come in contact with the juvenile justice system through a delinquency, dependency, or a Child in Need of Services (CHINS) complaint.

WHO IS CONSIDERED A CHILD IN NEED OF SERVICES?

A "Child in Need of Services" is a child who is in need of care, guidance, counseling, structure, supervision, treatment, or rehabilitation AND meets certain criteria (see criteria on p2.). If an eligible child[i] is brought before the court, services are provided to attempt to divert the child away from delinquency.

A MAP OF THE CHINS PROCESS



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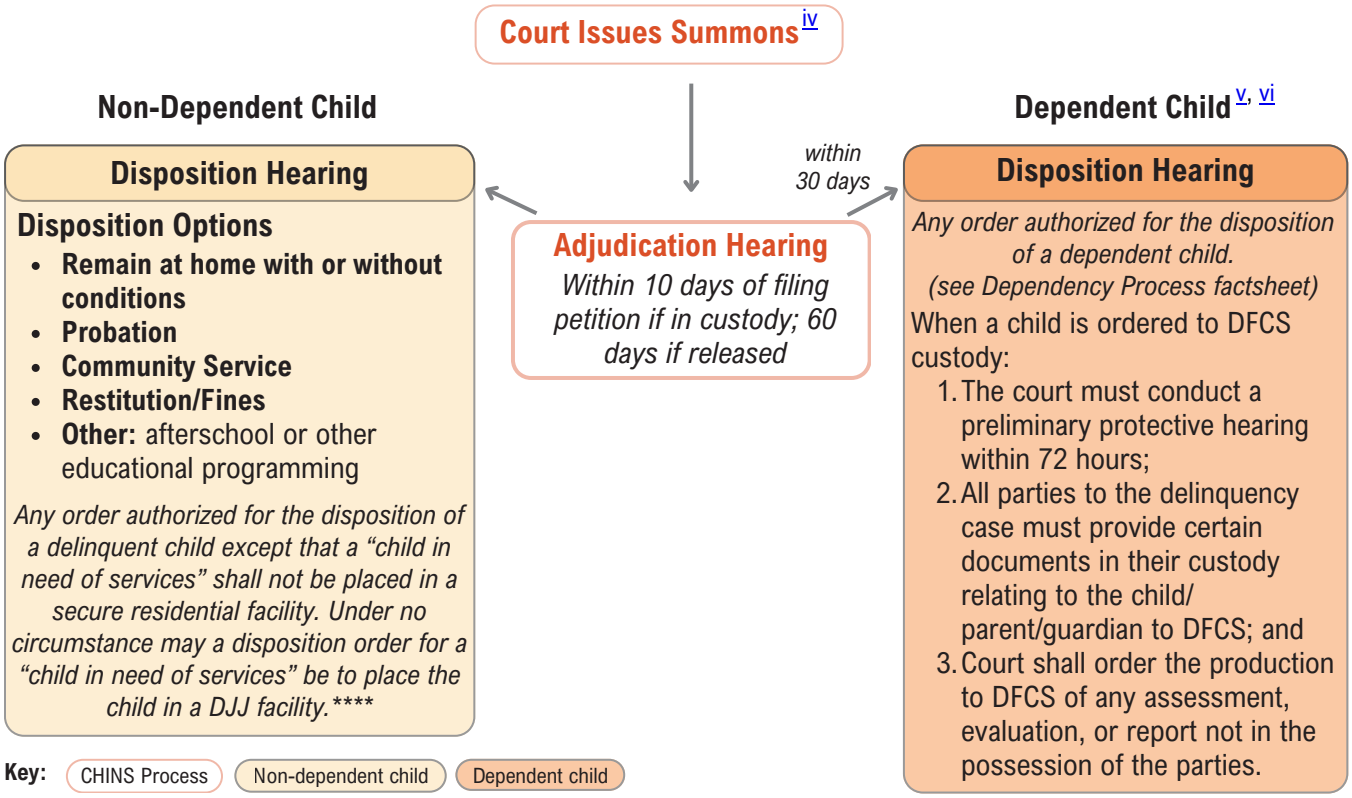

TERMS TO KNOW

Case Plan: If a child is alleged or adjudicated to be a Child in Need of Services and is placed in foster care, the child shall be required to have a case plan which addresses the child and parents' strengths and needs, the problems contributing to the child's behaviors, identification of the least restrictive placement for the child, and an assessment of services available to the child. (GA Code § 15-11-404)

"Child in Need of Services": A "Child in Need of Services" under Georgia law means a child who is in need of care, guidance, counseling, structure, supervision, treatment, or rehabilitation AND meets one of the following criteria: (GA Code § 15-11-2 (11))

- Habitually truant from school
- Habitually disobedient of the reasonable commands of his or her parent/guardian/legal custodian
- Runaway
- Committed an offense applicable only to a child (e.g., underage possession of alcohol)
- Wanders or loiters about the streets, highway, or any public place between the hours of 12:00am and 5:00 AM
- Disobeys the terms of supervision contained in a court order which has been directed to such child, who has been adjudicated a CHINS
- Patronized any bar where alcoholic beverages are being sold, unaccompanied by his or her parent/guardian/legal custodian, or who possesses alcoholic beverages
- Committed a delinquent act and is in need of supervision but not in need of treatment or rehabilitation

SCAN BELOW TO SEE FACTSHEET CITATIONS

TERMS TO KNOW, CONTINUED

Dependency Petition: A legal document that alleges that a child is abused, neglected, or abandoned which may be filed by the Division of Family and Children Services, a child's guardian ad litem, or any other person who has knowledge of the facts alleged. (GA Code § 15-11-3(5))

Least Restrictive Custody: The level of custody which safeguards the child's best interests and protects the community (e.g., release to parent, foster care, other court-approved placement that is not secure, or secure residential facility). (GA Code §§ 15-11-2 & 15-11-26)

Nonsecure Facility: Nonsecure residential facilities are community residential facilities that provide 24-hour care in a residential setting that are not hardware secured. These nonsecure community residential programs include group homes, emergency shelters, wilderness/outdoor therapeutic programs, and other placements that provide 24-hour care in a residential setting. (GA Code § 15-11-2(49))

Secure Facility: Secure facility is defined as a hardware secure residential institution operated by or on behalf of DJJ and shall include a youth development center or a regional youth detention center. (GA Code § 15-11-2(67))

SCAN BELOW TO SEE FACTSHEET CITATIONS

i For more information regarding the delinquency process, see A Guide to Delinquency in Georgia's Juvenile Justice Process.

ii If a youth is placed in foster care, the child must have a case plan.

iii If a youth is placed in a secure or nonsecure DJJ facility (for no longer than 24 hours), then:

1. a Detention Assessment Instrument must have been conducted,
2. statute criteria must apply (e.g., child is "alleged runaway, habitually disobedient, and/or failed to appear at a scheduled hearing")

iv A court-issued summons goes to the child, parent/guardian, DFCS, or other public agencies or necessary parties. The summons requires the person to come for the adjudication to participate in the hearing.

v Prior to being placed in the custody of DFCS, the court shall consider on the record what services have been provided to the child/parent/guardian; what efforts have been made to find other secure placement; whether a child protective services report was made.

vi In any case in which DJJ believes a child to be dependent, it shall make a report to the Statewide Child Protective Services Communication Center and notify the DFCS office in the disposition county.

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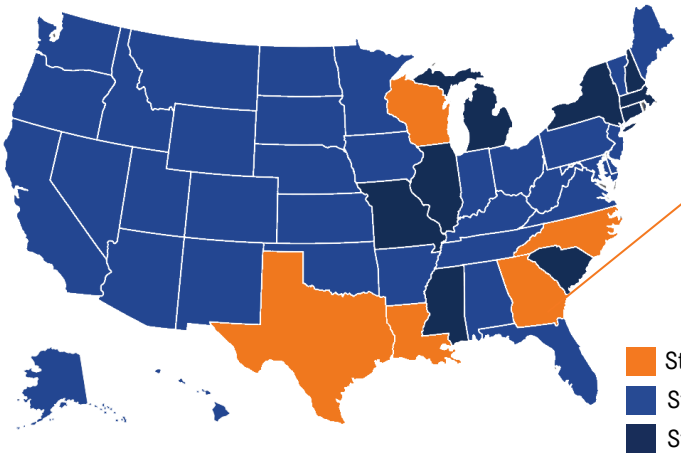
RAISING THE AGE OF JUVENILE COURT JURISDICTION

Georgia is one of five states that processes all 17-year-olds as adults in the criminal justice system, sending them to adult court rather than through the juvenile justice system.[1]



In 2024, in Georgia:

- **3,984** 17-year-olds were arrested[2]
- **24%** were for violent crimes[3]
- 140 counties had fewer than 50 arrests of 17-year-olds[4]

States that prosecute all 17-year-olds in adult court
States that have raised the age since 2007
States that raised the age prior to 2007

If Georgia raises the age of juvenile court jurisdiction to 18, youth as young as 13 charged with certain violent felonies may still be tried as adults. Such crimes include murder, rape, armed robbery committed with a firearm, aggravated child molestation, aggravated sodomy, aggravated sexual battery, terroristic acts on a school, and voluntary manslaughter.

WHY 17-YEAR-OLDS ARE NOT ADULTS

Research shows that 17-year-olds are still in adolescence, with brains that function differently from adults. Their executive functioning skills, like self-control, emotional regulation, and understanding different points of view, are still developing. When compared to adults, 17-year-olds are:[5, 6]

- less capable of impulse control
- more likely to overreact to situations
- less able to consider the consequences of their actions
- more susceptible to negative peer influences
- more likely to change course if given the right support

The U.S. Supreme Court* finds adolescents are **more capable of change** than adults and should be given the **opportunity to rehabilitate**.[7]

*Graham v. Florida (2010)

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HOW GEORGIA'S JUVENILE JUSTICE SYSTEM SUPPORT REHABILITATION

Juvenile court and juvenile court-ordered plans focus on rehabilitation rather than punishment, recognizing that 17-year-olds are still developing and highly capable of change. By addressing misbehavior with **developmentally-appropriate interventions**, the system helps **redirect behavior** into more healthy and socially positive outcomes, and reduce the likelihood that the child will commit offenses as an adult.[8] Below are examples of services offered through Georgia's Juvenile Justice System:

- Mental health treatment/ substance abuse counselors
- Diversion programs
- Career development and job readiness training
- Evidence-based programs
- Accountability courts
- Education opportunities

Juvenile courts prepare youth for adulthood while recognizing they are still children.

REDUCING DETENTION RATES WHILE IMPROVING PUBLIC SAFETY

Evidence-based alternatives to detention have been proven to reduce the likelihood of criminal activity.[9] By employing these strategies, Georgia has seen a **68% reduction** in juvenile incarceration since 2013.[10, 11]

Georgia's **Juvenile Justice Incentive Grants (JJIG)** and **Community Service Grants (CSG)** fund the delivery of evidence-based programs proven effective for juveniles: Seven Challenges, Trauma-Focused Cognitive Behavioral Therapy, Multisystemic Therapy-Problem Sexual Behavior, Multi-Systemic Therapy, Aggression Replacement Therapy, Functional Family Therapy, and Thinking for a Change.[12, 13] Together these grants make these therapies available to juvenile court jurisdictions encompassing 99% of Georgia's at-risk youth population.[14]

JJIGs in 2024

- Served **1,027** youth at moderate or high risk to reoffend [15]
- **70%** successfully completed their evidence-based programs [16]
- **94%** were actively enrolled in or had completed high school [17]
- **69%** reduction in out-of-home placements in JJIG-participating counties [18]

CSGs in 2024

- Served **355** youth at moderate or high risk to reoffend [19]
- **70%** successfully completed their evidence-based programs [20]
- **95%** were actively enrolled in or had completed high school [21]
- **52%** reduction in out-of-home placements in CSG-participating counties [22]

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OUTCOMES FROM RAISING THE AGE

States that have recently raised the age as part of their juvenile justice reforms have experienced lower arrest and detention rates. Connecticut, Illinois, and Massachusetts have all seen significant drops in juvenile arrests after raising the age to 18.[23]

Connecticut Outcomes

Juvenile arrests have decreased by 50% since moving 16- and 17-year-olds from the adult justice system in 2010.[24]

Massachusetts Outcomes

Juvenile delinquency arraignments have decreased by 60% since raising the age in 2013.[25]

FAST FACTS ON MENTAL HEALTH AND INCARCERATION

- Nationally, youth are **36 times** more likely to commit suicide in an adult facility than a juvenile facility.[26]
- In FY 24, the average daily caseload of youth in Georgia receiving mental health services was **564**.[27]
- From 2014-2023, more than **16,000 youth** have received individual or group therapy through evidence-based models delivered by the Georgia juvenile justice system.[28, 29]

PREPARING FOR THE FUTURE

The Georgia Department of Juvenile Justice (DJJ) is the 181st school district in the state. **Georgia Preparatory Academy** is the middle and high school within the DJJ school system with 28 campuses across the state in detention and transitional centers. An online version of the Georgia Preparatory Academy is available for youth under DJJ supervision who are unable to return to public high school. Additionally, **Pathways to Success** is an adult education program that offers GED instruction and testing. The **Connections Graduate Program** focuses on re-entry, work skills development, and post-secondary options.[30]

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GANG AND YOUTH VIOLENCE PREVENTION

Georgia law states a "criminal street gang" is any organization, association, or group of three or more persons who engage in criminal gang activity (e.g., rape, racketeering, criminal trespass, or any offense that involves violence, use of a weapon, or possession of a weapon, among others).

A gang can be established by a common name or identifying signs, symbols, tattoos, graffiti, attire, or other distinguishing characteristics.[1]

WHAT IS YOUTH VIOLENCE?

Youth violence is the intentional use of physical force or power by 10- to 24-year-olds to threaten or harm others. The estimated cost of youth violence is almost **$122 billion per year**.[2] Committing youth violence increases the risk for: [3]


Substance use


Depression


Suicide


Academic challenges and school drop-out


Future violence and victimization

FACTORS THAT IMPACT YOUTH VIOLENCE AND GANG MEMBERSHIP

The more risk factors a young person experiences, the greater their chance of committing youth violence, including through gang membership;[4] however, exposure to protective factors reduces this chance.[5] Given this, prevention strategies are aimed at increasing crucial supports in a youth's life, including security, connectedness, and safety.

Risk Factors:

- History of violent victimization
- Developmental disabilities or behavioral health conditions
- Substance abuse
- Poor behavioral control
- Exposure to family violence/conflict
- Extreme or inconsistent disciplinary practices
- Parental substance abuse or criminality
- Poor supervision
- Peer influence
- Gang involvement
- Poor academic performance
- Communities with high rates of instability, low-income residents, and incidents of crime

Protective Factors:

- High educational achievement/aspirations
- Social skills/competencies
- Parental involvement
- Positive social and peer connections
- Positive school environment

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PREVENTION STRATEGIES IMPLEMENTED IN GEORGIA

Strategy and Approach:	What This Looks Like in Georgia:
Promote Family Environments that Support Healthy Development	
• Early childhood home visitation • Parenting skill and family relationship programs	• Home visiting and parental skill building (through the Department of Public Health (DPH) and the Division of Family and Children Services (DFCS) • Strengthening Families Georgia
Provide Quality Education Early in Life	
• Preschool enrichment with family engagement	• Georgia Pre-K • Head Start • Childcare and Parent Services (CAPS) • Quality Rated Child Care
Strengthen Youth Skills	
• Universal school-based programs	• Georgia Apex Program • Youth Mental Health First Aid and Teen Mental Health First Aid • Positive Behavioral Interventions and Supports • Comprehensive school-based health centers
Wrapping At-Risk Children with an Array of Supportive Services	
• Cognitive behavioral treatment	• Douglas County CHANCE Court is an accountability court serving youth adjudicated as delinquent or as a Child In Need of Services which uses individuals case plans, intensive case management, peer support and a therapeutic court setting.
Connect Youth to Caring Adults and Activities	
• Mentoring programs • Afterschool programs	• Boys and Girls Club • 21st Century Community Learning Centers • Afterschool Care Program (DFCS) • Prevention Clubhouses (DBHDD) • YMCAs • 4-H • Cafe Momentum
Create Protective Community Environments	
• Modify the physical and social environment • Reduce exposure to community-level risks • Street outreach and community norm change	• Community-oriented policing • Afterschool programs and community centers like the @PromiseCenter • Front Porch Community Resource Center • Juvenile Detention Alternatives Initiatives • Norms change programs like Cure Violence (happening in some Southwest Atlanta neighborhoods)
Intervene to Lessen Harms and Prevent Future Risk	
• Treatment to lessen the harms of violence exposures • Treatment to prevent problem behavior and further involvement in violence • Hospital-community partnerships	• Trauma-Focused Cognitive Behavioral Therapy • Evidence-based programs for cognitive restructuring, problem-solving, and crisis management (DJJ) • Georgia Preparatory Academy (middle and high school within DJJ school system) • Pathways to Success (DJJ's high school equivalency program) • Connections Graduate Programs (DJJ's college, career, and life-ready program) • Educational and vocational opportunities • Mental health and substance abuse treatment through DJJ

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POLICY RECOMMENDATIONS

Prevention

- Increase the number of mental health and social work professionals in schools.
- Expand federal and state funding to afterschool and summer learning programs to increase access and ensure affordability.
- Ensure that school codes of conduct are evidence-based, trauma-informed, and include input from local child-serving stakeholders (e.g., mental health providers, social workers, juvenile courts).
- Ensure that training on trauma-informed care and implicit/explicit bias is provided to all stakeholders who engage with children in any way (e.g., law enforcement, school resource officers, school faculty and staff, child care and afterschool providers, DJJ staff, child welfare and foster care settings).

Intervention

- Increase funding for intervention programs that provide outreach workers and train community members as credible messengers to diffuse community conflict after violence occurs (e.g., Neighborhood Planning Units and CHRIS180).
- Strengthen partnerships between community-based afterschool programs, school districts, juvenile courts, and other community partners to align services for young people through Local Interagency Planning Teams or truancy prevention programs.
- Promote the use of mentoring and apprenticeships programs (e.g., partner with local chambers of commerce, rotary clubs, chapters of 100 Black Men, Big Brothers Big Sisters, or other civically-focused organizations).
- Increase funding for restorative programs for children and youth (e.g., Child in Need of Services (CHINS), Public Safety and Community Violence Reduction Grant, Juvenile Justice Incentive Grant Program, and Community Service Grants Program).

Restoration

- Raise the maximum age of juvenile court jurisdiction to 18 years of age.
- Develop effective juvenile accountability courts, including education on violence, community involvement, and wraparound services that support the youth and the youth's family.
- Increase access to evidence-based practices for mental and behavioral health in schools.
- Increase access to educational and work remediation.

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SCAN BELOW TO SEE FACTSHEET CITATIONS

POSITIVE BEHAVIORAL INTERVENTIONS AND SUPPORTS

Positive Behavioral Interventions and Supports (PBIS) is an evidence-based, data-driven framework that helps support students' behavioral, academic, social, emotional, and mental health.[1] PBIS is proven to reduce disciplinary incidents, increase the sense of safety, and support improved academic outcomes in schools.[2] Additionally, research shows stronger PBIS programs are linked with improved student attendance and lower chronic absenteeism.[3]

Multi-Tier Prevention to Reduce Absenteeism

PBIS incorporates a three-tiered approach to develop schoolwide, targeted, and individualized interventions and supports to improve school climate. [4]

What does Tier 1 look like?

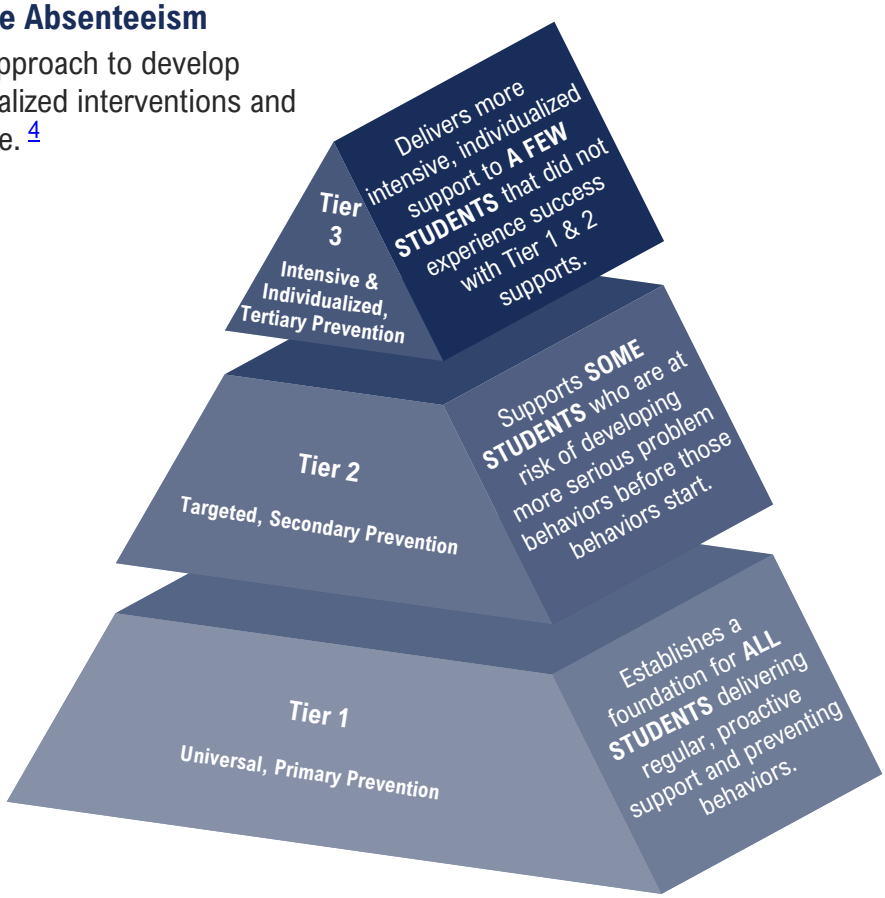
- Well-defined schoolwide expectations
- Explicit teaching of expectations and skills to set students up for success
- Response to unwanted behavior in a respectful, instructional manner

What does Tier 2 look like?

- Additional instruction and practice for behavioral, social, emotional, and academic skills
- Increased use or prompts or reminders
- Additional opportunities for positive reinforcement

What does Tier 3 look like?

- Engaging in functional behavioral assessments and intervention planning
- Coordinated support through wraparound and person-centered planning
- Individualized, comprehensive, and function-based supports



Tier 1 strategies, such as creating safe and engaging school environments have been show to reduce chronic absenteeism.

Tier 2 supports provide targeted intervention for students at risk of frequent absences

PBIS is not a curriculum, nor is it something that can be learned during a one-day professional development seminar. It is an ongoing commitment to supporting students, educators and families.

SCAN BELOW TO SEE FACTSHEET CITATIONS

Why implement PBIS?

Research shows that when PBIS is implemented as designed, there are improved outcomes:

Students

- Improved academic performance [5]
- Higher social-emotional competence [6]
- Reduced bullying behaviors [7]
- Decreased rates of student-reported drug/alcohol abuse [8, 9]
- Reduces absences [10]

Discipline

- Fewer office discipline referrals [11, 12, 13]
- Fewer suspensions [14]
- Lower rate of restraint and seclusion [15]

Teachers

- Improved perception of teachers [16]
- Better school organizational health and school climate [17, 18]
- Higher perception of school safety [19]

RECOMMENDATIONS ON HOW TO IMPLEMENT PBIS

Teachers and Students:[20]

- Arrange the classroom in such a way that facilitates the most typical instructional activities (e.g., tables for centers, separate spaces for individual work, circle area for group instruction).
- Maintain regular two-way communication with families to ensure families have the opportunity to share information and feedback.
- Explicitly teach and visibly post steps for specific routines to promote independence and attendance expectations.
- Adopt 3-5 schoolwide expectations as classroom expectations.
- Differentiate instruction to ensure needs of all students are met.
- Incorporate students' preferences into learning opportunities to increase connections during instruction.
- Implement early, positive outreach strategies following initial student absences to strengthen relationships, identify barriers, and encourage consistent attendance.

Teachers and Administration:[21]

- Collaborate and develop a shared vision and approach to support and respond to student behavior.
- Establish 3-5 positively-stated schoolwide expectations and other key social, emotional, and behavior skills to set students up for success.
- Establish a continuum of response strategies to provide specific feedback, re-teach appropriate behavior, and discourage inappropriate behavior.
- Integrate attendance data as a core component of PBIS fidelity checks to ensure a comprehensive understanding of student engagement and support needs.

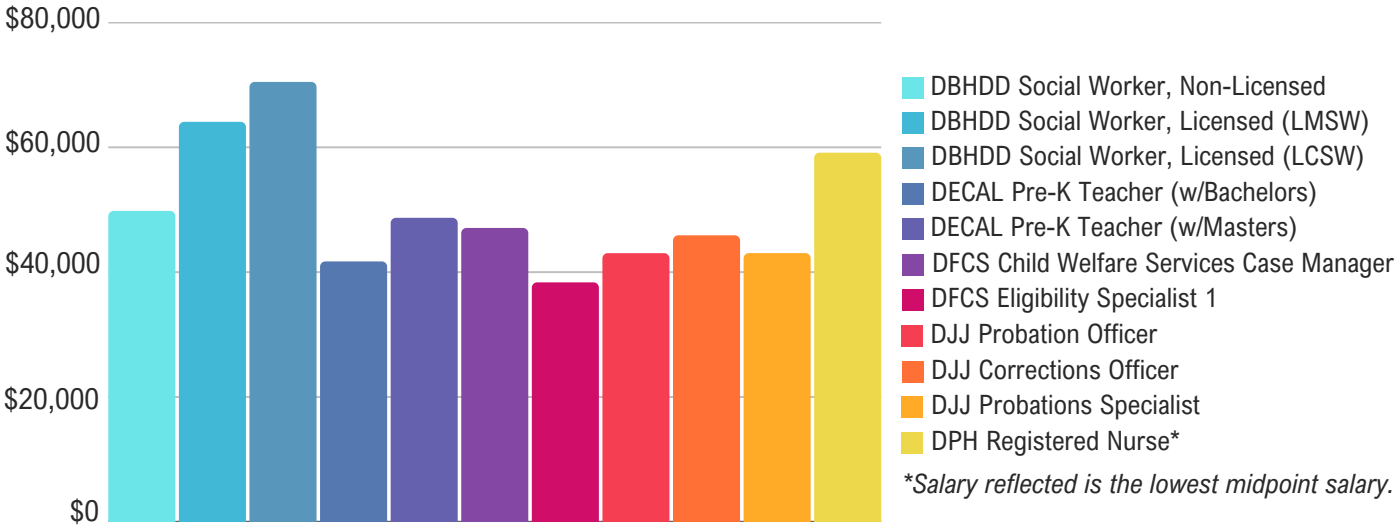
Georgia has 1,699 PBIS-trained schools.[22]

SCAN BELOW TO SEE FACTSHEET CITATIONS

SALARIES FOR CHILD-SERVING WORKERS AT GEORGIA'S STATE AGENCIES

State agency staff who serve children and families help them access essential resources to meet their most basic needs.

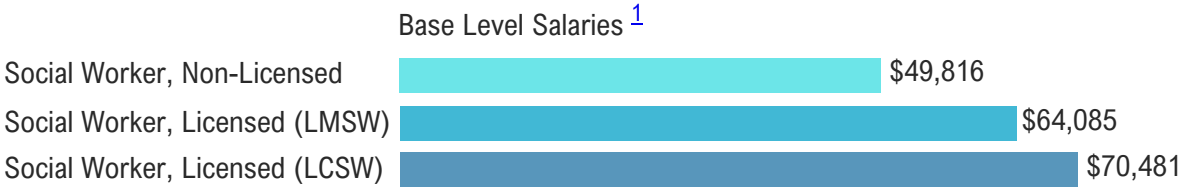
Child-Serving Agency Entry-Level Salaries (as of 2025)



**Salary reflected is the lowest midpoint salary.*

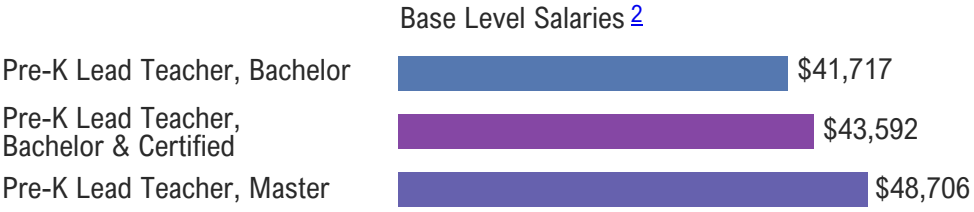
Department of Behavioral Health and Developmental Disabilities (DBHDD)

Clinicians and social workers at Community Service Boards (CSBs), which are community-based safety net providers for mental health, deliver direct services to youth both in the community and, at times, in schools. These services include individual, group, and family therapy. The salary information below reflects positions within DBHDD, including hospitals and community-based providers, but excludes CSBs. While many CSBs follow the state salary structure, their average starting salaries may vary.



Department of Early Care and Learning (DECAL)

Georgia Pre-K teachers educate 4- and 5-year-olds, 5 days a week, 180 days per year. The school day is 6.5 hours with many programs offering extended hours for before- and after-school care.



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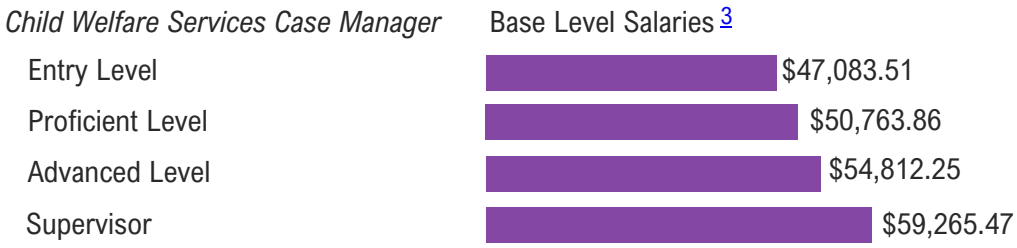
Department of Human Services/Division of Family and Children Services (DHS/DFCS)

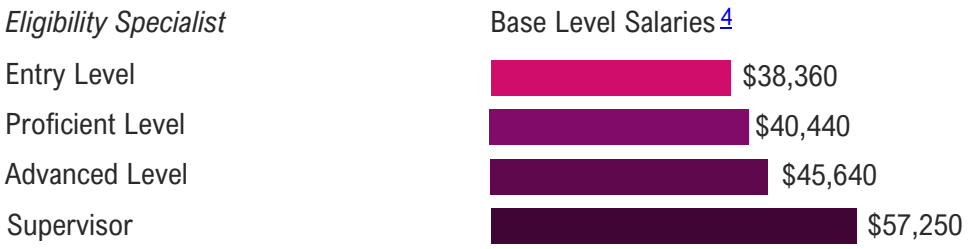
Child Welfare

Child welfare workers investigate cases of abuse and neglect and provide comprehensive care management for affected children. They assess safety concerns and identify physical, educational, and behavioral needs of children, parents, and foster parents – ensuring those needs are met.



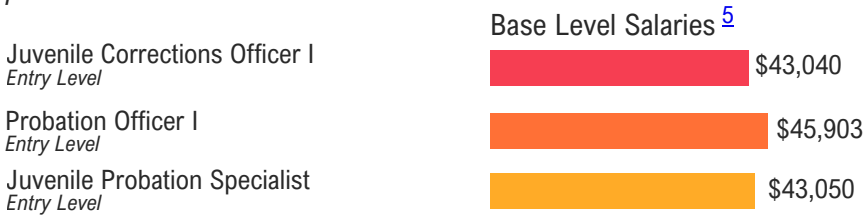
Office of Family Independence

Employees manage SNAP (food stamp) and Family Medicaid cases, determining applicant eligibility and process applications.



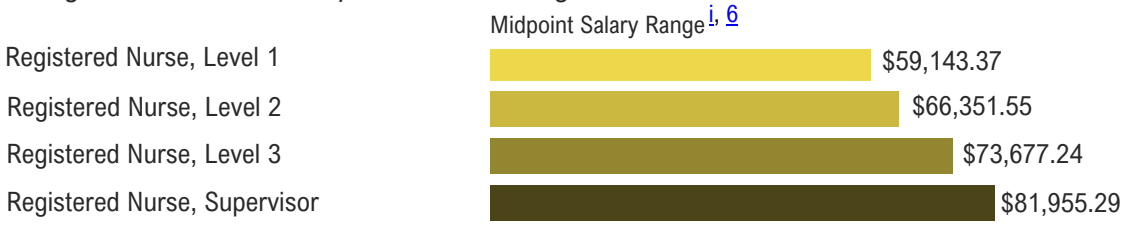
Department of Juvenile Justice (DJJ)

Staff are responsible for youth under the supervision of DJJ, both in detention facilities and on community probation.



Department of Public Health (DPH)

Registered nurses at DPH provide direct nursing care and support, including to populations with special needs during natural disasters and public health emergencies.



[i] Amounts shown reflect the midpoint salary ranges for the positions listed.

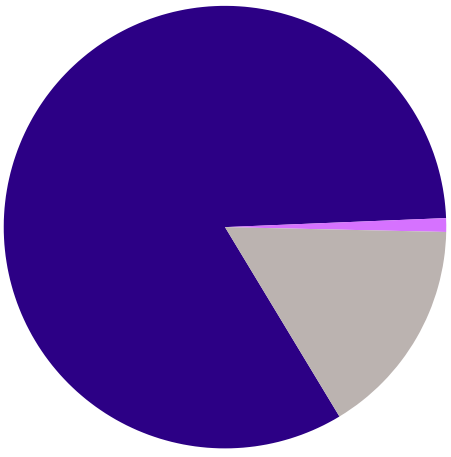
SCAN BELOW TO SEE FACTSHEET CITATIONS

HOW FEDERAL DOLLARS ARE USED IN GEORGIA

In state fiscal year 2026,[1] the following federal funds are allocated to support nine state agencies serving Georgia's children.

	State Agency	FY2026 Budget
DCH	Department of Community Health	$12,671,193,864
DHS	Department of Human Services	$1,294,397,784
DPH	Department of Public Health	$464,841,136
DBHDD	Department of Behavioral Health and Developmental Disabilities	$653,583,618
DECAL	Department of Early Care and Learning	$607,659,885
DOE	Department of Education	$2,264,165,683
CJCC	Criminal Justice Coordinating Council (administratively attached to the Georgia Bureau of Investigation (GBI))	$66,551,185
DOD	Department of Defense	$75,943,450
DJJ	Department of Juvenile Justice	$6,072,886
	TOTAL	**$18,104,409,491**

Federal Funding by Policy Area



83%
Health and Human Services

- Department of Behavioral Health and Developmental Disabilities
- Department of Community Health
- Department of Human Services
- Department of Public Health

1%
Public Safety

- Criminal Justice Coordinating Council
- Department of Defense
- Department of Juvenile Justice

16%
Education

- Department of Early Care and Learning
- Department of Education

SCAN BELOW TO SEE FACTSHEET CITATIONS

Funding Allocations from the American Rescue Plan Act[2]

Capital Projects Fund — Funding: $250 billion

Addresses many challenges revealed by the pandemic, especially in rural America and low- and moderate-income communities, helping to ensure that all communities have access to the high-quality, modern infrastructure needed to thrive, including internet access.

End date: December 31, 2026

Homeowner's Assistance Fund — Funding: $354 billion

Aids homeowners who have experienced financial hardship due to the pandemic with mortgage payments, homeowner's insurance, utility payments, and other specified purposes.

End date: September 30, 2026

Coronavirus State and Local Fiscal Recovery Fund — Total Funds: $4.8 billion

Fosters recovery and prosperity for all Georgians through strategic investments in workforce development, public health, and infrastructure programs as well as assistance to populations experiencing negative economic impacts.

Broadband

Infrastructure — **$408 million**

Provides grants to support broadband infrastructure projects. Approximately 70,000 locations are estimated to be served by funded projects.
End date: October 31, 2026

Economic Relief

Negative Economic Impact — **$325 million**

Funds projects that respond to economic harms to workers, families, small businesses, impacted industries, and the public sector.
End date: November 30, 2026

Housing/Neighborhoods

Georgia Investments in Housing Grant — **$100 million**

Supports nonprofits that are 501(c)(3) or 501(c)(19) tax-exempt organizations who provide affordable housing and aid individuals experiencing homelessness.
End date: October 31, 2026

Public Health

School-Based Health Centers — **$125 million**

Funds the Georgia Department of Education in providing grants that support the planning, infrastructure/ space renovations, start-up staffing, and start-up medical supplies for School-Based Health Centers for approved Title I schools in Georgia.
End date: October 31, 2026

Victim's Services — **$50 million**

Supports non-profits that are 501(c)(3) or 501(c)(19) tax-exempt organizations who experienced economic harms incurred as a result of the pandemic.

Improving Neighborhood Outcomes in Disproportionally Impacted Communities — **$223 million**

Supports projects that promote improved physical and mental health and safety outcomes (e.g., green spaces, recreational facilities, sidewalks).
End date: October 31, 2026

SCAN BELOW TO SEE FACTSHEET CITATIONS

Funding Allocations from the American Rescue Plan Act, continued

Public Safety

Judicial Grant **$120 million**

To combat violent crime and help support the Georgia's judiciary's recovery from COVID-19 with funding to address court backlogs in cases with a primary focus on serious violent felonies.
End date: December 31, 2026

Public Safety and Community Violence Reduction Grant **$83.5 million**

Funds to address violent gun crime and community violence that have increased as a result of COVID-19, or to address a decrease in public sector law enforcement staffing as a result of COVID-19.
End date: October 31, 2026

Water and Sewer

Drinking Water Projects to Support Increased Population **$484 million**

Supports drinking water projects that address present or prevent future violations of health-based drinking water standards.
End date: October 31, 2026

Water/Sewer Infrastructure **$600 million**

Supports investments in necessary improvements to water and sewer infrastructures.
End date: November 30, 2026

STATE PROGRAMS RECEIVING FEDERAL FUNDING

Health and Human Services $15,084,016,402

Department of Behavioral Health and Developmental Disabilities (DBHDD)

- Community Mental Health Services Block Grant
- Medical Assistance Program (Medicaid)
- Social Services Block Grant
- Substance Abuse Prevention and Treatment Block Grant
- Temporary Assistance for Needy Families (TANF) Block Grant

Department of Community Health

- Medical Assistance Program (Medicaid)
- State Children's Health Insurance Program (PeachCare for Kids)

Department of Public Health

- Infants and Toddlers with Disabilities Grant
- Maternal and Child Health Services Block Grant
- Temporary Assistance for Needy Families (TANF)
- Preventive Health and Human Services Block Grant
- Women, Infants, and Children Program (WIC)
- Immunizations and Vaccines for Children Grant

Department of Human Services

- Medical Assistance Program (Medicaid)
- Social Services Block Grant
- Temporary Assistance for Needy Families (TANF) Block Grant
- Child Abuse Prevention & Treatment Act (CAPTA)
- Child Care
- Supplemental Nutrition Assistance Program (SNAP)
- Low-Income Home Energy Assistance
- Title IV-E: Adoption Assistance and Foster Care
- Title IV-B: Promoting Safe and Stable Families
- Title IV-D: Child Support Enforcement
- Community Services Block Grant

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STATE PROGRAMS RECEIVING FEDERAL FUNDING, CONT.

Public Safety $148,567,521

Criminal Justice Coordinating Council

- Temporary Assistance for Needy Families (TANF)
- Family Violence Prevention and Services Act
- Edward Byrne Memorial Justice Assistance Grant
- Residential Substance Abuse Treatment for Prisoners
- Paul Coverdell Forensic Science Improvement Grants*
- Juvenile Justice and Delinquency Prevention
- VOCA Victim Assistance Formula
- VOCA Victim Compensation Formula
- Sexual Assault Services Formula Grant
- STOP Violence Against Women Formula Grant

Department of Defense

- STARBASE
- National Guard Youth ChalleNGe Academies
- United States Department of Agriculture Department of Defense Fruit and Vegetable Program

Department of Juvenile Justice

- Education
- National School Lunch Program
- Re-Entry/2nd Chance
- Residential Substance Abuse Treatment
- Title IV-E: Foster Care

*denotes grants that do not benefit children but contribute to the total federal funds received

Education $2,871,825,568

Department of Education

- 21st Century Community Learning Centers
- Career and Technical Education
- Charter Schools Program
- Child Nutrition Discretionary Grants
- Comprehensive Literacy State Development Grant
- Education of Migratory Children
- Family School Partnership
- Foster Care Provisions
- Fresh Fruits and Vegetables Program
- Grants to Local Education Agencies
- Grants for State Assessments and Related Activities
- Improving the Academic Achievement of the Disadvantaged
- Individuals with Disabilities Education Act
- Language Instruction for English Learners & Immigrant Students
- Maternal and Child Health Services Block Grant
- Mathematics and Science Partnerships
- McKinney-Vento Education for Homeless Children and Youth
- National Assessment of Educational Progress
- National School Lunch Program
- Neglected and Delinquent Children
- Rural Education Achievement Program
- School Breakfast Program
- School Improvement Grants
- Seamless Summer Option
- Special Education Grants
- Special Milk Program for Children
- Student Support and Academic Enrichment Program
- Substance Abuse and Mental Health Services

Department of Early Care and Learning

- Child and Adult Care Food Program
- Child Care and Development Block Grant
- Child Care Development Fund
- Head Start
- National School Lunch Program
- Preschool Development Grant
- Race to the Top: Early Learning Challenge Grant
- State Administrative Expenses for Child Nutrition
- Team Nutrition Grants

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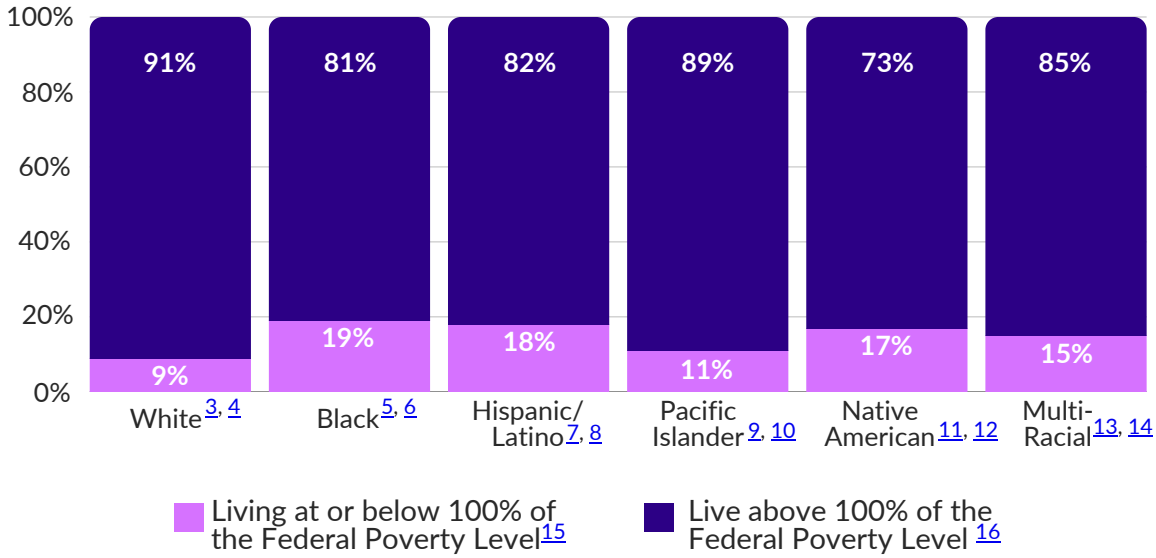
2025 FEDERAL POVERTY GUIDELINES

The U.S. Federal Poverty Guidelines determine financial eligibility for certain federal programs. The poverty guidelines are published in January by the U.S. Department of Health and Human Services, and are designated by the year in which they are issued (i.e., guidelines issued in January 2025 are the 2025 poverty guidelines).[1]

2025 FEDERAL POVERTY GUIDELINES [2]

Family/Household Size	100%	200%	400%
1 person	$15,650	$31,300	$62,600
2 people	$21,150	$42,300	$84,600
3 people	$26,650	$53,300	$106,600
4 people	$32,150	$64,300	$128,600

GEORGIA POVERTY RATES BY RACE/ETHNICITY, 2023*



In Georgia, the rate of Black, Hispanic, and Native American individuals living under the poverty line is twice that of White individuals.

**2023 is the most recent data available*

SCAN BELOW TO SEE FACTSHEET CITATIONS

Federal and State Program Eligibility Based on Federal Poverty Guidelines

Certain federal programs use the Federal Poverty Guidelines to determine eligibility. The following chart details specific programs and the maximum yearly income a family of four can earn to remain eligible.

Program and Description	Maximum Yearly Income (Family of 4)	Maximum % of Guidelines
Childcare and Parent Services (CAPS) - Initial Eligibility	$31,768[17]	150%[26**]
CAPS offers families with low incomes subsidies to pay for quality child care, afterschool, and summer programs for children up to age 12, and for children up to age 17 with special needs. See Voices' CAPS factsheet for more details		
Supplemental Nutrition Assistance Program (SNAP)	$40,560[18]	130% [27]
SNAP offers nutrition assistance to millions of eligible individuals and families with low incomes through electronic benefit cards.		
Medicaid		
Medicaid in the United States is a joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid also offers benefits not normally covered by Medicare, like nursing home care and personal care services. See Voices' How Medicaid and PeachCare Money Work factsheet for more details		
For Pregnant Women	$70,730[19]	220%[28]
Children up to 1 year	$67,515[20]	210%[29]
Children ages 1-5	$49,511[21]	154%[30]
Children ages 6-18	$44,367[22]	138%[31]
PeachCare for Kids® (children ages 0-18)	$79,411[23]	247%[32]
PeachCare for Kids is a comprehensive health care program for uninsured children (under age 19) living in Georgia, whose parents earn too much to qualify for Medicaid, but not enough to pay for private coverage. See Voices' How Medicaid and PeachCare Money Work factsheet for more details		
Marketplace (Health Insurance) Premium Tax Credit	$128,600[24]	400%[33]
Individuals with incomes at 100-400% FPL who purchase health insurance through the Health Insurance Marketplace can receive federal premium tax credits to reduce their monthly insurance premium payments.		
Women, Infants, and Children (WIC)	$59,478[25]	185%[34]
WIC provides supplemental foods, health care referrals, and nutrition education for pregnant, breastfeeding and non-breastfeeding postpartum women with low incomes, and to infants and children up to age five who are found to be at nutritional risk.		

***The threshold for initial eligibility is 30% of the state median income.*

****All adult recipients are required to participate in work activities and training for at least 30 hours weekly. These work activities help recipients gain the experience needed to find a job and become self-sufficient.*

Receipt of cash assistance is limited to 48 months (4 years) in a lifetime. Temporary extensions to the 48-month limit may be granted on a case-by-case basis via hardship waivers.

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Voices for Georgia's Children

G·san GEORGIA STATEWIDE AFTERSCHOOL NETWORK

Thank you for taking the time to explore this factbook. If you have any questions or would like to discuss our findings further, please don't hesitate to reach out to us.

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