Seattle Indian Health Board
For the Love of Native People
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Inclusion of Urban Indian Organizations (UIOs) in RFA Language:

Issue/Recommendation: Legislation and funding opportunities often limit eligibility to Tribes of Tribal Organizations while excluding UIOs. Yet of the 5.2 million Americans who identify as American Indian or Alaska Native (AI/AN), 71% live in urban areas, according to data from the Urban Indian Health Institute. This often unintentional oversight excludes urban relatives from benefitting from funding.
In legislation and grant eligibility requirements, add language explicitly including eligibility that includes all components of the IHS, Tribal 638, and Urban Indian Health Program (I/T/U) system of care. Use these definitions:

- "Indian" as defined by 42 C.F.R. § 447.50 (as in effect on July 1, 2010).
- "Indian Health Care Providers" (IHCPs) as defined by 42 CFR § 447.50.
- “tribes, tribal organizations and urban Indian organizations” as defined by 25 U.S.C. § 1603.
- “tribal epidemiology centers” as defined by 25 U.S.C. § 1621m

Background: As urban Indian organizations (UIOs), we are the “U” in the I/T/U system of health care delivery. Seattle Indian Health Board does not have tribal sovereignty, but we are recognized as an Indian Health Care Provider under Subchapter IV of the Indian Health Care Improvement Act (1976), which was permanently reauthorized through the Affordable Care Act (2010). As an Urban Indian Health Program, Federally Qualified Health Center, and Tribal Epidemiology Center, we are uniquely positioned to deliver culturally attuned direct services at the local level while also providing public health support and expertise at a national level to American Indian and Alaska Natives (AI/AN) people wherever they reside.

Historically, one of the ways the federal government has avoided fully allocating resources to AI/AN people is by undercounting or not counting us. When AI/AN people are not accurately reflected in population data, funding formulas exclude us. Blood quantum policies and restrictive definitions of identity have also contributed to this systemic undercounting. If you are not counted, you are easier to ignore in appropriations. That pattern is not accidental. It is structural.

With each administration change, we re-educate elected officials about this history and the lasting legacy of AI/AN migration to urban centers. Under the Indian Relocation Act, AI/AN people were encouraged to leave their homelands and move to urban areas with promises of employment, education, and healthcare. Many arrived in cities to find that those opportunities were not waiting for them. The federal commitments tied to relocation were never fully realized. Today, the majority of Native people live off reservations because of federal policy decisions. Of the 5.2 million Americans who identify as AI/AN, 71% live in urban areas, according to the United States Census Bureau.

If the purpose of federal funding is to create positive outcomes for AI/AN communities, excluding Urban Indians undermines that goal. At Seattle Indian Health Board, we do not seek to compete with tribal allocations. We advocate for strengthening investments across all of Indian Country, including for Native people living in urban areas.

It is critical that the IHS line item dedicated specifically to Urban Indian Organizations remains permanent and includes guaranteed advance appropriations. These funds do not take away from tribal allocations. In order to support these relatives, and to fulfill our role within the I/T/U system of health care delivery, it is essential that UIOs be explicitly named in funding opportunities and grant programs.

Exclusion through omission is still exclusion. If policy reflects where Native people actually live, funding must do the same.