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The American Guaranteed Income Studies: Ithaca, New York

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Front Cover Image: Aerial photo Ithaca, New York.

Inside Cover Image: Night photo of McGraw clock tower, a distinctive landmark in Cornell University, Ithaca, New York.

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Executive Summary

In collaboration with Mayors for a Guaranteed Income (MGI) and the Human Service Coalition of Tompkins County (HSCTC), former Mayor Svante Myrick first announced Ithaca, New York's guaranteed income (GI) pilot, Ithaca Guaranteed Income (IGI), in late 2021. Eligibile individuals consisted of caregivers, defined broadly to include people who spend significant unpaid time caring for children and/or aging, ill, or disabled adults (including parents) either in or out of their home. Applicants had to live within the City of Ithaca with a maximum income of 80% area median income (AMI).

As the independent research partner, the University of Pennsylvania's Center for Guaranteed Income Research (CGIR) randomized 242 participants from an initial pool of approximately 390 applicants, with the sample weighted according to the racial and ethnic distribution of Housing Cost Voucher (HCV) recipients. Of these participants, 110 caregivers in the treatment group received $450 monthly for 12 months from June 2022 to May 2023; the remaining 132 served as the control group and received no cash.

Ithaca has long been known for its progressive and inclusive nature. Over the years, the city and its environs have been home to multiple experiments in building new systems and communities, serving as a hub for alternative ways of thinking. Although Ithaca, like other places in the United States, is beset by deeply rooted systemic challenges, the IGI pilot sought to redress racial, gender, and income inequity.

The choice to focus on caregivers was timely given the impacts of COVID-19 on those performing unpaid care work. The pandemic highlighted the burden of unpaid care work for families with children, aging kin, and family members with complex medical needs, as well as a lack of structural support for caregivers in the US. It also exacerbated gender and racial disparities as workplace, school, and childcare closures forced caregivers to assume yet more responsibilities (Power, 2020). And at the time IGI launched, in June 2022, the US was experiencing the highest inflation rates it had seen in 40 years (U.S. Bureau of Labor, 2022).

In one sense, IGI was designed to support financial resilience and provide relief for caregivers amid these extreme, unprecedented

circumstances. However, IGI was also rooted in a broader recognition of the value unpaid care work brings to individuals, communities, and society. While integral to our shared humanity, the work of caring is often invisiblized and underrecognized. Unpaid caregivers are disregarded by a system that favors productive paid labor; caregivers of color, disabled caregivers, female caregivers, and those with marginalized positionalities are further diminished.

As HSCTC noted during the recruitment process:

> *Guaranteed income recognizes everyone's inherent dignity. We have to stop attaching dignity to work and instead attach it to our personhood. For Ithacans caregiving or watching children, are we saying that they don't have value because they don't receive a paycheck?*

The insistence on the inherent dignity of caregivers—independent of their labor market participation—was a strong validation of an often-ignored population.

Broadly speaking, the US has been unwilling to recognize or remunerate care work in comparison to other countries globally (Duffy, 2007; Glenn, 2010; Hochschild, 1989; Nadasen, 2021; Zelleke, 2011). The US is one of only a handful of countries in the world (Heymann & McNeill, 2013) that does not mandate paid leave for mothers of newborns (Gault et al., 2014; Livingston & Thomas, 2019). Many workers also do not have access to paid leave to care for children, aging parents, or other family members, forcing caregivers to choose between a paycheck and tending to loved ones. The federal Family and Medical Leave Act (FMLA) requires eligible employers to provide certain workers unpaid family leave (Wage and Hour Division, n.d.); however, this does not include those who are employed below a certain number of hours, or those unable to enter the labor market. Unpaid caregivers often experience financial precarity, poor mental and physical health, and decreased agency, satisfaction, and fulfillment, all while contending with the physical and emotional burden of care work itself in a system that does not recognize their labor (Reinhard et al., 2023; Schulz & Eden, 2016). This state of being has been referred to as "fragility by proxy," or the erosion of a caregiver's well-being due to care work (Castro et al., 2023).

On average, IGI pilot participants were in their mid-40s. Many were "sandwich generation" caregivers, or those responsible for both children and aging parents, making them part of a cohort who experienced outsized mental health and well-being impacts during the pandemic (Alburez-Gutierrez et al., 2021; Czeisler et al., 2021). A full 85% of sandwich generation members experienced adverse mental health symptoms during the pandemic, including a reported suicide ideation rate eight times higher than their peers who were not caregivers (Czeisler et al., 2021).

The majority of participants identified as single females, with an average of three household members including one child in the control group and two children in the treatment group. Both groups were primarily non-Hispanic, with almost half of treatment participants identifying as White. Most participants spoke English in the home, and roughly half had a high school education or advanced

degree(s). Median household incomes were $17,393 (M=$19,683) for the control group and $19,148 (M= $23,054) for the treatment group.

As part of CGIR's mixed-methods Randomized Controlled Trial (RCT), treatment and control group participants were invited to participate in compensated, voluntary research activities, including both in-depth interviews and four longitudinal surveys at Baseline, 6 months, 12 months, and 18 months (post-intervention). The IGI evaluation was guided by the following research questions:

1. How does GI affect participants' quality of life?
2. What is the relationship between GI and participants' subjective sense of self?
3. How does GI affect the balance of paid and unpaid work?

Additional research domains chosen by community partners included a focus on how GI affects housing stability and overall wellness for caregivers.

Findings revealed participants' experiences with multiple overlapping stressors, like financial precarity, time scarcity, and the physical and cognitive burdens of care. Many caregivers were managing their own chronic health conditions alongside their care obligations to others. High levels of mental distress were recorded throughout the pilot, evidencing the struggles caregivers faced without recourse to supports like affordable childcare, flexible work arrangements, or paid family leave.

Although Ithaca is touted by many as a tightly-knit, supportive place, caregivers did not have the time, disposable income, or emotional energy to engage with many of its resources, resulting in feelings of isolation and frustration. The dual burden of care work and economic strain functioned to lock people out from full participation in their communities. Fear and anxiety in the wake of the pandemic further heightened this sense of alienation. It is worth noting that caregivers in both treatment and control perceived the community in Ithaca as a resource and a source of meaning and connection, but they felt structurally prevented from truly participating in it.

Ithaca's housing affordability crisis represented a primary source of structurally driven stress for caregivers and has contributed to a rising sense of precarity. Increasingly, those who cannot afford to live in the city are pushed out to surrounding rural areas. While leaving Ithaca means a lower cost of living, it also decreases access to educational and employment opportunities and healthcare for residents and their families. Many participants in the IGI pilot feared displacement due to rising housing costs and expressed a willingness to make any and every sacrifice possible to stay within Ithaca's borders. They described wanting to remain in the city to maintain access to quality of life and education along with a strong desire to be part of the fabric of the community.

Research sought to identify the ways in which participants leveraged the GI to alter this litany of stressors. Findings indicate that the GI engendered greater financial stability and significantly improved physical health and mental well-being for caregivers. Consistent with research from other pilots, in the first few months of the GI disbursement, income volatility calmed as participants were able to catch up on bills and establish some measure of financial stability (Castro et al., 2023). After this point, however, both qualitative and quantitative data from Ithaca suggested a shift whereby the

GI unlocked self-determination and hope for the future. The time and mental space facilitated by the GI brought the opportunity for caregivers to more fully participate in their own lives and in the life of their communities. Respondents who had previously been isolated due to financial precarity and care duties were able to reinvest in social connections, spend time in nature, enjoy quality time with family, and engage in authentic forms of self-care.

Society has rendered care work invisible, stripping agency and meaning from the lives of those who provide it. However, both qualitative and quantitative findings suggest that the GI helped recipients to feel valued, underlining that people matter simply because they are human. Quantitative data revealed meaningful increases in measures of hope and mattering throughout the pilot. Mattering is the feeling of being seen by institutions and society, feeling valued by society and that your presence carries significance to others (Elliott et al., 2004). A sense of mattering is associated with stronger mental health, improved well-being, and decreases in social isolation while functioning as a protective factor against stress (Taylor & Turner, 2001; Taylor et al., 2018). In the words of Baumeister & Leary (1995), "belongingness can be almost as compelling a need as food" (p. 498). These findings suggest that caregivers receiving the GI felt validated, recognized, and seen as a function of the pilot and continued to do so after the pilot had ended.

IGI created an extraordinary milieu by testing the power of cash as a mechanism for valuing care work. The research findings record positive gains in a number of domains: financial, physical, and mental health, and a broader sense of hope and mattering. However, findings also highlight structural factors that GI alone cannot shift: at a local level, housing instability and increased cost of living; and at a national level, the dearth of supportive policies for caregivers and lack of affordable childcare. Without societal recognition of caregiving's true value, the observed gains may prove transient.

Quality of Life

Caregivers in the pilot faced intense pressures with little social support, including the physical and mental demands of care, embodied financial strain, and time scarcity. Often, caregivers were simultaneously navigating their own chronic health conditions while providing care to others. Many experienced high levels of mental distress, compounded by financial precarity.

The infusion of cash throughout the program contributed to financial stability and significantly decreased income volatility for the treatment group. Despite high levels of stress and mental distress, the GI also significantly improved physical health outcomes for caregivers. Improvements in physical health, particularly in overcoming physical limitations, suggest that the GI may have supported participants in managing their own health conditions alongside caregiving.

Quantitative findings also recorded small but consistent trends towards housing stability among the treatment group, suggesting it may have helped recipients stay in place amid an increasingly expensive housing market. However, the GI was only a temporary fix in the context of structural constraints. Neighborhood change and housing stress remain an issue in Ithaca, and $450 per month is not enough to support long-term housing stability. Positive health outcomes were also not sustained after the end of the pilot; without increased structural support for caregivers, it is likely they will continue to experience elevated physical and mental distress.

Work, Childcare, and Family Life

The price tag of care, or the material and time costs involved in care work, involves trade-offs around paid and unpaid work (Castro et al., 2023). However, quantitative findings revealed that the GI brought about a consistent increase in full-time employment within the treatment group compared to the control group throughout the pilot's duration. Qualitative data suggested that for some recipients, the GI supported them in taking risks, forging new careers, or pursuing previously inaccessible employment pathways.

On the other hand, however, almost a fifth of treatment participants remained stay-at-home caregivers. On the one, this suggests that with the GI, caregivers were able to value their time outside of the demands of the labor market. This was reflected in increased agency over parenting decisions, increased quality time spent with family, and sometimes, the ability to carve out time for self. Quantitative data found that the GI attenuated parental stress levels for treatment participants even after the pilot had ended.

However, other participants were forced to make difficult choices around paid employment. Some were able to use the GI to pay for childcare. However, for others, the prohibitive cost of childcare in relation to wages (an average 16.7% of median family income in Tompkins County [Women's Bureau, n.d.]) posed an obstacle to pursuing employment opportunities or entering the labor market at all. Participant narratives reflect a wider, often gendered issue of one caregiver scaling back or giving up their career after having a child due to childcare costs. They also reflect the lack of supportive policies like affordable daycare and paid family leave in the US.

Sense of Self, Hope, and Mattering

Caregivers live in a societal context where much of their labor is taken for granted. This broader status quo can contribute to a feeling of invisibility among caregivers and a sense they do not matter to their broader community. During the IGI program, participants were able to meaningfully engage in their surroundings, taking advantage of the resources that abound in Ithaca but that previously had been inaccessible due to financial and time constraints. The GI created the space for recipients to spend time in nature, invest in themselves and in relationships, and engage in their communities. Quantitative findings recorded a decrease in caregiver's overall sense of burden, underlining the importance of social connection and agency over the use of time for overstretched caregivers.

GI removed barriers to the conditions for hope, allowing recipients to set goals, visualize pathways, and move from a place of scarcity mindset to long-term aspiration. While colloquial understandings of hope are emotive, hope and mattering are key pre-ingredients for pathways towards economic agency and poverty alleviation (Castro et al., 2021; Lybbert & Wydick, 2018). Quantitative findings reflected an increased sense of hope among participants: improvements were observed in the treatment group across all subdomains of the Adult Hope Scale (Lybbert & Wydick, 2018), including increased sense of agency and ability to activate life pathways. Findings also suggest a significant, sustained increase in the percentage of treatment participants reporting high levels of hope, indicating a potential shift towards deeper levels of hopefulness among GI recipients. Receipt of the GI validated caregivers' dignity and humanity, engendering a sense of being seen and recognized for the care they provided.

KEY FINDINGS AT-A-GLANCE

- **Elevated sense of hope and mattering:** Participants experienced a significant increase in their sense of hope and mattering, reflecting a positive shift in subjective well-being and perceived social value.
- **Income stability and housing security:** The GI effectively smoothed income volatility and decreased housing stability concerns, indicating improvements in financial resilience essential for long-term well-being.
- **Improved physical health outcomes:** Improvements in physical health, particularly in overcoming physical limitations, suggest that the GI may have supported participants in managing chronic health conditions and enhancing overall physical well-being.
- **Reduced levels of parental stress:** A marked reduction in parental stress levels highlight the GI's efficacy in alleviating the pressures associated with parenting, increasing agency over time, and fostering healthy family dynamics.

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MAYORS FOR A GUARANTEED INCOME

Founded by Michael D. Tubbs, MGI is a coalition of mayors advocating for a guaranteed income to lift all of our communities and build a more resilient, just America. Since launching in 2020, MGI has grown its ranks from 11 to over 125 mayors, supported the launch of 50-plus guaranteed income pilots across the country, and delivered more than $250 million in direct, unconditional relief to everyday Americans. MGI has also launched two affiliates, Counties for a Guaranteed Income and United for a Guaranteed Income Action Fund. MGI's work has ensured that guaranteed income spreads from a single moment in Stockton, CA to a national movement—pushing the conversation forward in cities, state capitals, and Congress.

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Background

Over the years, people have been drawn to Ithaca, NY in pursuit of alternative ways of living. A hub for the "back-to-the-land movement" in the 1970s, Ithaca and its environs were home to several experiments in building new systems and social structures, including Lavender Hill, a queer feminist commune, and Moosewood, a collective that is now the country's longest-running vegetarian restaurant (Chaisson, 2013, para. 8; The History Center, n.d.-a; Williams, 2022). There is a vibrant community arts and music scene; murals and quirky street art can be found throughout the neighborhoods. The city is well known for its political activism and inclusive nature, and a colorful cast of characters call Ithaca home.

Many people are also drawn to Ithaca for its proximity to nature. It is located in the Finger Lakes region of upstate New York, with steep gorges and swathes of forest and farmland. There is water in every form and facet: the rush of waterfall over rock; streams and brooks running through town; the stillness of the lake. As the tongue-in-cheek "Ithaca is gorges" bumper stickers suggest, it is a gorgeous place to live.

Cornell University and Ithaca College are both anchor institutions in the area. Cornell was founded as a land-grant University in 1865, receiving almost one million acres of land from the government (Cornell University, n.d.). Much of this land was sold, with the revenue going into Cornell's budget. While land-grant universities purported to broaden the pool of those who could access university education, the acquisition of the land itself also reflects the dispossession of Indigenous peoples who had lived there, namely the Gayogo̱hó:nǫ' (the Cayuga Nation), members of the Six Nations of the Haudenosaunee Confederacy (sometimes referred to as the Iroquois Confederacy) (Jordan, 2023). Research shows there was wholesale clearing of Indigenous land by 18th-century European settlers, including burial grounds (Byeon, 2015); yet some place names and their meanings still bear traces of the Cayuga language, including, of course, Cayuga Lake (The History Center, 2018).

Surveyor General Simeon De Witt named Ithaca after the Greek island home of Ulysses, the hero of Homer's epic poem, *The Odyssey* (Tompkins County New York, n.d.). It was incorporated as a village in 1821 and became a city in 1888. The early 19th century saw significant growth, fueled by transportation advancements such as the Erie Canal and the Ithaca and Owego Railroad, which connected the rapidly expanding community to broader markets including New York City, Albany, Buffalo, Syracuse, and the Midwestern states (Erie Canalway, n.d.). The mid-1970s and 1980s witnessed a decline in traditional manufacturing, driven by globalization and technological advancements. This shift impelled Ithaca to diversify its economy, focusing on higher education, research, and tourism.

Over the years, Ithaca has become known for its active, engaged citizenry and strong political progressivism. Some of this derives from the population of students and scholars, but it also comes from Ithaca's status as a hub for alternative ways of thinking. At one point, the city had its own currency, the HOUR, introduced by activist Paul Glover as a way to keep money in the community, rather than the global financial system (Grover, 2006). Although no longer in circulation, the HOUR constituted a source of local social, as well as financial, capital.

Ithaca is often at the forefront of progressive ideals: in 2019, Ithaca became the first city in the US to pass a Green New Deal resolution, committing to carbon neutrality by 2030. The city is a safe haven for gender-affirming and reproductive care (Reaves, 2023), a longstanding champion of the LGBTQ+ community, and a sanctuary city for refugees and migrants (The History Center, n.d.-a; Ithaca, N.Y., Mun. Code, 2017). Jonathan, an artist and father, explained:

> *I love our small-town vibe with lots, um, you know, a liberal progressive town in a very conservative state. And so if we draw a lot of people that come here because of the liberal and progressive values and, um, let's say something I love about our community is that we're small enough that there's an accountability here of people talking with each other or knowing each other.*

Many pilot participants cited Ithaca's spirit of mutual support and community connection; interviews suggested the small-town nature of Ithaca manifests in a tightly-knit social fabric. They described a sense of warmth and openness, of like-minded, caring people. Sophie related:

> *There's this catchphrase we have [for Ithaca] called, "10 Square Miles Surrounded by Reality," and that's super true. It's just an incredibly warm and open and accepting place, … um, there's a really big, beautiful sense of community. People take care of each other. It's—it's a really unique and amazing place.*

Pilot participants also cited how Ithaca is a great place to raise children, due in part to access to nature and the abundance of parks and playgrounds. Susie A., a graduate student and mother of two, noted that, "even though we're like this uh, small town, we like to think that we're a big city and have all these nice resources… It's been a great place to raise our young family." Andrea, a university employee and mother of two, concurred that, "raising kids here, the ease and the safety is really nice, um, for them and for me as a parent too."

Equally, however, it has become increasingly challenging for many Ithaca residents to afford to stay. A Cornell study on living wages calculated that the 2023 living wage for Ithaca was nearly 10% higher

than in 2022, the highest increase in 3 decades. The most important factor driving the increase was the cost of housing (Cornell University, 2023). In part, this stems from the high number of transient student renters; the students outcompete low-income residents, resulting in higher rents and greater housing insecurity for the latter. Broadly, renters in Ithaca face severe cost burden. Prospects for aspiring homeowners are also limited, as the area has low turnover in housing stock and tight zoning restrictions for new construction.

The state of housing in Ithaca has contributed to a rising sense of precarity among residents; increasingly, those who cannot afford to live in the city are pushed to the outskirts and surrounding rural areas. While leaving Ithaca means a lower cost of living, it also decreases access to educational opportunities, employment, and healthcare for residents and their families. Many participants in the IGI pilot feared displacement for these reasons.

The lack of affordable accommodation also poses obstacles for low-income people seeking permanent housing. Tompkins County has a higher rate of homelessness per capita than other parts of the state, with increased difficulty in finding housing for families at risk of homelessness and a higher number of people cycling in and out of houselessness (Horn, 2022). The quantity of emergency shelter space is insufficient, with many people in temporary hotel rooms and others couch-surfing or living in encampments.

One of these encampments, a patch of land called “the Jungle,” has been a lightning rod for political and community tensions around agency, prevention, harm-reduction, and policing. An off-the-grid encampment with its own transactional economy, its roots stretch back to the shantytowns of the early 20th century (Barry, 2024). Conditions in the Jungle worsened with the economic upheaval of the pandemic and a surge of fentanyl and methamphetamine into the community. On the one hand, progressive policies have allowed for continued habitation of the encampment, whether or not those living there desire transitional housing, thereby preventing criminalization of homelessness or addiction. On the other hand, a number of deaths and concerns related to sanitation and violence have dogged the encampment, and it remains a controversial part of Ithaca’s physical and political geography (Butler, 2019; Jordan, 2024b).

Although Ithaca is a vibrant place by many accounts, it is not immune to the challenges of housing inequality and resource disparities. It also deals with the challenges of structural racism, as qualitative interviews with IGI pilot

participants suggested. While the discourse around the city is one of equity and allyship, participants noted that divisions persist. Several White participants described a culture that is well-intentioned but out of touch. Elnora Bell, a White resident and mother of two, talked about Ithaca as a "bubble":

> *There are universities here, and it's like, there's a lot of turnover. It's a, it's a fresh city, it's a progressive city, right? Like things happen, people move through, it's really educated. Um, because of that, I think people don't really feel as if we can succumb to the problems that [others] succumb to, like racism and classism, but we do. And so sometimes it feels like there's not enough movement, not enough is changing in those conversations.*

Ellen, a 43-year-old White single mother, also suggested there is a mentality that because a community is liberal, it must be immune to racism. She outlined some struggles that her biracial son has faced in Ithaca:

> *I'd say Ithaca is pretty progressive in a lot of ways. Um, but I've also learned that it's, it's not. There's this, like, idea that it's progressive, but I've had my run-ins, my son is half Black. So in the school system, having this naïve, ignorant idea that, like, my son is safe in Ithaca and especially in the school system, and unfortunately, um, that has not been the case with, you know, teachers and that.*

Jay, a nonbinary parent of two, also suggests that more could be done:

> *This is just such a, I don't know, such a gentle place—in a way and, you know, I think Ithaca can trip over its gentleness, you know, often and maybe think that there's not as much work that needs to be done as, as, you know, does need to be done...*

The experiences of some residents of color suggest that Ithaca, like other places, has work to do. John, a Black father of five and lifelong Ithaca resident, described his experience being profiled by police when he was on the "wrong side of town," the history of segregation within Ithaca, and the many discriminatory experiences he has faced in applying for jobs or applying for housing:

> *Even if you say it, you have to prove it, and it is hard to prove because it's easy to say, ["I'm not racist."] [It's easily said,] I have a Black friend. It's easily said, I understand the struggle. I was a part of the Black Lives Matter Movement—all that, all—all that bullshit. But when it comes down to it, you can see the eyes, you can see it in the actions, you can see it in the handshakes, you can see it in the gestures, you can see it when it comes to things. So, just— it's still to this day, how your credit is looked at, how your name is looked. You know, I—I've dealt with it all my life.*

In contrast to White interviewees' experiences of Ithaca as a tight-knit community, several interviewees of color found it a cold, dangerous place. Grabba, a young Black father originally from New York City, talked explicitly about negative experiences with a number of systems. In addition to feeling discriminated against in educational and employment opportunities, he also cited instances of racism

within medical settings and traumatic interactions with police after an officer pointed an assault rifle at him when responding to a call in the community.

To some extent, individual experiences of racism are symptomatic of local history and geography; these in turn reflect broader systemic trends. Like many cities, Ithaca is segregated by race and class. Race-restrictive deed covenants in the neighborhoods around Cornell were common until the 1950s, when the impact of the Civil Rights movement began to desegregate Ithaca's neighborhoods to some extent (Bauer, 2001). Places like Fall Creek and Cornell Heights are still the provenance of wealthier White residents, boasting views of Cayuga Lake and Ithaca Falls, proximity to Cornell's Botanic Gardens, hiking trails, and a golf course. Cornell itself is literally situated on a hill, a proverbial ivory tower looking down on the city.

Historically, Ithaca's Black community was located in the Southside neighborhood, near downtown. At its center was the St. James AME Zion Church, formerly a station for the Underground Railroad and still a space for religious services today (The History Center, n.d.-b). The church was also a center for political and social activism over the years. The wider neighborhood became a hub for Black-owned businesses, fraternal organizations, a women's club, and a chapter of the NAACP (Hill, 1994). In the 1930s, a campaign to build a community center took place; it was opened by Eleanor Roosevelt in 1938 (Engst & Friedlander, 2014). Several leaders of the Civil Rights movement, including Dorothy Cotton, passed through or came to reside in Ithaca over the years (Sandomir, 2018).

As housing stock aged and the Southside became run down, White policymakers floated urban renewal and public housing development as the solution, as elsewhere in the US. This further reinforced class and race segregation. Investment in the commercial downtown core came at the expense of the historic Black neighborhood that existed beforehand. As Debra, a Black resident and mother who grew up in Ithaca, noted, "when you're in an area where a lot of, uh, the rich non-melanated people go to hang out and drink coffee, we can't really afford that. We can't afford those things."

Urban renewal and the encroachment of downtown commercial development pushed residents to affordable housing complexes, destroying previously tight-knit neighborhoods and creating the conditions for community violence and substance use (Crandall, 2016). Several interviewees, mostly people of color living in affordable housing, shared recent experiences of crime and fears around safety in these areas. Lacie had lived in Ithaca since she was 15 and reflected on the dual nature of the city—the sense of community, on one hand, and the invisible but durable reality of structural disparities, on the other. In Lacie's case, this included having family members who were victims of violent crime and interactions with the police, who profiled and targeted her son on a number of occasions. Debra also talked about the crime that she perceived in the wake of the pandemic. She grew up in Ithaca but had lived abroad for several years; after returning recently, she was struck by how the city had changed.

Lilly, mother of two, said their neighborhood was bifurcated by "this imaginary line where people have a little bit more money and you know, two-parent households, and people have yards and things like that." Frank, a White interviewee with two children, noted separately that, "it definitely feels like there's a lot of invisible fences in Ithaca."

The city's above-average rates of income inequality also reflect structural racism: census data indicates that people of color in Ithaca have significantly lower median household incomes compared

to their White counterparts, highlighting systemic issues such as limited access to high-paying jobs, educational opportunities, and essential resources (U.S. Census Bureau, 2022b). Among Black or African American residents, nearly three out of every five workers (58.8%) earn less than $18.45 per hour (the calculated living wage), whereas the figure for White workers is just above one in three (35.0%) (Cornell University School of Industrial and Labor Relations, 2023). Given Ithaca's housing challenges, this limits options for moving to a better-quality home or safer neighborhood.

In the wake of George Floyd's murder in 2020, Ithaca was one of many cities to create a Black Lives Matter (BLM) street mural (Epps, 2020); it was conceived by a West End local and organizer, Harry O., who said:

> *There's a mythology that systemic injustices don't go on in Ithaca, but it's impossible for it not to exist when we operate under the same system as everywhere else, and we've been doing a lot of protesting and a lot of marching, hopefully we can connect and this can be the start of healing.*

During that time, Ithaca residents came out in droves to protest police brutality—although the protests were not organized or endorsed by the local chapter of BLM. As part of a state-wide initiative around examining policing practices in response to George Floyd's murder, the City of Ithaca and Tompkins County engaged in the Reimagining Public Safety process. The city created a proposal to replace Ithaca Police Department with the Community Solutions and Public Safety Department, causing periodic showdowns between Cornell and Back the Blue protestors. The final proposal does not disband the police department but calls for unarmed community first responders (Reimagining Public Safety Working Group, 2022).

Despite the systemic challenges Ithaca faces, it also has resources to draw upon: strong civic engagement, progressive policies, educational institutions, and access to nature. Perhaps its strongest resource is its citizenry. People tend towards a propensity to embrace new ideas and perspectives, no matter how out-of-the-box, and to vocalize and organize for change.

Context and Demographics

Ithaca, with a population of 32,724 individuals, presents a distinctive demographic profile. The median age is 24 years, reflecting its substantial student population from Cornell University and Ithaca College. The economic divide between affluent university professionals and the student population is mirrored in the city's financial profile: a median household income of $45,468, a poverty rate of 33%[1], and a Gini Index[2] of 0.56, indicating substantial income inequality (U.S. Census Bureau, 2022a). Educational attainment is high, with a significant 69.4% of residents holding a Bachelor's degree or higher. This highly educated population is partially attributed to alumni of local institutions choosing to remain in Ithaca after graduation, as indicated by some study participants.

The racial composition is 66.5% White, 6.5% Black or African American, 15.7% Asian, and 8.0% Hispanic or Latino. Female-identifying individuals comprise 49.9% of the population. Median home values stand at $324,300, with median gross rents of $1,391 per month.

Table 1: 5-Year Estimates of Poverty in Ithaca, NY in 2022

	FAMILIES BELOW POVERTY LEVEL (%)	INDIVIDUALS BELOW POVERTY LEVEL (%)
White alone	2.0	30.6
Black or African American alone	42.8	57.2
Educational attainment less than high school	51.4	25.6
Bachelor's degree or higher	0.5	5.7
Some college	10.5	16.2

Source: U.S. Census Bureau, 2022c.

The study sample comprised residents of Ithaca, NY, with annual incomes at or below 80% of the AMI for their household size and significant caregiving responsibilities. The sample was weighted according to the racial and ethnic distribution of Housing Cost Voucher (HCV) recipients. The mean age of participants was 42 years in the control group and 41 years in the treatment group. Participants were predominantly female: 75% in the control group and 74% in the treatment group. Both groups were primarily non-Hispanic (control: 72%; treatment: 87%), with White people comprising 38% of the control and 48% of the treatment group. Household characteristics were similar across groups, with an average of three household members comprising one child in the control group and two children in the treatment group. Most participants were single (control: 63%; treatment: 64%) and primarily English-speaking. Educational attainment at or below high school level was 46% in the control group and 48% in the treatment group. Those with an Associate's degree made up 19% of the control and 10% of the treatment group, while Bachelor's degree holders comprised 13% of the control and 19%

1 High individual poverty rates reflect local student populations; family poverty rates are a more reliable indicator.
2 The Gini Index is a statistical measure of income inequality, ranging from 0 (perfect equality) to 1 (maximum inequality).

of the treatment group. Median household incomes were $17,393 (M=$19,683) for the control and $19,148 (M=$23,054) for the treatment group. About half of the respondents in both groups received Supplemental Nutritional Assistance Program (SNAP) or other benefits. Overall, while minor variations were observed in the baseline demographic characteristics between the groups, the joint multivariate test revealed a statistically significant difference based on ethnicity only.

Table 2: Participant Demographics

ITHACA, NY		TREATMENT	CONTROL
SAMPLE SIZE		**110**	**130**
AVG. AGE OF RESPONDENT (YEARS)		41	42
GENDER (%)	Male	24	22
	Female	74	75
	Other	3	3
CHILDREN IN HOUSEHOLDS (%)	Yes	84	72
AVG. NUMBER OF CHILDREN IN HH		2	1
AVG. HH SIZE		3	3
ETHNICITY (%)	Non-Hispanic	87	72
RACE (%)	White	48	38
	African American	24	25
	American Indian/Alaska Native	2	1
	Hispanic, Latino, or Spanish origin	3	12
	Asian	7	5
	Other/Mixed	16	19
MARITAL STATUS (%)	Single	64	63
	Married	19	23
	Partnered/In-relationship	17	14
PRIMARY LANGUAGE AT HOME (%)	English	91	91
	Spanish	2	7
	Other	7	2
EDUCATION (%)	High school or less	48	46
	Associate's degree (2-year college)	10	19
	Bachelor's degree (4-year college)	19	13
	Trade or technical school	5	6
	Other	18	16
ANNUAL HH INCOME (IN $)	Median	19,148	17,393
	Mean	23,054	19,683

Theoretical Framework and Methods

All research methods were approved by the Institutional Review Board of the University of Pennsylvania and rest on a multi-site pre-analysis plan (ABT Associates, 2023).

This research is based on a theoretical framework suggesting that chronic scarcity diminishes cognitive capacity, heightens financial vulnerability, and curtails an individual's ability to handle stress (Mani et al., 2013; Shah et al., 2021). Consequently, material hardship fosters a scarcity mindset that adversely affects both physical and mental well-being, hampers goal-setting, diminishes hope, and traps individuals in the present (West & Castro, 2023). When trapped in scarcity, most of a person's cognitive resources are consumed by navigating financial stress, leaving little room for visualizing pathways out.

These stressors are exacerbated by the feminization of poverty (Peterson, 1987) and the physical, emotional, and financial toll of unpaid care work, or social reproduction, which references "the maintenance of people, through various domestic tasks, and transmission of knowledge, social values, and the construction of individual and collective identities" (Bezanson & Luxton, 2006, p. 6). Despite the centrality of unpaid care work to reproduction of the workforce and maintaining society, these tasks are undervalued and frequently assigned to female-identified people (Duffy, 2007; Parreñas, 2010). This includes shopping, childcare, managing children's educational and enrichment needs, eldercare, cleaning, managing household finances, cooking, caring for the ill, and the cognitive burden of constantly managing the logistics and emotional needs of a family (Castro et al., 2023). These stressors carry an outsized impact on people of color contending with weathering, which references the physiological and cellular impact of chronic stress stemming from racism and marginalization (Geronimus, 2023). In short, persistent financial stress as an unpaid caregiver amounts to constantly navigating time and resource scarcity in a structural context ill-suited for supporting caregivers. Therefore, GI provides a pathway for alleviating the twin burdens of financial scarcity and time scarcity, which in turn creates the mental bandwidth for alternative pathways.

This RCT is anchored in a parallel mixed-methods design with two independent strands of data-collection and analysis (QUANT + QUAL), with data integration occurring at the conclusion of analysis within each strand (Tashakkori et al., 2020). The research questions are as follows:

- How does GI affect participants' quality of life?
- What is the relationship between GI and sense of self?
- How does GI affect income and through what mechanisms?
- How does GI interact with unpaid care work?

Quantitative Methodology

This RCT was conducted to evaluate the impact of GI on the overall health and well-being of participants. The study sample comprised 242 participants selected from an initial pool of approximately 390 applicants. Eligibility criteria included individuals aged 18 and above, with annual incomes at or below 80% of the AMI, who were residents of Ithaca, NY, and had significant caregiving responsibilities.

One hundred ten participants were assigned to the treatment group, receiving $450 per month for 12 months, while 132 were assigned to the control group and did not receive any cash. The initial randomization strategy employed weighted allocation by race to mirror the demographic distribution of HCV recipients in Ithaca. Treatment group participant replacement during the onboarding process inadvertently altered the planned proportions, resulting in a deviation from the original weighted design. To mitigate potential bias from this Baseline imbalance, ethnicity was incorporated as an interaction term in the regression models. This statistical adjustment effectively accounted for the demographic disparities between groups, thus enhancing the robustness and validity of the estimated treatment effects.

Two control group participants subsequently withdrew from the pilot, reducing the final analysis sample to 240; their data were excluded. Data collection occurred at four intervals: Baseline (December 2021), 6 months after GI began (November 2022), 12 months (May 2023), and 18 months (November 2023), which was 6 months after the final cash disbursement. Participant onboarding spanned approximately 6 months, with the first disbursement occurring in June 2022. This delay necessitated the postponement of the 6-month survey. All participants were compensated for their time completing the surveys. Detailed response rates are provided in the Appendix.

Outlier detection and management followed a standardized framework, utilizing winsorization to minimize the influence of extreme values. Missing data were addressed using Multiple Imputation by Chained Equations (MICE) (Azur et al., 2011). This iterative imputation method, well-suited for complex data structures, generates accurate imputations for missing data through multiple iterations. MICE was applied to specified outcome variables and select demographics, ensuring a diverse range of imputed results. Post-imputation validation involved distribution analyses, plausibility checks, convergence diagnostics, sensitivity analyses, cross-validations comparing models trained on original versus imputed datasets, and assessment of model fits. This rigorous process yielded a comprehensive set of imputed datasets for subsequent analyses.

The impact of the GI intervention was assessed using a comprehensive analytical approach. Generalized Estimating Equations and Linear Mixed Effects models were used alongside regression-adjusted means analysis. The latter provided direct mean differences in outcomes across the four time points. To account for potential confounding due to initial imbalances, each regression model controlled for ethnicity. Data were structured in long format, with observations representing participant outcomes at specific time periods. The model incorporated fixed effects for treatment, time, ethnicity, and their interactions, as well as a random intercept per participant to address within subject correlations in repeated measures.

Qualitative Methodology

The theoretical framework noted prior informed each stage of qualitative data collection and analysis. Semi-structured interviews were conducted at the midpoint of disbursements and again 5 months after the final disbursement. All interviews were conducted in English, recorded on a digital voice recorder, and professionally transcribed verbatim. During the qualitative interview process, all participants selected pseudonyms to help protect their identities. All data is connected to participant pseudonyms. Participants either interviewed at home or chose their own location in the community. Some participants elected to interview on Zoom to minimize COVID-19 exposure risk.

The first-round interview guide included domains focused on health, well-being, care work, values, relationships, and economic well-being. Thirty participants were recruited to participate in interviews lasting 1.5–2 hours, with a final sample of 23 respondents (20 treatment; 3 control). The remaining seven were canceled at the last moment due to work and childcare responsibilities, underscoring the time complexities faced by unpaid caregivers. Participants were compensated with a $40 gift card.

The same respondents were recruited to participate in second-round interviews, and 12 responded. An additional 8 participants who were unable to interview during round one participated in round two for a total sample of N=20. In response to inflation, compensation was increased to a $50 gift card for round two. The second-round interview guide focused on care work and decision-making pathways as the pilot ended. This included an oral history component focused on the theoretical anchors of the hope, mattering, and belonging scholarship which captures the antecedents for hope noted in the positive psychology literature (Baker et al., 2021). A structured and recursive "thick description" memo-writing process was carried out throughout the entire research process (Ponterotto, 2006, p. 358), including post-interview, after de-identification, and at each phase of the analytic process.

In keeping with mixed-methods parallel design (Tashakkori et al., 2020), qualitative data analysis occurred in two phases before being integrated with quantitative findings. In phase one, transcripts were coded in Dedoose by a team of research assistants without the use of AI. Analysis followed the blended approach described in the pre-analysis plan (ABT Associates, 2023), which involved thematic analysis on the semantic level and grounded theory on the latent (Braun & Clark, 2012; Charmaz, 2014). Values and process coding were used on the semantic level for understanding decision-making and structural vulnerability, and focus and theoretical coding were used for understanding agency, care work, and meaning-making in relationships (Saldaña, 2021). In phase two, a framework-guided rapid analysis (RA), which involved recursive in-depth immersion in the transcripts and a theoretically driven template to organize and analyze the data (Gale et al., 2019), was utilized. Thick description analytic memos were then generated and cross-checked against the summary tables and phase one analysis before integration.

Findings

1. Fragility by Proxy: Health, Housing, and Quality of Life

Summary: Caregivers in the pilot faced intense pressures with little social support, dealing with the physical and mental demands of care, embodied financial strain, social isolation, and time scarcity. Despite high levels of mental distress, the GI significantly improved caregivers' physical health outcomes and attenuated stress levels. Improvements in physical health, particularly in overcoming physical limitations, suggest that the GI may have supported participants in managing their own chronic health conditions alongside caregiving. The infusion of cash throughout the program also contributed to financial stability and significantly decreased income volatility for the treatment group. Quantitative findings recorded small but consistent trends towards housing stability, suggesting it may have helped recipients temporarily stay in place amid an increasingly expensive housing market. Participants noted that financial, physical, and mental health were mutually reinforcing, pointing to improved overall quality of life and well-being.

Care and Precarity

"[My child] is like the heart in the, you know, body of my whole existence."

As Fisher and Tronto (1990) define it, care "includes everything we do to maintain, continue and repair our 'world' so that we can live in it as well as possible" (p. 40). Unpaid care work is an intrinsic part of being human. Some of this work is visible and physical: household activities such as shopping, cooking, cleaning, childcare, and eldercare are necessary for maintaining society and reproducing the workforce for the next generation. Other facets are more subtle: the labor of maintaining relationships, of making others feel safe, secure, and loved. Unpaid care work also includes the mental burden of managing household finances and invisibly monitoring the schedule and emotional needs of a family. In most of the world, these unpaid responsibilities are assigned to women (Castro et al., 2023).

All types of caregivers participated in the IGI pilot: men and women who were single parents; people caring for children and elders with complex medical needs; and others engaging in paid or volunteer care work outside of their family circle. Some benefited from support networks of partners, extended family and friends; some relied upon social services like SNAP and Section 8 (also known as HCV); others were geographically or socially isolated.

IGI participants shared beautiful examples of what caregiving meant to them. Amy, a single mother of a teenager, left her job in public service to become a full-time caregiver for her elderly father, who has dementia. She did so in hopes that he could live his last months with dignity and joy. As Amy put it, she "acts as his hands." One afternoon, for instance, he wanted to plant 250 flowers in the garden, and she brought him out in the wheelchair so he could watch her do it. She said:

> *I think that there's, especially when you're providing care for one person, it's very intimate… You're taking care of one person's full spirit… I know it's the meaning of life: love and love those who—who love you. That is—it's just the way it should be.*

Sophie, who provided care for her chronically ill mother, described her perspective on care work:

> *Just hearing or seeing the sense of relief when something is taken care of and that person just doesn't have to stress about it anymore… You can just, like, see it in their face when they're just like,* 'Thank you,' *or just like, they just knowing they don't have to worry about. It is a really awesome feeling.*

The life-affirming, deeply fulfilling nature of care was apparent throughout participants' narratives. However, the dual burdens of financial precarity and time scarcity prevented caregivers from being able to provide care in a way that felt present, joyful, and rooted in community. Instead, they cited feeling physically and emotionally drained, stretched to breaking point amid competing obligations, and overwhelmed by financial strain. As Haley, a woman with sole responsibility for her elderly father, put it:

> *If you have never been in a caregiving role before, then you have absolutely no idea how difficult it is. Like physically, emotionally, there's so many things, so many ways that it takes a toll on you and most people just don't realize…*

The multiple pressures caregivers faced negatively impacted their health and functioned to isolate them from their communities, embodying fragility by proxy.

The average age of pilot participants was 42 in the control group and 41 in the treatment group. Consistent with other research (Baker et al., 2018), the intersection of middle adulthood and heavy care burdens can erode physical and mental health and well-being. Many participants were members of the "sandwich generation" (Alburez-Gutierrez et al., 2021), caring for their children and aging parents simultaneously. Caught between the competing demands of paid work and unpaid care work, these individuals experience high levels of stress, illness, and early-onset health problems directly linked to the pressures of caregiving.

Caring for others depleted IGI participants, physically and mentally. As Lilly said, "you can't really take care of anybody else without sacrificing a part of yourself either." Many caregivers were struggling to manage a litany of their own chronic health conditions on top of care obligations. Haley's medical conditions prevented her from working full-time. Lacie, who was supporting her children and grandchildren, was currently unemployed because of her chronic health conditions. Kelly, a full-time caregiver for her grandchildren, had cancer and was being treated for persistent mental illness. Paul, a father of two and a caregiver for an elder, had also been diagnosed with mental illness and struggled with anxiety which he attributed to the burden of care work. Kristina, sole caregiver for her child with severe developmental delays, experienced an amputation after complications from diabetes. All of them had multiple care obligations that they had to navigate alongside their own health issues. Participants described doing household chores and care work—changing diapers, shaving elderly parents, clipping their nails, cleaning, washing, and comforting—all while grappling with their own physical limitations, some of which were exacerbated by these tasks.

Figure 1: The Invisible Toll of Care Work

A number of caregivers in the pilot were unable to work in the labor market due to health issues. Some were receiving disability payments, while others were struggling to navigate the system in order to apply. Still others were unemployed because of chronic health conditions but were nonetheless ineligible for disability benefits. These situations often led to financial instability and exacerbated conditions like depression and anxiety.

Poor physical and mental health, combined with financial instability, constrained decision-making, multiplied stressors, and led to a scarcity mindset where individuals had limited space to hope or think about the future (West & Castro, 2023). As Debbie, a scientist and single parent, noted:

> *Being in desperate straits doesn't help people make good decisions. It's not the best way... And you're kind of condemning people to a level of stress and fatigue that doesn't—doesn't help them, and doesn't help our society as a whole, and necessarily limits the options they can have and how, you know, so how do you— How do you have the healthiest society with people doing what is best for all?*

Selena, a single mother and control participant, was struggling to make ends meet, caught in a cycle of anxiety and precarity. She used to be "a happy person," but no longer felt that way because of financial pressures. Her daughter was the reason she continued to get up in the morning. She said, "I love being a mom. I love, you know, being her mother. It's just sometimes I feel like I'm trapped."

Ellen also described how financial precarity contributed to stress, anxiety, and depression:

> *When I was working, like, the 45 hours a week I felt like I was, I was spiraling, like I said, my health was not good. I was, um, I, was getting too, I wasn't eating, I was really sick. Um, and I think part of that was just like my anxiety, my depression like, and again, just like, I don't have time to do all these other things and I'm anxious because I don't have the time for my son, but I'm just trying to make ends meet, like, it's just this constant battle.*

Poor mental health was exacerbated by a pervasive sense of isolation. Although Ithaca is touted by many as a tightly knit, supportive place, caregivers did not have the time, disposable income, or emotional energy to engage with many of its resources, further heightening a sense of alienation. "Our society is no longer, like, set up to really be like that village mentality and really be, like, a caring for others kind of mentality," Elsa said. A stay-at-home mother of two, she also cared for her aging father. She experienced chronic pain following a car accident, but she did not qualify for disability payments because she owned her home. She discussed feeling lonely and overwhelmed in her role as a primary caregiver.

The legacy of the pandemic also compounded feelings of isolation. Participants spoke about how lockdown had impacted their social ties and described residual fear and anxiety. Ziggy, a musician with two children, was dealing with the lingering effects of COVID-19. Although his family was extremely cautious during lockdown, his immunocompromised son contracted COVID-19 when schools opened again. Ziggy, too, was hospitalized. His son subsequently suffered from Long COVID, requiring daily care, and the family remained homebound to avoid exposure:

> *It's been a real challenge, I would say, the past three years. I feel, you know, quite isolated and alienated from a lot of my, you know, what could or would potentially be a support system. I also feel like many people have been going through really difficult times themselves. Um, so I'm less likely to even reach out for that reason. Um, you know, we've mostly been, like, kind of in lockdown for three years.*

Geography also contributed to isolation. As previously mentioned, Ithaca has traditionally functioned as a hub of opportunity within a broader rural milieu. For caregivers living outside the city without dependable transportation, their isolation was further underlined. Bus services have been cut between Ithaca and rural areas over the years (Collins, 2022). Jade, a mother of three, was unable to drive, and her disability made it difficult to walk to the bus stop, so she had no options for transport. Kristina's car broke down and without the money to repair it, she was stuck.

In light of this context, it is unsurprising that participants in both the treatment and control groups recorded high levels of mental distress, as measured by the Kessler Psychological Distress Scale (Kessler et al., 2003), throughout the pilot. Other research has highlighted the toll that caregiving takes on unpaid caregivers (Lindt et al., 2020). The GI alone was not enough to mitigate overlapping stressors like multiple forms of isolation, financial and time scarcity, and the lack of structural support for caregiving. At Baseline, both groups reported elevated levels of mental distress, with the treatment group showing marginally lower distress (M=22.85) than the control group (M=22.96). Psychological

distress in the treatment group (M=23.29) increased marginally at 12 months but remained lower than that of the control group (M=24.54). Six months post-intervention, while the treatment group reported marginally lower scores than at the previous time point (M=23.25), the mental distress levels for the control group had elevated further (M=25.07). Despite these trends, mental well-being scores for both groups consistently remained above the global cut-off for moderate levels of psychological distress throughout the study period and did not yield clinically meaningful improvements in mental well-being of participants. Indeed, these findings align with a recent Community Health Assessment Report highlighting a significant increase in adults reporting both depressive disorders and a prolonged poor mental health state (Tompkins County Whole Health, 2022).

Income

The GI pilot was also unable to fully bridge the gap between the cost of living and earnings—another source of stress. As inflation continued to outpace wage growth in late 2022, households faced significant financial challenges making ends meet. Although the minimum wage was set at $15.00 an hour in New York State, Cornell's Living Wage Measure estimated that a single adult with no children in Tomkins County needed $18.45 per hour (working full-time) to meet basic needs (Cornell University School of Industrial and Labor Relations, 2023). Participants felt the stretch—as Vicky noted, "I think the fact that inflation has raised, like, over four times the amount in the last 50 years and minimum wage is barely doubled [makes it hard for people to get by]."

Figure 2: Average Household Income, Treatment vs. Control

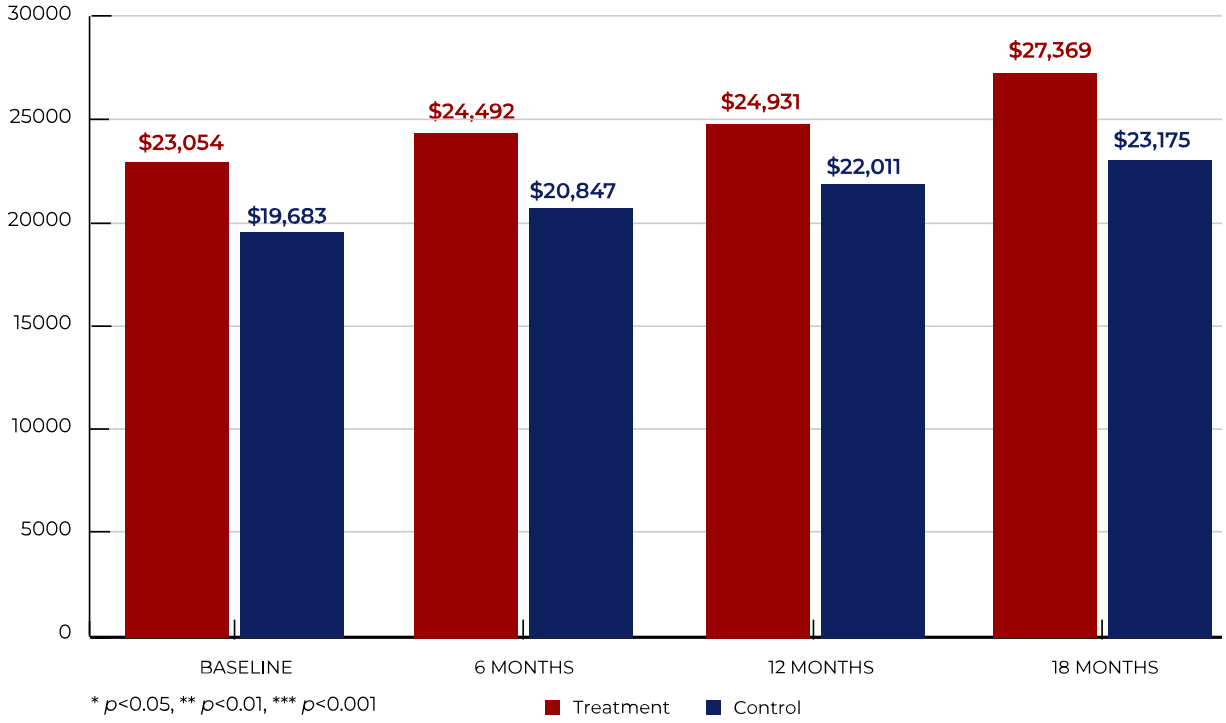
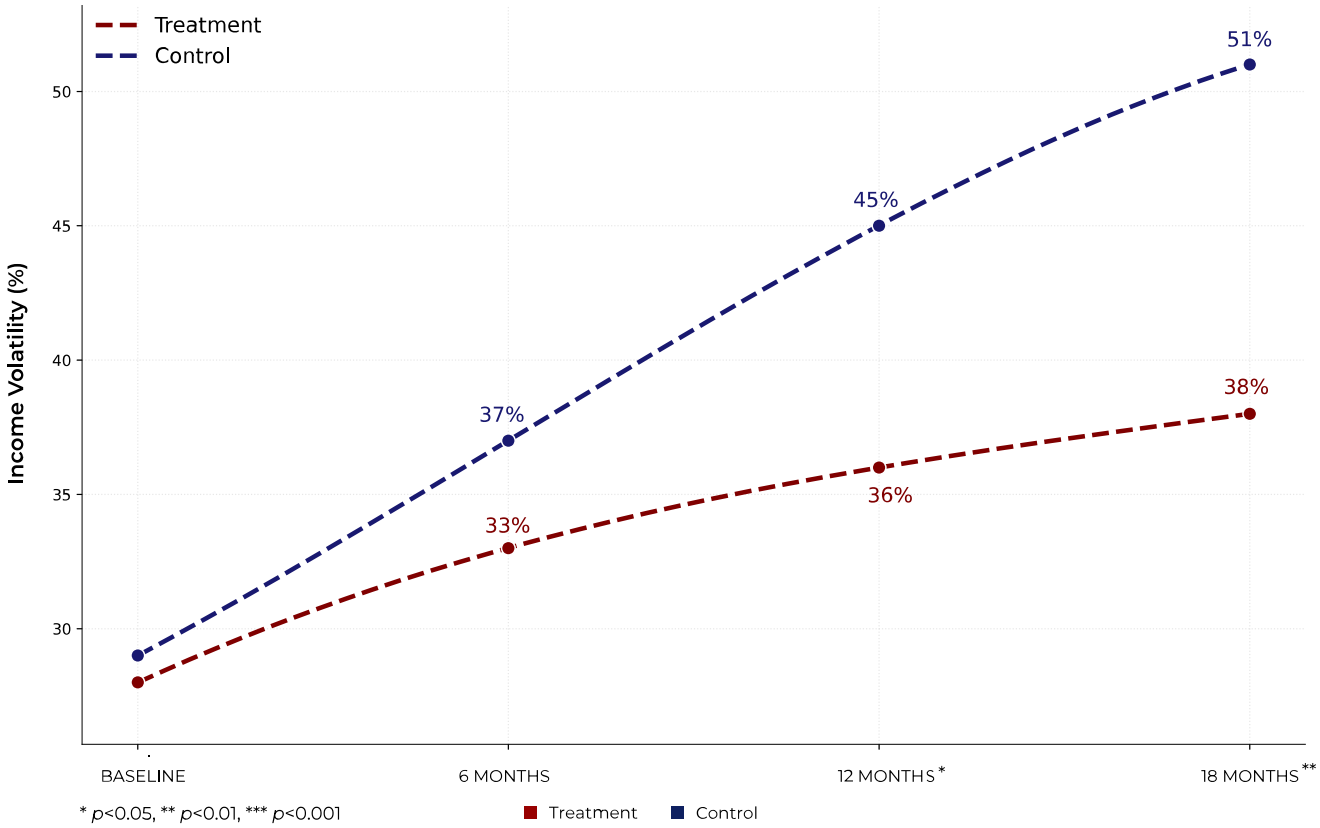


Figure 3: Income Volatility over Time, Treatment vs. Control



Findings suggest that the GI increased overall financial stability and decreased income volatility for the treatment group. At Baseline, the mean annual household income for the treatment group (M=$23,054) was higher than that of the control group (M=$19,683). Over time, households in the treatment group consistently reported higher mean incomes compared to the control group: M=$24,492 vs. M=$20,847 at 6 months, M=$24,931 vs. M=$22,011 at 12 months, and M=$27,369 vs. M=$23,175 at 18 months. Although these income differences did not reach statistical significance, they suggest a potentially positive impact of the GI, with the observed differences approaching significance at the 6-, 12-, and 18- month marks.

Participants noted how financial stability improved their mental health. As Susie B. said:

> *[There were] many winters where I didn't know like how I was going to pay for Christmas or, you know, wasn't going to get through and, like, did I pay enough ahead of my car payments so that I can make it to the next tax season? And, um, I didn't have to stress this year. Like, I didn't have to worry about that slightly higher winter heating bill, you know which, it was paid for.*
>
> *So my internal stress was much less, which I feel like is much healthier, because you know, you already have enough to worry about as a single parent as, you know, the current environment, COVID and everything else and then to add money to it. You know, that's like, you know—that's the kind of thing that gives people ulcers, um, you know, stresses them out, you know. So it was the first winter since I can remember being a parent that I haven't had to have that stress.*

Case Study: Haley

"Taking care of my dad, it is a full-time job."

When Haley first started to take care of her elderly father, she was also working part-time. When the pandemic happened, she lost her job and transitioned to the role of a full-time caregiver:

> *And, for me, I was working part-time contract, I was single, it wasn't like I was in a relationship or married, I didn't have any children. So it was very easy for me to say okay, I'm going to step into this role, but I didn't think that it was going to like—I didn't for a second think that I was still going to be here, navigating this role years later. Like, I just, I really thought it was temporary and then, you know, turned into a few weeks and, a few months, and, here I am.*

Haley was solely responsible for her father's care, including household duties like cleaning, cooking, grocery shopping, and budgeting. Her siblings seemed to think that since she lived with her father rent-free, it was a fair trade. But caring for her father presented several challenges. Part of it stemmed from navigating the power dynamics of their relationship. Haley felt she didn't have authority to enforce healthy decision-making.

> *With my dad, you know, he's a grown up, he's set in his ways and if he doesn't want to do something, then, I can't really like—taking a shower, for example, that's something that we've battled for years and he's just like, "I don't want to take a shower," and I'm like, "Just fucking shower!"*

He was also stubbornly set in his ways around communication, which put Haley in the difficult and emotionally fraught position of managing health emergencies.

> *He never communicates with me when things are bad, like anytime he's not feeling good, he associates that with, I have to go to the hospital or whatever. So he won't, like, he won't communicate that with me until it's way too late. And then we're on our way to the hospital because he's having a heart attack, or whatever. Like, I just, I've witnessed, at least 4 really severe health crises with him over these past few years. And like, I literally almost watched him die several times.*

Caregiving without support made Haley feel isolated. "I don't really feel like... I have... a huge support network," she said. Yet her caregiving obligations had also prevented her from "getting out in the world." She described the uneven feelings of need and responsibility that she encountered caring solo:

I mean I would love to just have a partner, and to be like going through life in that way, you know? … It'd be nice to like, have like, a partnership where, you're in a relationship and you're each contributing things and you kind of each have your role, and, in this sort of weird partnership, right, I have certain roles and, my dad doesn't really have any role and, trying to like work on that…

I feel like I put my life in this little holding pattern. And, I'm running to sort of get out in the world again and feeling better health.

The emotional burden of caregiving—from negotiating with her father to facing everyday obligations alone—took a toll on Haley's mental health. "It, I mean, it ranges," she said, "but there is everything from guilt, because I don't feel like I have been the best caregiver that I possibly could be, to utter exhaustion and burnout, because I can't do anything else." Every 6 months or so, she went through a period of exhaustion where she felt, "I need a break and I can't be doing this."

At the same time, Haley was managing her own chronic health issues and had left her full-time job because of her health. She held a part-time job in Ithaca along with her caring responsibilities. Eventually, the pressures of juggling work, care, and her own health became too much:

I was having a really big, like, total mental breakdown in the fall, just because working and taking care of my dad got really freakin' tough, and it was the longest stretch that I've ever done both working and taking care of him, and I was recovering from surgery. So I got to, I was in a really bad place, physically and emotionally.

After one particularly brutal bout of burnout, Haley reached out to a weekly caregiver support group. She later described both the camaraderie and the opportunity for information-sharing as a tremendous help. Rather than trying to go it alone, Haley was able to avail herself of the resources available in her community, moving from social isolation to support.

The GI enabled Haley to support her own physical and mental health. With her first GI payment, "that's when I started my gym membership, because I wanted, like to do something positive for myself to make myself be a better person to be healthier so I could give my dad better care." She made it a point to exercise consistently and eat healthily.

The GI also helped Haley to invest in time for herself—"little moments of self-care"— outside the bounds of caregiving.

I've lived frugally for a long time now, especially, uh even more so since the pandemic hit and like being back here taking care of my dad full-time. Um, but [the GI] allowed me to, you know, splurge a little bit on things like, you know, going to get a pedicure, um, you know, little things like that, but it's also helped me to, you know, splurge a little bit on food and dining out and things that I wouldn't have normally done.

Haley took time off from caregiving during the pilot to visit friends, a profound source of emotional fulfilment. "[The GI], it's given—I mean, that's part of what's given me the flexibility to leave and take this little break." She was able to use the GI for gas and food. Being cared for by others, rather than caring for her father, was a welcome change:

> ***There's nobody that I really rely on [in Ithaca], though, which was just part of why I took this little journey, because, I mean, along the way I had so many friends that I saw, and stayed with, that stepped up to take care of me.***

At first, Haley felt she had to justify caring for herself—although she received multiple government supports, like Medicaid, SNAP, and heating assistance, Haley was a strong believer in work ethic, frugality, and making one's own way.

> ***I believe in a nice sort of blend where, if you work your butt off, you can achieve whatever you want to achieve. But at the same token, you know, there are times when things are a little bit more challenging, and it's not quite so black and white, and you may need assistance.***

She seriously thought about applying for disability payments but chose not to take them because she "didn't want to be labeled as such… I want to be a productive citizen." Since her health prevented her from working, though, she found the GI as "a way to sort of supplement that has been really great."

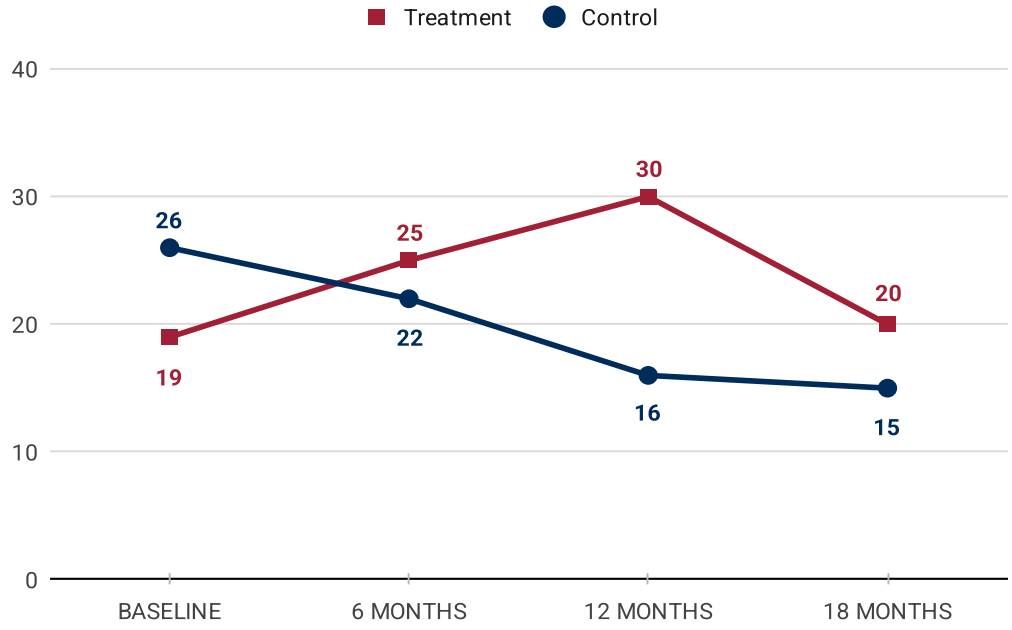
Haley sometimes worried about the future, knowing that her health, her part-time work, and her caregiving had not set her up for long-term financial stability.

> ***Most of my life I've kind of had gig work, um, so I don't really have like a 401k and like, some huge nest egg that people have to fall back on, and because it's gig work, you know, you're not necessarily—like the tax table is a little bit different.***

As the pilot ended, Haley was also considering her long-term goal of becoming a health coach. Having completed a training several years ago, she had finally begun, "just time management, carving out the time to figure out exactly like what I want to do and, having balance… like, who I want to market it to and, how I want to look and just really take that time to create an outline and a plan." She wanted to share her knowledge of supporting physical and mental health with others.

Additionally, income volatility was relatively lower and more stable in the treatment group across all observed time periods, with percentages ranging from 33% at 6 months to 38% at 18 months. By contrast, the control group experienced higher income volatility, increasing to 45% at 12 months and 51% at 18 months, approximately 1.3 times higher than the treatment group by the end of the pilot. Regression estimates confirmed statistically significant differences in change of income volatility over time between groups (B=-6.917, p=0.013). These findings underscore the potentially stabilizing effect of the GI, allowing recipients to establish a level of financial stability that eased the stress of survival while caring for others.

Figure 4: Savings Trends for Amounts Above $500, Treatment vs. Control



* p<0.05, ** p<0.01, *** p<0.001

However, participants' ability to save was likely constrained by the economic context of high inflation and low wages. At Baseline, a large majority (73% of the treatment group and 68% of the control group) had savings under $200, with slight improvements observed by 6 months. Savings in the $200–$500 category increased in both groups, peaking at 18 months for the treatment group. Yet, it was in the highest savings bracket (>$500) that the treatment group showed a significant increase at 6 months (25%), peaking at 30% at 12 months before declining back to Baseline levels, while the control group fluctuated and ended lower (15%). Transition analysis from Baseline to Endline revealed a 13% improvement in savings within the treatment group during the GI phase, indicating a temporary capacity to set aside funds. However, this difference lacked statistical significance between groups, and the GI proved insufficient to promote sustainable savings beyond the pilot's duration.

Participants were also slightly better able to manage $400 emergency expenses during the pilot, suggesting increased financial resilience, although the differences between groups were, again, not statistically significant. At Baseline, 31% of the treatment group and 26% of the control group reported

being able to cover such an expense. By 6 months, this percentage increased to 34% for the treatment group, while remaining unchanged for the control group. At 12 months, this ability rose further to 37% for the treatment group and to 34% for the control group. However, by 18 months, both groups saw a decline, with 27% of the treatment group and 25% of the control group able to handle such an expense. These trends highlight initial improvements in financial resilience within the treatment group, followed by a decline, suggesting ongoing economic vulnerabilities. As Kristina said regarding the end of the pilot, "I was just kind of like, oh, okay. You know, that sucks. But, you know, I'm used to doing what I gotta do. So, um, we just kind of adjusted."

Table 3. Ability to Cover a $400 Emergency, Treatment vs. Control (% yes)

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Yes	31	26	34	26	37	34	27	25

* $p<0.05$, ** $p<0.01$, *** $p<0.001$

Physical Health

Quantitative and qualitative findings suggest the GI contributed to significantly better physical health outcomes for caregivers. This is especially notable given the strain of managing their own preexisting health issues alongside caretaking obligations. Improvements in physical health, particularly in overcoming physical limitations, suggest that the GI may have supported participants in managing chronic health conditions and enhancing overall physical well-being, although these effects were not sustained post-pilot.

The SF-36 measure (RAND, n.d.) was used to assess study participants' overall health and well-being. The analysis focused on three domains from this validated instrument: general health, role limitations due to physical health, and health limits. At Baseline, general health scores were comparable for both treatment (M=57.55) and control (M=57.69). This parity continued at 12 months, with the treatment group showing a slight improvement (M=57.95) while the control group's scores declined (M=53.85). However, this advantage was not sustained post-intervention, with both groups reporting lower scores than at Baseline (treatment: M=53.23; control: M=53.77).

The impact of the GI on participants' role limitations due to physical health also varied. Both groups reported similar scores at Baseline (treatment: M=57.67; control: M=56.15). However, the treatment group's scores improved over time, while those of the control group declined, resulting in a statistically significant difference at 12 months (B=12.88, $p<0.04$), though this significance was not sustained post-intervention. A similar trend was observed for health limits, with the treatment group reporting higher scores at every evaluation time period, and a significant difference at 12 months (B=6.75, $p<0.04$).

Participants described the interconnected relationship between GI, their physical health, and mental well-being—each positively reinforced the other. According to Michael:

> *My level of anxiety is, is less, which in turn is good for my health. Both physical and mental. Those have been the really big changes. And they're incremental changes. So, it's hard to pin it down or quantify, um, but the [GI payments] have definitely enabled us.*

While psychological distress remained high throughout the study period, the GI was able to attenuate stress levels in the treatment group. At Baseline, the treatment group reported marginally higher stress levels (M=7.86) relative to the control (M=7.73). This trend was reversed 6 months after the inception of the GI. At 6 months, the mean difference between groups was -0.33 points, which increased slightly to -0.59 points at 12 months. By the 18-month follow-up, the positive trend was still sustained with a mean difference of -0.96. This pattern suggests that while the GI did not eliminate high stress levels, it did help a portion of participants manage their stress more effectively, leading to improved health outcomes. As Sophie put it, "how I was my day-to-day before [the GI], um, and my day-to-day now, and how much of a difference that is, um I, like, I'm physically healthier now because I'm not as stressed or depressed." She recounted how before the GI, a bill arriving made her feel physical panic, whereas she felt elation at being able to pay on time with the GI.

Better health outcomes also reflected the increased agency that recipients had over their time and finances. While their care responsibilities remained the same, they were able to use their time more intentionally in ways that benefited their well-being. Participants described a newfound ability to take care of themselves: several participants used part of the GI towards gym memberships, reclaiming time for their own physical health. Haley used the GI to exercise regularly and get periodic massages, which provided "night and day" benefits for her autoimmune issues. Participants also cited cooking healthy, fresh foods, like Elnora, who tried to stay healthy by "exercise a lot, lots of time in nature, um, cooking whole foods like, just trying to nourish myself."

Food insecurity affects approximately 11% of the population in Tompkins County (New York State Department of Health, 2023). This high rate is particularly concerning for vulnerable populations such as SNAP recipients, who already face financial hardships. The pandemic and subsequent inflation exacerbated the situation, making it harder for low-income households to afford nutritious food as grocery prices surged. While the increase in SNAP benefits during the pandemic provided some critical relief, its subsequent expiration left many households vulnerable to food insecurity. Local efforts, including food banks and public health initiatives, continue to address this critical issue, but the challenge remains significant.

Although many participants noted the importance of fresh food, and the region is home to numerous farms, food insecurity remained a significant concern throughout the study period. The prevalence of very low food security increased over time, rising from 22% at Baseline to 26% at 12 months and 35% at 18 months for the treatment group. The control group showed a slightly higher trend, increasing from 23% at Baseline to 34% at 12 months and 33% at 18 months. Both groups also reported a marginal increase in consuming less-preferred foods by the study's end, indicating a potential decline in dietary quality. This aligns with an observed uptick in food pantry usage in Tompkins County in 2023 (Fichter, 2023). It also coincided with the end of pandemic-era SNAP expansions in February 2023, three months before the pilot ended (Long, 2024). Those who had received emergency SNAP allotments during the pandemic saw their benefits expire, with a concomitant rise in food insecurity nationally (Richterman et al., 2023).

Case Study: Ellen

"I feel like my life has been less stressful"

Ellen is a White woman in her mid-40s and a single mother of a teenage son, who moved to Ithaca over a decade ago. Initially, Ellen could not afford a place in the city, instead renting an apartment in a rural town on the outskirts. However, her sister owned property in Ithaca and offered to rent to her for a discounted rate. "I'm so thankful that that came along," she said, "because honestly, yeah, just rent in Ithaca is insane." She had noticed a shift over the years whereby "the people that need to live in town because their work is there or, um, they don't easily have access to transportation or whatever, they need public transportation. They're now getting pushed out of Ithaca because they can't afford to live here."

Ithaca suited Ellen's curious personality and open-minded approach to life—she described it as a "bubble" of friendly, progressive people and "magical" surroundings. However, she noted that even progressive communities are not immune to systemic racism: her son is a person of color and had experienced subtle forms of racism in Ithaca, including in its school and medical systems.

Ellen often felt like she did not fit in with society's norms, calling herself "a square peg in a round hole." She had resisted the idea of higher education, but her parents insisted that she should go to college to become a teacher. "It's like the path of life was already kind of carved out and that it was determined by like how, what my parents thought was best for everybody." After training as a teacher, she first worked with children with complex learning needs. She later worked as a health aide at an assisted living facility, a job that she described as emotionally taxing and exploitative for both residents and staff: "[to] management, you're absolutely disposable."

Juggling paid work with her unpaid care work proved difficult. Ellen explained how a lack of time and money created extra pressures and constrained her decisions around time:

> *Like when you don't have money, it's like, okay, so you have an apartment that you, you know, is on the cheaper side, but it doesn't have a dishwasher. Like people take that shit for granted. But it's like, those are the things that I have to work into my day, where I have to wash every single piece of all the dishes. No washer/dryer so you have to make the time to go to the laundromat. Like all these little things that you have to work into your day where you're already working... I mean, at one point, I didn't have a car, and so... you have to factor in your, like, your transportation and how much time... [it's] more time away from home, my son, and doing the things that I, I would like to be doing.*

Over the years, she grappled with depression, anxiety, and poor health. These were exacerbated by the stress of making ends meet with a job that undervalued her labor. Sometimes, her mental health made it difficult to function, but she had no choice but to move forward:

I've lived so many years and like, constant state of like stress and anxiety and depression. Um, you know, I was using alcohol as like, a crutch just to like function. I mean, I've been sober for three years. Um, you know, and then my issues with like food, so if I'm like stressed out, it's like I don't eat and/or, or it could go the other way where I'm, like, over consumption of food, so, yeah, it's like this, it's the stress, it's stress and it ends up being like, the financial stress just like, living that creates the stress.

Where I'm like, I can't get up, like, I, I can't, like, I, I actually have to, like, say out loud, like, put your feet on the floor, stand up, get up, walk over to the sink. Do that, do you know what I mean?

When another job came along, she leapt at the chance to leave the facility. For the following 6 years, she provided private care to two small children for 45 hours a week. However, this role, too, proved draining. Ellen was brought to tears describing how those years came at the expense of spending time with her own young son or sustaining a social life for herself.

To be that like super present, involved parent—like "I'm at every like concert" —you know, it's like I, I couldn't even do that because I'm having to work just to make ends meet, just to provide the, the necessities for my son... just to pay rent, just to make sure we have a, you know, a roof over our heads, just to make sure we have food, like all the necessities we need.

The burden of making ends meet and caring for her son as a single parent weighed heavily on Ellen.

You're so burnt, like, you're so spent just from the work, just from working. Um, that it's like—and then coming home, and, and taking care of one child, you know, like, yeah, I just have one child, but it's still, it's a lot of work.

When the children reached school age, the private care job ended—a pause which happened to coincide with the IGI pilot. "Spent and bent" after years of paid caregiving, Ellen said that the GI enabled her to prioritize her mental health instead of finding other work immediately:

I just, so this program allowed me to take the time off that I really needed, um, for my physical health, but also my mental health. Um, and, and I know like the pandemic has affected everybody I feel for the most part. Um, so, yeah, I've always dealt with like anxiety, depression, that sort of thing, but certainly like 2020, just like exacerbated all of that, you know, so much and yeah, so I was dealing with some health issues, mental health issues, and took the time off.

Without the GI, Ellen would have had to find a job “right away, back in the grind, miserable probably.” However, the GI “helped me take the time I needed just to like reset essentially." In doing so, Ellen had to confront her own preconceptions. At first, she found it difficult, citing her upbringing and strong work ethic.

> ***You have... just like the hustle, the grind. Like, that's what you're supposed to do. That's how you prove that you're worthy and, you know, like, oh, if you're resting at all, like you're lazy or if, you know, you constantly have to be on the move. So I'm just, I still have that in me where it's, like, got to do more than I'm supposed to do.***

She also reluctantly signed up for SNAP during the transition: “for a long while, it's like, you're kind of prideful. Like, I don't wanna, I don't wanna depend on the government.” Between SNAP and the GI, Ellen was able to maintain financial stability while taking a few months to rest and reevaluate.

She ended up finding a position taking care of elderly and vulnerable individuals per diem as part of a caregiver network. She enjoyed the increased ownership she had over her time—she worked by the day and was able to make her own schedule. And increasingly, she felt frustrated by unhealthy societal expectations around paid work —“I want to see more people rest.”

> ***I've totally shifted [my approach to work] probably in the last year, where I'm just like, I feel like it's more of a flex to be like, no, I don't, I don't want to work like excessive hours for what—what do I have to prove or like, what if I, what, what do I have to show for all of the years of hard work?***

Asked about the risks she took with the GI, she said:

> ***I think just taking the time off [to be with my son]. I know that probably sounds kind of lame. That's like a goal or risk or whatever, but essentially it was just taking the time off so that I could actually be present for my child because again, I, I felt like the majority of his life, his childhood, I was not able to... truly be present for him physically and even emotionally which I'm like, it sucks like saying that, because he gets one childhood.***

For Ellen, the GI introduced increased agency over her time, including decisions around work and time spent with her son.

Table 4: Trends in Household Food Insecurity: Treatment vs. Control (% Yes Responses)

IN THE PAST FOUR WEEKS...	TIME PERIOD	TREATMENT	CONTROL
Did you worry that your household would not have enough food?	Baseline	46	47
	6 months	35	39
	12 months	30	39
	18 months	44	42
Were you or any household member not able to eat the kinds of foods you preferred because of a lack of resources?	Baseline	44	45
	6 months	34	31
	12 months	34	35
	18 months	40	41
Did you or any household member have to eat some foods that you really did not want to eat because of a lack of resources to obtain other types of food?	Baseline	38	39
	6 months	33	30
	12 months	36	28
	18 months	40	41
Did you or any other household member have to eat less in a day because there was not enough food?	Baseline	23	22
	6 months	22	25
	12 months	26	34
	18 months	33	35
Did you worry that your household would be unable to pay a utility bill?	Baseline	55	58
	6 months	45	51
	12 months	41	49
	18 months	45	45

* $p<0.05$, ** $p<0.01$, *** $p<0.001$

While utility hardships decreased similarly for both groups, the overall findings highlight the persistent and potentially worsening nature of food insecurity among participants and the need for sustained support mechanisms. These observed trends were, in part, the result of the 5.8% increase in food prices reported by the USDA in 2023, despite a slowdown in overall inflationary pressure (Economic Research Service, 2024). They may also reflect that access to food is uneven, especially for those without a vehicle in more geographically remote parts of the county. A 2021 food access assessment found that in addition to geographically isolated citizens, low-income workers, those with disabilities, and Black community members are particularly food insecure in Tompkins County (Tompkins Food Future, 2022).

Spending data from the Guaranteed Income Pilots Dashboard reveals that participants primarily allocated their monthly $450 payments toward necessities, with food and groceries commanding the largest share at 38.45% (Center for Guaranteed Income Research, et al., n.d.). When combined with retail sales and services (25.03%), transportation expenses (8.44%), and housing and utilities (6.7%), these essential categories account for nearly 80% of all spending. The significant portion dedicated to food expenses underscores the critical role of GI in addressing food insecurity among participants, establishing how these funds function primarily as a tool for meeting basic needs rather than discretionary purchases, with less than 3% allocated to travel, leisure, and entertainment combined.

Housing Stability

Another source of stress for caregivers was maintaining housing stability in Ithaca. Over the years, housing costs have increased significantly, leaving many cost burdened and housing insecure. In Ithaca, 61% of renters are cost burdened (paying over 30% of their total income on rent), and 46% of those are spending over 50% of their income on rent (Office of Policy Development, n.d.). This number is due in part to a lack of low- and middle-income housing; it also evidences rent increases year on year without concurrent income growth. "Sometimes I do have a fear of getting evicted, you know," said Lacie, a control participant.

Quantitative data indicated that cost burdens were consistently high for both the treatment and control groups across all time periods evaluated. Over half of the participants in both groups were cost-burdened, allocating over 30% of their monthly income towards housing costs. Additionally, one-third of the participants in both groups reported being severely cost-burdened, with housing costs exceeding 50% of their monthly income. For families who need more space, rent can be even more prohibitive, with two bedrooms estimated at $1,664 a month and three bedrooms at $2,056 (U.S. Department of Housing and Urban Development [HUD], 2024).

From Susie A.'s perspective:

> *Most properties that, you know, would house the family would be at least $1,700 plus utilities, um, which, you know, for a low-income, even middle-income, it's extremely hard to be able to afford those things. And then, you know, even those are kind of diamonds... A lot of them are upwards of like $3,000 a month um, because we're catering to the Cornell professors and students that are visiting and can afford those prices.*

Sophie said, "Most people I know, I'm trying to think— Everybody I know, except for one person, has a roommate, and they're like, in their mid-30s. Yeah, they either live with their parents or they have a roommate." Jonathan lived with four roommates in a downtown three-bedroom, and while he professed enthusiasm about communal living spaces, he also could not afford to move elsewhere.

Housing quality emerged as a significant concern among participants, with several reporting substandard living conditions that potentially contravene New York State rental regulations (Tenants Advocacy Project, 2022; Warranty of habitability, 2014). Several participants lived in basement apartments or places with no insulation and contended with poor conditions. There were leaks and old building issues and mice. "It's kind of like, 'Oh, landlords used to be much more invested,'" said Randall Thomas, father of two young sons. Debra cited roaches, bedbug issues, and "raggedy cabinetry" in her apartment building. Study findings indicate that a higher percentage of participants in the treatment group transitioned to better quality homes compared to the control group over the study period, although the shift was small (53% at Baseline to 56% at 18 months). This could be due to lack of options in already limited housing stock.

Table 5: Housing Cost Burden

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Median housing cost ratio	35	42	40	44	40	40	40	38
Cost burdened (cost ratio >30%)	59	65	62	62	65	55	65	58
Severely cost burdened (cost ratio >50%)	32	34	38	41	35	36	37	32

* $p<0.05$, ** $p<0.01$, *** $p<0.001$

Note: The cost ratio is the percentage of household income spent on rent or mortgage (minus utilities).

Some cited the large student population as an enduring factor in housing affordability and quality. "Students will pay anything, so landlords don't care," said Ellen. Others pointed out that new apartment buildings are being built with students and young professionals in mind; according to Debbie, "people are—are very concerned that all the new housing is out-priced for most people, and that it's geared towards students whose parents can pay more, and that normal, average people can't afford to live downtown anymore, because it's so hard to find." Frank said, "it's a perfect storm where a lot of the working-class people get pushed out of town to further and further areas."
A number of participants were concerned about the "hollowing out" of Ithaca, where people who worked in the city could no longer afford to live there, replaced by wealthy students and remote workers. Sarah said:

> *The people that are living in town, and all these sort of new high rises, and this development, they're not working in retail or service or other things that kind of, you know, keep the town appealing, you know, they're at the colleges or, you know, working for a company that isn't affiliated at all with Ithaca, you know, so, you know, they're working from home. So I think it, it, it matters, like it matters that people can't live close to their job.*

A few participants had bought homes in Ithaca years ago—"I was grandfathered in," said Kelly—but acknowledged a very different context now. For aspiring homeowners, house prices have also increased year over year. From 2019 to 2022, the median sales price for a home in Tompkins County rose from $230,000 to $325,000, a 41.3% increase, and in 2024, the average property values in the county increased another 19.8% from the previous year (Tompkins County Department of Planning, 2023; Jordan, 2024a). As Susie B. related, she was living in her family's home with her four children but would not be otherwise able to afford the property:

> *I am kind of stuck between a rock and a hard place. Um, the house that I am in is a family-owned house... But I, at this point, could not buy it outright from my family or even buy a house anywhere. One, because the taxes alone are like regular rent*

> *anywhere else. We're just talking taxes, homeowner's insurance, and the water bill. So, um—and I just happened to, you know, like overhear a conversation recently from a local realtor, and they're like, "Oh yeah, there's only about 25 or 30 houses in total on the market right now." So how do you find a home when there are none available?*

Randall Thomas was able to buy a home in 2009 but described how people have been pushed farther out over the years:

> *If you want in the city, I don't even know if [$250K] is going to do it for you. People are looking way out into [more rural] districts for that same price range of 150 to 200 but probably closer to 185. And that would be people in the same budgets and the same financial needs, and that just puts you in a completely different situation. I mean, you're commuting—commuting is now an installed, consistent cost in your whole life. Even for just grocery shopping, you're commuting, and many other things. We, we were just—we got in at this time where it was very easy for us.*

The consensus among a multitude of pilot participants was that residents are increasingly forced to move further away from the city. Lilly bluntly put it: "The most noticeable change to me is that you can't afford to live here. You just can't… Everybody has just been pushed out. Um, you know, to the outline, like little areas outside of the city of Ithaca."

Particularly for caregivers already isolated as a function of their care work, the prospect of being pushed into geographical isolation was daunting and came with the steep price of transportation. Although participants loved Ithaca, they increasingly feared the costs of neighborhood change and its impact on their ability to afford to stay. To assess these changes, we deployed the Perceptions About Change in Environment and Residents (PACER) Index, a series of questions to capture perceived neighborhood transformations over the past 3–5 years (Hirsch et al., 2021). The findings revealed significant perceptions of change among residents. At the conclusion of the study, 58% of the treatment group observed that "new businesses are opening" (categorized as "happening a lot"), an increase from 48% at Baseline. Similarly, concerns about "increased cost of rental housing or homeownership" remained high, with 83% of the treatment group by the end of the pilot acknowledging it as "happening a lot."

These perceptions align with recent data from the New York State Department of Labor (2024) and the U.S. Bureau of Labor Statistics (2024), which highlight substantial disparities in industry-specific employment growth within Ithaca. Sectors such as leisure and hospitality have experienced the highest employment increases, leading to increased investment and development in certain neighborhoods. In contrast, professional and business services have seen modest growth or declines, leaving associated neighborhoods facing economic challenges and stagnation. The ongoing influx of the student population has also transformed housing markets, local businesses, and community character. Taken together, these variations have profoundly impacted neighborhood dynamics, exacerbating fears among residents—particularly caregivers—about the ability to remain in their communities amid rising costs and uneven economic development, intensified by the pandemic.

Analysis of the Neighborhood Change and Gentrification Scale (DeVylder et al., 2019) indicates that participant support for neighborhood improvements, even at the cost of increased living expenses, remained stable in the treatment group (48% to 45% over 18 months), suggesting a degree of resilience to neighborhood change; by contrast, this support declined in the control group (42% to 34%). However, a majority of participants in both groups felt neighborhood changes were not meant for them (57–69%) and expressed uncertainty about their future in the neighborhood (59–69%). Fear of displacement remained relatively stable, with 27–35% expressing concern. Qualitatively, it seems that people stayed in Ithaca despite the expensive housing costs because of the many resources available. However, this put them in a place of forced vulnerability and stress—if they could not afford to stay, their access to these resources would decrease.

Several participants cited Ithaca's physical and mental health resources as the reason they had moved there in the first place, or the reasons why they stay despite the prohibitive cost. Vicky had lived outside Ithaca but needed resources for her son that rural areas could not provide. He required several surgeries for a congenital birth defect that otherwise would drastically impede his mobility. Susie B. also mentioned staying in Ithaca for her son. He has ADHD and benefited from resources he could not access outside of the city: "I couldn't move my son to a small place and expect the same kind of services that he could get here. So, that's kind of my why [I stay]."

Others brought up the school system. "I love the schools here," Lilly said. "I have a hard time picturing sending my kids elsewhere." Monica had been living outside Ithaca but moved back a few years ago, saying her favorite thing about the city was "the support and the programs and the education for my children." She talked about the educational opportunities available to her daughter, a teenager of color enrolled in a STEM high school— "trying to just open the doors for other things for her, and we'll see." Susie A. agreed that "our school systems are amazing and there's lots of support in terms of class size and um, communication. There's great resources through the city."

Despite New York State's 2019 tenant protections, which include laws against income-based discrimination, HCV holders also face difficulties in securing suitable housing, forcing them to move from Ithaca to the wider Tompkins County area. Vicky, mother of two young children, described a friend who had secured housing with her Section 8 voucher:

> *The housing that they ended up getting [with a voucher] is an hour and a half bus ride from here… So, like that three months with her having a child, being that far out, she hasn't been able to find a job yet. She hasn't been able to find childcare.*

Table 6: Participants Concerned About Housing Stability (% Yes responses)

	TREATMENT	CONTROL
Baseline	28	41
6 months	21***	41
12 months	22**	42
18 months	18***	39

* $p<0.05$, ** $p<0.01$, *** $p<0.001$

Moving out of Ithaca also meant limited educational opportunities for some participants and their children. For example, Jade described facing housing insecurity and knock-on effects in access to developmental services for her children after her landlord decided not to renew her lease. Unable to afford housing in Ithaca, she had to relocate to a small rural town and, without access to a vehicle, she described feeling separated from the resources previously available to her. She was fighting to secure transportation for her children, both of whom were neurodiverse and required strong support from the district's Department of Special Education. Kristina, who lived in a rural area outside Ithaca, was unable to afford the gas to drive her daughter to her learning center in town. For her daughter, a disabled, hands-on learner, virtual education had not proved to be a good option. Jade and Kristina's geographical isolation and lack of reliable transport exacerbated the complexities of their care obligations.

Leaving Ithaca for a lower cost of housing is a short-term solution that may influence long-term health problems and can trigger downward economic mobility. In this sense, housing and health are intimately interlinked. The Tompkins County Health Department report noted that "the County still shows a rural-urban health disparity" (Tompkins County Whole Health, 2022). Geographically, services and resources tend to be clustered in a few parts of the county, and lack of transportation between the rural and urban areas in turn impacts access to healthcare.

Sophie, who grew up outside Ithaca in a small town, talked about disparities in medical access:

> *There's stuff that I need that insurance won't cover, like, there's only one dentist in it that takes my insurance, that takes Medicaid one, and they're awful. So, I have to travel up to, like, Rochester to get dental care, and if I could just pay for it out of pocket, I would.*

She described having a serious medical emergency as a result of not getting dental care.

Kristina shared a horrific outcome of lack of access to medical care. She is a full-time caregiver for her disabled daughter, who has a rare genetic condition. Although Kristina was diagnosed with diabetes, her caregiving obligations led her to put her own health concerns to the side. Her job at the time made her ineligible for Medicaid, and she couldn't afford insurance, contributing to her worsening health: "I couldn't afford healthcare. So I said, you know, I'm not going to, I, I, I can't afford the doctors. I can't afford the doctors." She eventually developed diabetic neuropathy and necrosis, leading to the need for an amputation.

The GI was not enough to overcome intersecting structural issues around health and housing. However, quantitative findings did record small but consistent trends towards housing stability among the treatment group, suggesting it may have helped recipients stay in place. The treatment group reported significantly lower concern about short-term housing instability at every time point evaluated, with the gap widening over time: 28% (treatment) vs. 41% (control) at Baseline to 18% vs. 39% at 18 months. At Baseline, fewer treatment group members felt they could afford an intra-neighborhood move compared to the control group (8% vs. 13%), but this trend reversed by 18 months, with 16% in the treatment group reporting this ability versus only 7% in the control group. It seems as though the GI bolstered recipients' perceptions of stability amid fears of displacement.

In this context, the documented gains in physical health outcomes also take on further significance. For some, the GI seemed to function as a buffer, helping people to afford to stay in place in the city; for those in places not well-served by public transit, GI may have mitigated issues like the cost of fuel and transport in accessing medical care.

Data also indicated a small but nonetheless notable trend towards homeownership in the treatment group over the 18-month period, with an increase from 21% at Baseline to 27% at Endline. At the same time, the percentage of renters in the treatment group decreased from 63% at Baseline to 57% at the 12-month and 18-month marks, suggesting a shift towards more stable housing. The control group, on the other hand, reported a higher percentage of participants receiving rental assistance and living in Public Housing Authority housing compared to the treatment group. While GI was not enough to combat longstanding housing pressures, it did allow some people to feel more stable and to remain in place, at least throughout the course of the pilot. However, given the durability of housing stress in Ithaca, these gains seem temporary.

The physical and mental demands of care, coupled with the physical effects of financial strain, saw caregivers experiencing high levels of mental distress. This was particularly acute for those simultaneously managing their own chronic health conditions. Despite this, the GI significantly improved caregivers' financial, physical, and mental health. Each was mutually reinforcing: having financial stability encouraged people to invest in their health and redistribute time to support mental well-being. However, the GI was only a temporary fix in the context of structural constraints. Housing pressures and neighborhood change remain enduring stressors for Ithacans.

2. The Cost of Care: Trade-offs and Time Use

Summary: Caregivers had to make trade-offs, whether personal or career-oriented, in order to care for others. This is the "price tag of care," or the material and time costs involved in care work. For caregivers, prioritizing their responsibilities to others over their own potential life trajectories required an element of sacrifice. However, for some recipients, the GI restored agency over seeking career pathways that they otherwise would not have been able to pursue. For other caregivers, the exorbitant cost of childcare proved to be an obstacle to employment, highlighting deeply rooted systemic constraints. Several participants calculated that the cost of daycare would outweigh their earnings and had to exit the labor market as a result. The cost of care has a gendered element, too, affecting women's labor market participation in particular. GI also helped shift or mitigate trade-offs between paid work and unpaid care, resulting in more agency around the way some caregivers balanced their time. Findings suggest that recipients experienced increased quality time with family, decreased parental stress levels, and sustained household stability.

For many caregivers, the trade-off between paid work and unpaid care work is a perennial challenge. Employment is a complex issue: the shifting and multi-layered time demands of care do not always fit comfortably with paid work, and the costs of childcare can eclipse monthly wages, forcing people to choose between employment and caregiving. These stressors can be referred to as "the price tag of care," or the material costs of both performing unpaid care work and employment in the formal labor market (Castro et al., 2023).

Quantitative findings indicate a consistent increase in full-time employment within the treatment group compared to the control group throughout the pilot's duration. Initially, the control group reported marginally higher rates of full-time employment (24% vs. 21% at Baseline). At 12 months, the treatment group was significantly more likely to be employed full-time (B=1.06, p=0.016). Post-intervention, this positive trend was maintained, though not significant, with the treatment group showing a 2 percentage point advantage in full-time employment. Unemployment rates decreased uniformly in both groups from 10% at Baseline to 5% post-intervention, a change potentially attributable to overall economic recovery. The treatment group also consistently maintained higher rates of part-time and seasonal employment across all time points. Both groups also reported an increase in gig economy participation, reaching 5% by the study's conclusion. The proportion of stay-at-home caregivers decreased more substantially in the treatment group, from 27% at Baseline to 18% post-intervention, compared to a less pronounced decrease in the control group. Despite this reduction, caregiving responsibilities remained a significant factor, with approximately one-fifth of participants still engaged in this role post-intervention. This ongoing caregiving role highlights the enduring presence of unpaid care work, even alongside available economic opportunities.

Table 7: Employment Trends over Time (in %)

	BASELINE		6 MONTHS		12 MONTHS		18 MONTHS	
	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL	TREATMENT	CONTROL
Employed FT	21	24	27	22	31*	16	25	23
Employed PT or seasonal	20	17	23	17	19	16	21	19
Stay-at-home parent or caregiver	27	34	15	24	15	22	18	25
Business owner/ Self-employed	12	6	8	10	9	19	9	8
Gig worker	0	0	4	4	3	5	5	5
Retired/Disabled	8	6	12	15	14	15	13	13
Student	0	2	2	2	2	1	3	1
Unemployed looking for work	11	10	7	5	6	5	5	5
Unemployed not looking for work	1	1	2	1	1	1	1	1

* $p<0.05$, ** $p<0.01$, *** $p<0.001$

Qualitative findings offer several potential explanations for the rise in employment among the treatment group participants. First, the GI may have mitigated the conflict between career-building and caregiving by allowing recipients to pursue previously inaccessible opportunities in the labor market. For instance, Debbie described the choices she had to make to provide for her son's pervasive developmental needs rather than pursue her academic career:

> *There are trade-offs that are really significant. If you decide to spend that kind of energy on your family, then academic jobs in particular, you absolutely can't really carry. It won't—at least it looked that way to me. The publishing requirements, um, the availability requirements were pretty inflexible... So that's what I guess I was thinking about, was, I made decisions I—that chose that, and— In that way, it's a kind of undervaluing of caregiving work, I guess. That our system is not very, not very generous in that way.*

Randall Thomas, an academic on the job market, was struggling to reconcile his identity as a researcher with his work as a full-time caregiver. A previous health crisis and his care responsibilities changed the trajectory of his career path. Although philosophically he knew the value of his care work, he was also negotiating his career goals, his love of research as a vocation, and the societal expectation of being engaged in full-time paid employment:

> *It's an active struggle I would say, in my life right now, is trying to basically assign my own level of value to parenting. So that I believe it when my kids say I'm a great dad, who come home with amazing drawings about what a great dad I am, or my wife gives me a— She gave me a mug recently that says like, great dad, and has pictures of me being a father, and I'm like, I want that to go right to the heart, but it's not, you know— The heart wants to hear that I'm hired by a [university] department, that's what my heart wants. So that's where I'm at.*

He noted that the GI provided a financial buffer, allowing him to take one more year to pursue the job search and invest in being a viable candidate. He had a few promising leads and interviews lined up and wondered if this might change the financial equation for him and his family. Debbie also felt that the GI gave her the flexibility to continue looking for work more aligned to her career interests; when asked if the GI encouraged her to take risks, she said: "You might look at continuing to look for the right job as a risk, as opposed to just taking one that I could get."

As a full-time caregiver for her chronically ill, disabled mother, one of Sophie's outlets was pursuing art. With the GI, she was able to parlay her talent into a career. She initially used the cash to buy art supplies and to support the piecemeal sale of her artwork at galleries and markets. By the end of the pilot, she had built up a portfolio, which helped her to secure a design job in the fashion industry. She attributed her career move directly to the GI. Post-pilot, Sophie was making a steady income and planning a trip to visit her brother out of state. "I'm gonna be able to travel for the first time," she said. "I smashed [my goals]." Meanwhile, a family friend had taken over many of the care responsibilities for Sophie's mother, decreasing the time she spent caregiving.

Although Sophie was able to shift her caregiving responsibilities to pursue paid work, other caregivers remained constrained by care obligations. Here, the lack of affordable childcare was a key consideration. Cornell University School of Industrial and Labor Relations' 2023 Living Wage Study found that in Ithaca, the average cost for full-time care of one infant is $24,620 per year. The New York State childcare market rate survey also shows average costs for the wider geographic area (including rural areas) at almost $1,500 per month per child (New York State Office of Children, 2022). Against Tompkins County's median household income ($45,468) or the median income of the pilot treatment group ($19,148), these costs are prohibitive indeed. Andrea lamented:

> *What are we doing here as a society? If, like, all the parents are working till 5 and school is over at 2, and we all have to pay out of pocket for care in those hours, which is like astronomically expensive. It just doesn't— None of it, like, makes sense.*

A few caregivers used the GI towards paying for childcare so that they could work in paid employment. For instance, Sarah struggled to balance her care obligations with her job at a bar and restaurant. She used the GI to pay for her daughter's summer program and for a babysitter so she could go to work:

> *When we started getting the guaranteed income, we felt a little like we can get, like, a babysitter sometimes now. And like, they're really expensive now. It's crazy. So we only do it to work, which is, it's like, we don't have any family here... We don't have any*

> *free childcare here, and it makes it really, really hard to do anything. Like you're really kind of stuck, um, in this one world. So we sort of, how we, how we figured that was like, when we had that little extra income coming in, and then we would only get a babysitter to go to work.*

Other participants cited the cost of childcare in relation to wages as an obstacle to pursuing career pathways—or entering the labor market at all. For instance, Elsa's husband worked as an overnight manager to pay the bills, and although she held several degrees, they decided the cost of daycare, at an estimated $1,000 per child per month, would not be worth her reentering the labor market.

> *We live in a sexist society, and so we're just— We're just conforming to gender norms, um, and expectations, uh, about, you know, our roles and stuff like that. And I mean, like, even, you know, I never in a million years I, thought I would be a stay-at-home parent, a stay-at-home mom. Like, never, like, you know, I have three college degrees and a license, you know what I mean?*

Chelsea, the primary caregiver in her family, shared that motherhood came at a cost to her own career. She was treading water at a job with no upward trajectory, but it kept her in the workforce and paid for daycare, so she could advance once her children grew:

> *I work from home [part-time] remotely, but, you know, I have, I have other ambitions and other things I would like to do. Um, and my kids, they're just too young right now for me to really factor that in, um, for myself personally. I know there are other women who could handle it, but I know my limits because I've reached them. And, um, you know, that's the position we're in right now, is I just can't work more. So right now, my work more or less covers my kid's daycare, sort of. You know what I mean? Like, it's not even really covering it, but it's just to keep me kind of tethered to the workforce, even if it's not, like, necessarily advancing me in any career way. Just so I don't like drop, essentially drop out of the workforce.*

Both Elsa and Chelsea's stories reflect a wider, often gendered, issue of one caregiver pausing, scaling back, or giving up their careers after having a child. Research has found that care work has detrimental effects on women's labor market participation, termed the "motherhood penalty" (Kahn et al., 2014, p. 56; Samtleben & Müller, 2022), and that wage considerations inform the decision to stay home rather than pay for childcare (Grundy, 2024; Ruppanner, 2020). Chelsea's choice to stay in an unfulfilling part-time job also reflects the difficulties parents (typically mothers) face in re-entering the workforce after a period of opting out (Jacobsen & Levin, 1995; Weisshaar, 2018). If they return to waged labor, they are unlikely to receive their prior level of employment (Wakabayashi & Donato, 2005).

The cost of childcare also posed an obstacle to those participants weighing the tradeoff of working in the labor market vs. caring for those with complex medical needs. Vicky's daughter is disabled, and her son had a congenital condition requiring several surgeries. She was barely making ends meet, relying solely on the GI and benefits, but was unsure whether to return to waged work:

> *Like you just, you can't afford anything on a one-income household, but you also can't afford for two people to work and you to pay daycare. Any job that I get is gonna be equal or less than the amount for daycare.*

Kristina also mentioned the childcare trade-off in her description of applying for benefits; her daughter has a rare condition that requires round-the-clock intensive care, but she felt demeaned while applying for benefits to help her stay at home:

> *Degrading would be what I—what I wanna use. Um, like, it just makes, you know, makes you feel like a piece of crap. Like, hi, you know, can you write this note to social services? So I don't have to find a job. Like, it just kind of makes you feel like a piece of crap, like, you know, um, but at the same time, like, if you want me to get a job to take care of, you know, my family. So I don't have to be on welfare and get cash assistance or whatever. That's fine. I'll do that.*
>
> *But who is going to take care of my child? Daycare is exorbitant. I can't afford to hire nurses to come in. Um, so it's, it's kind of like I said before, a catch-22, you're damned if you do and you're damned if you don't.*

A final consideration in the relationship between paid and unpaid work was caregivers' own health. As previously noted, many caregivers indicated they could not work in the labor market due to their own health challenges.

Structural obstacles—unaffordable daycare as well as work hours unresponsive to care responsibilities, benefits eligibility, and chronic health conditions—therefore posed challenges for many primary caregivers in terms of labor market participation. As Ziggy described it, our system is structured in a way that privileges profit over care, and those who can work over the vulnerable. Yet, despite these constraints, the GI helped support some caregivers to take risks and exercise agency in pursuing meaningful employment as they were able.

Reclaiming Time

The GI also allowed caregivers to more effectively balance their paid and unpaid work by valuing their time outside of the demands of the labor market. This was reflected in increased agency over parenting decisions, increased time spent with family, and sometimes, the ability to carve out time for themselves.

For many caregivers, time is a precious commodity and a constant consideration. As Debbie noted:

> *I think for caregivers in general, there are—there are time demands that are hard to even quantify, like just the amount of juggling of time that you have to do or think about, um, is—is significant and is a dent in [your day].*

For IGI participants, a typical list of time demands might include household chores, getting children ready for school or daycare, picking them up and dropping them off, conducting them to after-school activities, and preparing meals. It might also include shaving and bathing adult care recipients, keeping track of and bringing them to medical appointments, and picking up prescriptions. Care work encompasses a never-ending litany of tasks large and small in service for others. These contribute to an enormous mental burden, or cognitive load, for caregivers as they attempt to balance the needs of others while experiencing their own emotions around care (e.g. depression, anxiety, and stress) (Domingues et al., 2018; Paradise et al., 2014).

Time scarcity reflected financial precarity. Selena, a control participant, spent all of her spare time working or commuting via public transit to her job at a hotel in order to make ends meet:

> *I don't catch a break in life regardless. See, what I'm saying. And I barely get time to myself, whether it's my physical well-being, having a night out with the girls. Like, it's just like, it's really, it's really just been like, overwhelming sometimes.*

On the other hand, GI recipients were, to varying extents, able to reclaim their time, and therefore their humanity. Rather than existing in a constant state of stress, they could prioritize time spent outside the labor market. Several acknowledged that the nature of time as a caregiver did not fit comfortably into the capitalist system of paid labor—and that society tends to only value work that makes a profit. Participants thought critically about their time as a resource, not merely a commodity. As Chelsea explained:

> *If we were to look at what is, what is the greatest return, it takes time to raise children, it takes time to care for people the right way, and that's not a profitable enterprise. So like, American capitalism doesn't necessarily line up with long-term values, and long-term change, and long-term support.*

Pushing back against capitalist narratives of productivity, Elnora noted it was sometimes enough to just exist and be present—to be human:

> *I think there' s a pressure to use our time well and feel like we have to be like learning something, we have to be partying, we have to be this. Like, we have to be socializing, we have to be going somewhere, we have to be like, bettering ourselves in one of a million ways … Yeah. I think that there's a lot of that like pressure put on us, and to me as an adult with three children and a job, and a happy, bustling life, I can say with certainty that using time well is often doing nothing with it.*

Elnora noted GI improved not only the amount of time but the quality and significance of time spent with her children: it was more peaceful and authentic. Similarly, Randall Thomas reflected that the GI quieted the constant churn of stressful thoughts, allowing him to direct his energy toward parenting and improving the quality of his time:

> *I've definitely felt that this last year, it just, it's at the back of the mind. It's like, um, do I, how much do I need to hustle today, this week, this month? Um, can I focus a little bit more on the parenting and not kind of run these kind of stressful thoughts, cycles in the background? And I could just not have to do it as much, not have to stress out so much, basically. That's, I mean, it's kind of like the time hasn't really opened up, but there's the time, the quality of time has been better. That's one way to put it.*

The decrease in stress that Randall described was supported by quantitative data, which found that the GI had an effect on parental stress levels for treatment participants even after the pilot had ended. Regression results for parental stress (Berry & Jones, 1995), measured on a scale ranging from 18 to 90 (with higher scores indicating elevated stress), revealed that the treatment group's stress levels held steady or marginally reduced over time compared to the control group, where stress levels heightened. Starting from similar Baseline scores (control: 41.4, treatment: 41.9), the treatment group also exhibited statistically significant stress attenuation at 12 and 18 months. Mean differences were -1.6 at 6 months, -3.7 [CI: -6.82, -0.75] at 12 months, and -5.8 [CI: -9.50, -1.78] at 18 months. That parental stress levels attenuated even after the pilot had ended speaks to the potential lasting impact of the GI on recipients' time.

Rather than trade-offs where paid work took priority, GI recipients instead privileged quality time with family. They valued the ability to be present and engaged rather than stressed and overburdened. The GI allowed Flora to give up a second job that had asked her to work extra hours, cutting into the time she spent with her son. Ziggy, too, was able to give up some of his piecemeal gig work, like Zoom teaching and academic editing, in order to spend more time with his family.

Jay shared that the GI had come into their life at a time when they were already questioning the notion of value and labor—something that had been spurred by the pandemic. The money subsidized their ability to turn down extra work in order to be with their son:

> *I think that, you know, with my own personal development and with the way things changed with the pandemic, it's just, it's very, very important to me to not, you know, place my value in how I'm evaluated at work, or how much money I have in my bank account, you know, but to, to focus on my own, you know, passions and my connections*

> *with others and taking care of my son ... And it's just, it's coincided with getting IGI and, and IGI has, has helped, you know, because, you know, I always have this feeling of, well, I could be doing something more. Um, and at least with, you know, adding hours, you know, that I don't really want to add that would... reduce my time with my son, for example? To me, it's, it's not worth it, you know?*

Increased ability to rest, restore, and spend quality time with others may also reflect in quantitative findings from the CHAOS scale (Matheny et al., 1995), which assesses the extent of environmental instability and disorganization on household dynamics. Economic instability often pervades multiple facets of daily life, including disturbances in regular schedules, challenges in maintaining order, and elevated levels of ambient noise within the living environment. Other research has suggested that reduced work-related stress and increased family time potentially leads to lower levels of household chaos and improved child-family outcomes (Duncan et al., 2014; Marsh et al., 2020).

Survey data suggests differential impacts on household environments between the treatment and control groups over the course of the pilot study. Initially, the treatment group reported marginally higher scores on the CHAOS scale compared to the control group (M=30.71 vs. M=29.98). Six months after the first disbursement, scores for the treatment group remained relatively stable (M=30.95), whereas the control group experienced a notable increase (M=31.27). This trend continued, with the treatment group maintaining lower household chaos at 12 months (mean difference=-1.41), and even though their scores slightly increased 6 months post-intervention (M=31.27), they remained significantly lower than those of the control group (M=33.28). Additionally, the proportion of participants reporting low levels of household chaos decreased by almost 11 percent points for the control group between Baseline and Endline, compared to a 2 percentage point increase for the treatment group. Collectively, these findings imply that the GI may have been effective in sustaining or improving household stability and reducing environmental chaos.

3. "Somehow, some way, one day": GI, Hope, and Mattering

Summary: During IGI, caregivers were able to fully engage in their surroundings, taking advantage of the resources that abound in Ithaca but that previously had been inaccessible due to financial and time constraints. The GI created the space for recipients to spend time in nature, invest in themselves and in relationships, and engage in their communities. This served to reduce feelings of isolation and decrease caregivers' overall sense of burden, underlining the importance of social connection and time for self for overstretched carers. Findings also demonstrated a significant increase in levels of hope among participants; being more fully able to participate in their own lives may have fostered a sense of increased agency over their futures. Meaningful differences were also recorded across all three dimensions of mattering during the pilot. Caregivers shared that they appreciated the institutional and societal recognition that IGI represented. The GI underlined the value of their care work and validated caregivers' dignity and humanity.

Living in financial precarity often precludes people from living with intention. Caught between overlapping financial and care obligations, people in poverty remain trapped in survival mode (West & Castro, 2023). Lilly said:

> *I really want to, like, live life right now, which is like a thing also, like, in the past couple of years coming to me. Like, I just want to like, I don't want to just survive. I want to, like, enjoy, like, somehow, some way, one day…*
>
> *Somehow, some way—one day I want to be able to enjoy life and not just be here like doing it, you know? Which is a lot more easier said than done. Because everything costs money.*

Ithaca is a beautiful place, and there are many opportunities to live well and enjoy one's surroundings. However, this requires some level of disposable income: whether it is fueling up the car to get out on a hike, buying gear for outdoor pursuits, or stocking up at the local farmer's market. As Lilly noted, "everything costs money." Such activities also require time—as previously noted, a scarce resource for caregivers stretched to the brink.

However, during the IGI program, participants were able to meaningfully engage in their surroundings, taking advantage of Ithaca's many resources. They signed their children up for drama, soccer, and summer camps, and took them fishing and hiking. Jay described how they were able to participate more fully in life with the GI:

> *I didn't really have the ability to do some nice things for my kids, you know, and I just, sometimes just use that money to—to do something fun together… Even just, like, go out to dinner, you know, which is something I normally can't do. Um, or with [my son], the things that he loves, like he's really into fishing, and, you know, there'd be a fishing pole he'd look at, and I'd just be able to get it for him, when I wouldn't have been able to otherwise.*

When asked how people might spend the cash, Sarah said:

> *I think most people— I think most people would be spending it on basic needs… Or like any sort of thing that brings them joy that they could now do… Like, now, do you have more free time? Can you, can you join an adult activity maybe that brings you joy that costs money, you know? I mean, that's another piece of it. Like, maybe you can go to a yoga class now or whatever.*
>
> *Like, I like, uh, it doesn't mean… That's what I like so much about this program is that it's like, it doesn't have that thing of like, well, you're struggling, so you should have no joy, you should have no fun.*

As Sen notes, the value of capabilities—"the freedoms people have to experience, to be and to become—are integral to human flourishing" (Lybbert & Wydick, 2022, p. 3). The GI offered a glimpse of how life could be outside the status quo of financial and emotional stress. Jay said:

> *I think [the GI] is just humane. It's just been humane. It's just felt like, you know, at first it felt like, oh, this is amazing. I feel so lucky, but then going through [the program], I'm like, well, this is just sort of working, working me up to where things should be anyway, because it's so unbalanced in this world, you know?*

Another participant, Sophie, shared a similar sentiment:

> *It's awesome. [The GI] um, it's— it's really humbling and very humanizing. Um, there was, like, there's a lot of stuff you can do for free, but, like, there's a type of dignity that you kind of lose out on when you're not able to participate with your peers, and whether it's, like, work-related stuff or projects or social. There's, like, you kind of get stripped of this level of dignity that you don't get back unless you're participating in those things. And I was definitely able to regain a lot of that and felt a level of dignity and I felt, I don't know, it's just very humanizing and humbling, and just, yeah, just dignity is like a big word because I—I was able to get a lot of that, which is amazing.*

Respondents who had previously been isolated as a function of financial precarity and care duties were able to reinvest in social connections. They took part in social events and met with friends. For instance, Haley took time off from full-time caring to travel for a few weeks and see people. She talked about how amazing it was to eat food cooked for her by others—to be cared for by others instead of providing care full-time. Chelsea was able to attend her best friend's wedding, something that would not have been possible without the extra cash.

The GI also afforded caregivers the time and space to care for themselves. Unpaid caregivers exist within a system that devalues their existence, with caregivers of color, disabled caregivers, female caregivers, and those with intersectional identities further diminished (Wyatt & Ampadu, 2022). Among a population that experiences disproportionate cognitive burden, wage inequity, and other forms of

systemic oppression that impact mental and physical health, the capacity for self-care is critical (Wyatt & Ampadu, 2022). Although the term self-care has become by turns popularized, commercialized, and co-opted, its roots are deeply political. Audre Lorde, a revolutionary Black feminist, lesbian, and poet (*About Audre Lorde*, n.d.), wrote about self-care as a tool of resistance for oppressed peoples: "Caring for myself is not self-indulgence, it is self-preservation, and that is an act of political warfare" (Lorde, 1988, p. 53).

Through this lens, self-care is about claiming time to preserve one's spirit despite existing in a system designed to compromise one's well-being (Kim & Schalk, 2021). This is something that cannot be achieved through candles and skincare, nor performative self-improvement. The cruel paradox is that under capitalism, being able to engage in authentic self-care does tend to require some measure of disposable income and time, both typically in short supply for caregivers. With the GI, participants were able to explore pursuits that brought them joy and healing—finding ways to redistribute their time in service of authentic self-care.

Iterations of self-care included creating for the sake of being creative. Although Amy had chosen to leave work to care for her father, she described feeling isolated. Arts and crafts brought her joy amidst the demands of her father's care. She crafted using natural materials and "even using the GI to buy a glue stick," she said, was meaningful. Other forms of self-care she mentioned were weekly therapist appointments and voracious reading. Chelsea, too, valued crafting as an outlet, saying: "I tend to do crafting, um, sewing, you know, that when I do have time, I like to create things."

Participants were also able to reconnect to nature. Michael, a single father caring for his teenage daughter, bought a fly-fishing rod with some of the GI, "which I might not have otherwise. [The GI] gave me a little bit of breathing room to do that." He looked forward to being able to go fishing and "stock the larder" in the springtime, an exercise he described as "very enjoyable and therapeutic."

Jay talked about having more time for writing as a tool to work through their PTSD. Writing has sustained them since childhood: "I [have] hung onto it like a piece of driftwood in a river."

> *[During the pilot] I've done a lot of my own writing and a lot of, you know, a lot of time in nature, which is really renewing for me. Um, there's a creek near my house, and I just spend a lot of time down there. Um, so I'm— I'm— I'm— My routine is much, it has a lot more self-care to it than it would have in the past.*

Caregivers also seemed to recognize the value of their time with the GI: that they deserved space for creativity and joy, and that such space was necessary in order to prevent burnout. Jay said:

> *There's just been a, you know, a progression in my life of working on these things and thinking about these things. I think one of the things the pilot helped with was just, you know, offering me a little more breathing room to have my own time and take my own time and... I think that allowed me to start thinking about my self-care differently. And once I started to feel what that felt like, I was like, "Oh, I actually really need this," you know.*

> *Um, and I think it made me think about money a little bit differently, because it's a value system, you know, beyond just currency. And, um, I mean, for so many people, it's tied to their sense of self and— I just, I started to look at that a little bit more. And to know that there are like other kinds of currency that are more important, you know... well, again, the self-care, uh, the time with my son, you know, because he's not going to be 12 forever. Um, and trying to—to think more about the things that are my—my dreams, you know, things I've always put on hold...*

The increased capacity for self-care and connection evident in the qualitative findings may have contributed to a decrease in caregiver's overall sense of burden. To capture the impact of cognitive load and environmental stressors on caregivers, the Short Form Zarit Burden Interview (ZBI-12) was utilized (Higginson, et al., 201). This is a validated tool measuring caregiver burden, including the impact of care work on caregivers' health, relationships, and social life. Results from the ZBI-12 reveal distinct caregiver burden patterns between groups over time. Initially, the treatment group showed higher burden levels (42% vs. 40%). However, by 6 months, the percentage of the treatment group reporting high burden decreased (34%), while the control group increased (41%). At 12 months, this trend continued, with 36% of the treatment group reporting high burden and an increase in no/mild burden (26%), contrasting with the control group's significant rise in high burden (49%). At 18 months, the treatment group maintained lower burden levels compared to the control. These results suggest the GI's potential effectiveness in reducing caregiver burden.

As caregivers were freed up, to some extent, from immediate caring and financial pressures, this in turn seemed to create space to think about the future. Some participants were able to more fully express their own goals and desires, bringing them out of survival mode and into a more hopeful mindset.

An indelible part of the human experience, hope is conceptualized by Snyder (2002) as having three main conditions: an individual is able to determine specific, meaningful goals; to visualize pathways to achieve those goals; and to possess the agency to make progress along these pathways. Those experiencing financial precarity may struggle to find hope in their circumstances, instead feeling futility and fatalism (Cidade et al., 2016; Lybbert & Wydick, 2018).

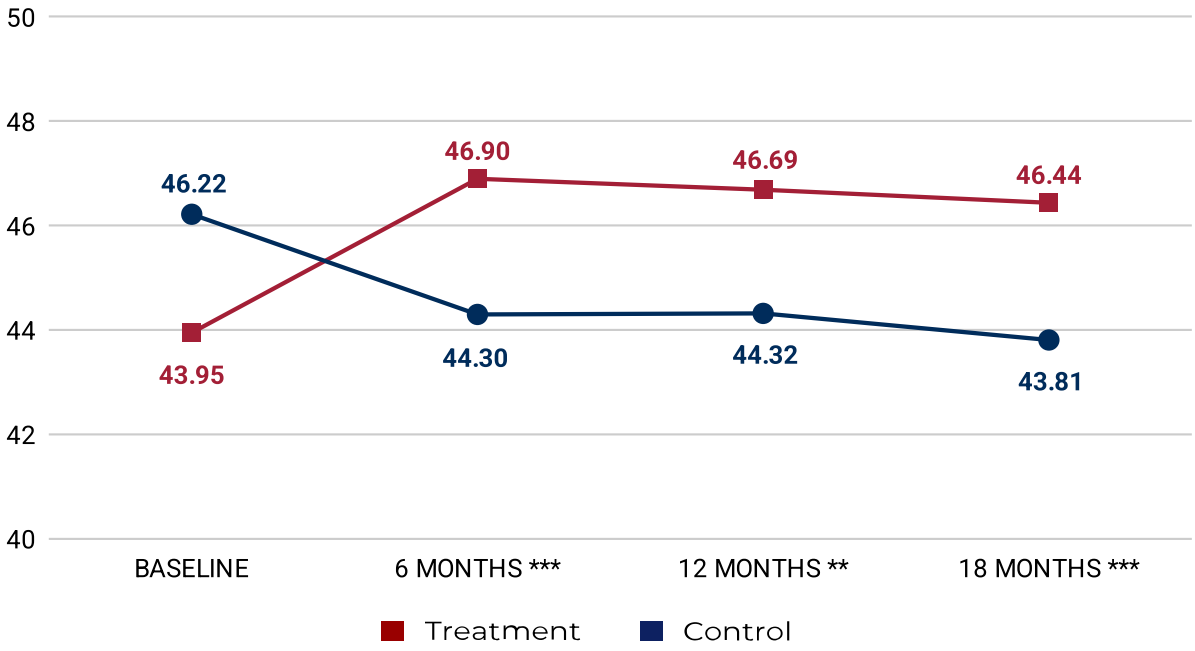
GI removed barriers to the conditions for hope, spurring recipients to dream, feel joy, and move from a place of survival mode to long-term goal-setting. Flora, a graduate student and single mother of a preschool-age boy, explained how removing necessities like housing, education, and healthcare from the financial balancing act might allow one to reach their fullest expression as a human; she likened it to Maslow's (1943) hierarchy of need. For her, the GI was a possible way to bring people towards that place:

> *Yeah, you can dream bigger dreams for yourself if you're not limited to like, what can pay these bills, or how can I climb out of this, you know, dungeon of debt, you know? Like you can, um, dream bigger dreams for your family.*

Quantitative findings strongly supported this theme, reflecting an increased sense of hope among participants. Improvements were observed in the treatment group across all subdomains of the Adult Hope Scale, including increased sense of agency and ability to activate life pathways. At Baseline,

there was parity in the Pathway scores between the groups (control: M=23.92, treatment: M=23.09). However, 6 months after the first disbursement, a statistically significant difference was observed, with higher scores in the treatment group compared to the control, and this trend continued at all subsequent time points: 24.47 vs. 23.17 at 6 months (B=1.96, p<0.01), 24.15 vs. 22.85 at 12 months (B=1.59, p<0.04), and 24.36 vs. 22.81 at 18 months (B=1.82, p<0.01). Agency sub-scores followed a similar trend, as did the scores for Total Hope. The GI therefore seemed to underline a sense of possibility that outlasted the bounds of the pilot.

Figure 5: Total Adult Hope Scores over Time, Treatment vs. Control



* p<0.05, ** p<0.01, *** p<0.001

Findings also suggest a significant and sustained increase in the percentage of treatment participants reporting high levels of hope, indicating a potential shift towards deeper levels of hopefulness among GI recipients. At Baseline, a larger proportion of the control group expressed feelings of high hope (17% for the control vs. 10% for the treatment). The dynamics shifted by 6 months, with both groups reaching parity in the high hope category (18%). By 12 months, a 2 percentage point difference was observed between groups (treatment: 17% vs control: 15%), and at 18 months, this difference amplified (16% in treatment vs. only 9% in the control group).

Increased levels of hopefulness are notable given that caregivers live in a societal context where much of their labor is taken for granted, its importance beyond social reproduction typically unacknowledged. This status quo can contribute to feelings of invisibility among caregivers and a sense they do not matter to their community. “It’s one of those things where people, um, will say how amazing it is that someone’s doing it, but no one wants to be the one to do it,” said Sophie. She did not feel that society valued the importance of her care work. In her experience, people either pitied her or looked down on her for not having a “real job”:

> *It's hard to talk about with other people, because you either get looked at like, oh, I'm sorry, or a welfare queen, um. There are no set hours. It never ends. You're on call 24/7. If something happens in the middle of the night, then you need to get up and take care of it right away. There's you—I mean, when you leave like a job on, on the books, I guess, um, you clock out, and you go home, and you relax, but when your job is in your home and it never ends, it's—I mean, I would like people to think about that more, I guess.*

Randall Thomas, primary caregiver to his two sons, also described this tension:

> *People say, what did you do today? If you say that you cared for your kids today? I don't know if it's just internal in my own sense of how it's valued. I think that people generally think that that's not a work or a labor of value. I mean, it's reflected very well in the monetary, um, reward [or lack thereof] for caretaking…*
>
> *I think that the value or the prestige associated with that labor is like nothing. It's— It might even have negative value. Um, so I really think strongly on that subject. It's, it's been one of the, you know, one of the things you navigate as parents.*

Chelsea shared an additional gendered dimension of primary caregiving:

> *Talking about people who are underemployed or unemployed, especially if they're caregivers primarily, you know, which tends to be women. Um, so, I don't know, it just, it just, it's not valued and it's not supported essentially. And I've, I felt that—I have felt that as a mother. Um, and I don't want that for my children, but I don't also really know how much is gonna change between now and then.*

For those balancing paid and unpaid care roles, their work, too, felt unacknowledged. Ellen described her role as a caregiver for elders as, "we're doing the hands-on direct care work, the hardest part of it physically and emotionally, but just treated like garbage. Like we are disposable and we weren't ever heard."

Society has rendered care work invisible, stripping agency and meaning from the lives of those who provide it. However, both qualitative and quantitative findings suggest that the GI helped recipients to feel valued. The concept of "mattering" has been described as a sense of making a difference in the lives of others and being significant in the world (Jung, 2015; Rosenberg & McCullough, 1981); that people feel seen by both those around them and by social institutions with power over their lives (Castro et al., 2021). In general, most empirical studies suggest a positive relationship between a sense of mattering and psychological well-being. Negative consequences ensue when people feel they do not matter (Jung, 2015).

Quantitative data revealed meaningful differences across all three dimensions of mattering (Importance, Reliance, and Awareness) during the pilot, though the impacts varied across time periods. While Baseline scores were comparable between control and treatment groups, divergent trajectories emerged at subsequent time periods. Awareness scores in the treatment group remained stable, whereas control group scores declined over time. Significant between-group differences were

observed at the 6-, 12-, and 18-month marks (mean differences: 0.87, 1.15, and 1.34, respectively; B=1.88, p<0.02). For Importance, a significant difference emerged 6 months after the first disbursement (mean difference=2.09; B=1.84, p<0.04). Although the treatment group maintained higher scores subsequently, these differences did not reach statistical significance. Reliance scores remained consistent in the treatment group but fluctuated in the control group, and a significant difference was noted at 18 months (mean difference=1.28; B=1.26, p<0.03). These findings suggest the GI had meaningful and enduring impacts on mattering, even after the pilot had ended.

This was also borne out in the qualitative data: among participants, ascribing both financial and symbolic value to care work was a means of validation. Elsa acknowledged that typically, one's worth is connected to one's output in the labor market. This means unpaid caregivers are often ignored. In contrast, she said, the GI made her feel seen and recognized:

> *I really appreciated that I got picked, and it was really very nice, and very helpful, and it was—it was nice to feel, even though I know it wasn't like nobody knew me and picked me. It was nice to feel, like, almost appreciated, since we do live in a society where everything is based on your money effort. You know what I mean? And how much you make, and how much you do, and all that kind of stuff. So, it kind of gave, you know, it kind of gives you, you know, a little, I don't know, I can't even think of the right word. A little something, make you feel a little appreciated. A little, you know, more [secure].*

Jay spoke to the recognition inherent in the GI, noting caregivers are often "forgotten" by social institutions:

> *It's like one of the few things, um, financially that's ever felt like I was treated with respect, you know, and, um, you know, not having to—not having to sort of prove to someone that I am, you know, needy enough, or broken enough, or things are bad enough so that I should get this money. But just like, no, I'm a human being, I deserve to have a little bit of money to help me get by...*
>
> *It's just, I feel like we are always forgotten in favor of—of something else— And that other thing never touches our lives, you know. All the sort of things that are touted as great news for New York or whatever, it—it rarely comes down and touches individual lives.*

In another sense, the GI functioned as a subsidy for care work, assigning value to unpaid labor within the existing system. Other research has explored the tensions in mixing the realms of care and compensation, sometimes referred to as care "for love or money" (Folbre, 2012; Folbre & Nelson, 2000, p. 123). Some commentators decry the commodification of care, arguing that the expectation of payment degrades care work's inherent altruism and brings the specter of privatization into the mix: "care work for profit." Others, however, frame economic recognition for caregivers as a political endpoint, like the Wages for Housework movement (Federici, 1974). They reject the role of unpaid care work as capitalism has invented it, suggesting that through remuneration, caregivers might subvert the expectations that care is socialized, feminized, and free.

For some caregivers, treating their labor as akin to paid labor felt equalizing, as Randall Thomas argued:

> *[The GI] is earned. It is earned. So let's just put it that way. If there's any dialogue or rhetoric talking about "it's not earned, they're not earning it." It's absolutely earned. I mean, it's, uh, the labor that goes into caretaking is, this deserves, deserves recognition, and money is one way to do it.*

Under capitalism, worth is typically measured by how much money one earns in the labor market. Findings underline the potential of cash to both validate care work within the current system and to recognize the inherent dignity and humanity of those providing care.

Limitations

This study's findings must be interpreted within the context of several limitations. First, the participant pool (n=240) consisted of Ithaca, NY residents with incomes ≤80% AMI and significant caregiving responsibilities. Ithaca's large student population artificially inflates local poverty rates, potentially affecting sample representativeness. While the initial randomization strategy aimed to reflect the demographic distribution of HCV recipients by employing weighted allocation by race, participant replacement during onboarding inadvertently altered the planned proportions, resulting in a deviation from the original design. Ethnicity was incorporated as an interaction term in regression models to address this Baseline imbalance. While this statistical adjustment enhanced the robustness of our estimates, imperfect equivalence may impact result precision.

Ithaca's unique demographic and economic landscape may limit the external validity of the findings. The interplay between the large student population and the housing market—characterized by high demand and elevated rental prices—may not reflect conditions in cities with different demographics or housing dynamics. This student-driven market distortion has led to higher rents and reduced affordable housing availability for non-students. Consequently, the study's findings on housing stability and economic outcomes, particularly for participants using HCVs, may reflect challenges specific to Ithaca's context, potentially limiting generalizability to other regions.

The study employed MICE to address missing data. While MICE is a robust approach, all imputation methods introduce some degree of uncertainty. Despite validation checks, imputed data may not perfectly capture true underlying distributions and patterns. This inherent limitation of data imputation warrants consideration when interpreting the results.

Finally, the study's timing during the post-COVID-19 recovery phase introduced confounding factors. Pandemic-related impacts—including uncertainty, grief, and changes in social policies—likely affected participants' mental health and stress levels. The economic recovery also brought stressors such as inflation, employment and income fluctuations. These uncontrolled variables may influence the findings' applicability to different contexts, potentially limiting their generalizability.

Discussion

Care work is intrinsic to the way we sustain ourselves as humans: it is nurturing, it is active, it is love embodied. And it is taken for granted in our society, which tends to be centered around productivity and profit-making rather than an ethic of care. IGI is an example of what can happen when we begin to put care at the center of life and to recognize its importance. The pilot challenged how our society values and supports care work by placing caregivers at the forefront. In return, findings reflect important gains in financial, physical, and mental health—gains that, in turn, strengthened relationships and community ties.

Quantitative and qualitative data suggested that the cash supported significant increases in physical health and decreases in parental stress and caregiver burden. These improvements were notable given that many caregivers were simultaneously managing their own chronic health conditions while enduring the intense physical and emotional impacts of care work on the body. Income volatility lessened and financial health improved as well; participants described a mutually reinforcing cycle whereby decreased financial stress led to better mental and physical health. And despite the rising cost of living and lack of affordable housing in Ithaca, recipients also temporarily felt more able to stay in place, with small gains in housing stability. The result was improved quality of life for caregivers who had previously been stretched to the brink.

While the GI promoted tangible outcomes, it also facilitated a subtle but powerful mental shift by creating space for caregivers to feel like they mattered, unlocking agency and altering the trajectory of financial and health-related stressors. Rather than existing in financial and social isolation, GI freed up time and money for caregivers to participate in their broader community. It mitigated the tradeoff between paid work and unpaid caring, enabling caregivers to be fully present and to reinvest in relationships with family and friends. More broadly, GI recipients expressed a sense of agency over

their time. For some, this manifested in an increased ability to take risks and pursue goals; for others, it meant the ability to rest, restore and engage in authentic self-care. These developments seemed to inform overall higher levels of hope and mattering among the treatment group.

Ithaca's specific context may have helped amplify the impact of the GI. The cost of living, though increasing, is lower than the New York state average (Bureau of Economic Analysis, 2023; Greco, 2023). Some participants had housing vouchers that covered part of their rent, others had family members who contributed income to the household. Still others had benefited from the city's formal or informal social supports and resources. With basic needs met, it is possible that these recipients were able to leverage the GI more effectively than those experiencing deep poverty, for instance.

The study offers promising evidence on the potential of GI's influence on multiple aspects of daily life. At the same time, findings also suggest that a dosage of $450 per month is not enough to support long-term change. Physical health outcomes, for instance, were not sustained after the pilot's end. In providing for the needs of others, caregivers often put their own health to the side; as finances tightened, carers may not have had the capacity to exercise, take care of themselves, or afford healthy food as they had during the pilot. The GI was also unable to allay fears of neighborhood change, nor meaningfully disrupt the ongoing trend of displacement to more rural areas. This also has implications for health, with documented rural health disparities in Tompkins County. Residents feared not only losing access to medical resources by leaving Ithaca, but educational and employment opportunities. Without increased options for affordable housing within Ithaca's boundaries, it seems that these challenges will continue.

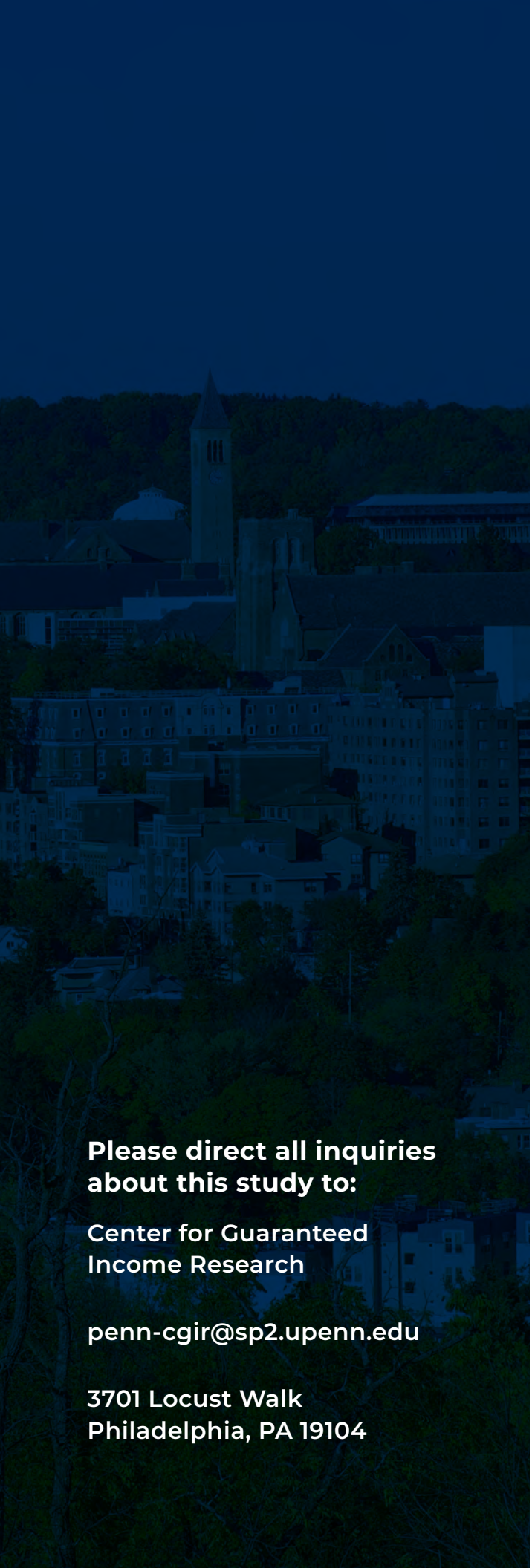
The largely negative way in which US society understands, values, and remunerates care work was clear in the lack of structural support for caregivers' needs, and at the current dosage, the GI was not enough to mitigate these obstacles. This includes the prohibitive cost of childcare, which forced some parents to give up or scale back waged employment in order to stay home. There is often a gendered dimension to these choices, which leave caregivers in financially precarious situations and disadvantages them from eventually reentering the labor market. The Biden-Harris administration recognized the burden of childcare cost and proposed investments in the childcare sector as part of the Build Back Better Act (The White House, 2023). However, there has been debate on how funding should be distributed—through means-testing or as universal subsidies (Yavorsky & Ruppanner, 2022)—and the trajectory of progress depends on the new administration (U.S. Department of Health and Human Services, 2023). Meaningful change also hinges on wider societal acceptance of early childhood education as a priority; as an iteration of paid care work, childcare provision, too, is undervalued.

Another concern is the lack of paid leave in the US. Caregivers face impossible decisions around juggling paid labor and unpaid care work, leading to high levels of stress and cognitive burden. New York State has made some steps towards mitigating this issue, instituting one of the most robust paid leave programs in the country in 2016. Residents can apply for up to 12 weeks of paid leave for the birth of a child or to care for family members. As of January 2025, paid prenatal leave will also be available for procedures and doctors' appointments. Like other social support programs, however, individuals must meet eligibility criteria in order to apply. Unemployed persons and those engaged in not-for-profit work, for instance, do not qualify (New York State, n.d.). There is still a need for paid leave protections that recognize all caregivers, both within and outside the labor market.

The lack of institutional recognition for care work at a broad level is stark, but at a local level, the IGI pilot remedied this by providing acknowledgment of an often-devalued population. By giving caregivers permission to exist outside the demands of both care and capitalism, the GI emphasized that people matter simply because they are human—a position reflected by increased feelings of hope and mattering among the treatment group. This sentiment has the potential for restoring trust in institutions, as recipients feel seen and recognized. As Ziggy noted:

> *I guess we have to have trust in… Yeah, that our society cares for us, and I think that relates to [GI] too and I think many people have lost that… People have just, uh, no one cares for me. Government doesn't care. So let's bring the whole thing down. Um, so I think these sorts of initiatives are incredibly important.*

In a social and political context that can feel alienating, GI reminds people that they matter. IGI is a move towards a politics and ethic of care that values people above their worth in the labor market and validates their humanity. Ziggy pointed to GI as a means towards "making our society a better place to be, a more caring place to be."



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Center for Guaranteed Income Research

The Center for Guaranteed Income Research (CGIR) was established in 2020 at the University of Pennsylvania School of Social Policy & Practice with the aim of developing a shared body of knowledge on unconditional cash transfers.

At CGIR, distinguished academics and professionals in this field lead pilot guaranteed income programs and oversee the planning and implementation of research initiatives. CGIR is led by two Founding Directors: Dr. Amy Castro, Associate Professor of Social Policy & Practice at the University of Pennsylvania, and Dr. Stacia West, who holds a faculty fellowship at the University of Pennsylvania in addition to her primary role as an Associate Professor at the College of Social Work at the University of Tennessee-Knoxville.

CGIR conducts applied cash transfer studies and pilot designs that contribute to the empirical scholarship on cash, economic mobility, poverty, and narrative change. Our investigations build upon existing literature on cash transfers and incorporate evaluation practices and lessons learned from our previous research on guaranteed income and the gender and racial wealth gap.

All of our research is grounded in Durr's (1993) fundamental question: "What influences policy sentiment?" With this in mind, we are committed to conducting public science that challenges prevailing narratives surrounding poverty, deservedness, and economic mobility, utilizing diverse approaches such as multi-site ethnography, politically-driven sampling, and data visualization.

Our dashboards, created in partnership with Stanford Basic Income Lab, feature filters at the pilot level, allowing individuals to access and compare information while obtaining detailed insight into our investigations.

CENTER FOR GUARANTEED INCOME RESEARCH
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Appendix A

Table 8: Comparative Analysis of Select Outcome Measures: Treatment vs. Control Groups

OUTCOME	TREATMENT	CONTROL	ESTIMATED IMPACT	STANDARD ERROR	95% CI LOWER	95% CI UPPER
FINANCIAL WELL-BEING						
Baseline	38.64	38.56	0.34	1.38	-2.37	3.04
6 months	39.98	39.74	0.28	1.20	-2.08	2.63
12 months	41.33	40.92	0.22	1.25	-2.24	2.67
18 months	42.67	42.09	0.16	1.51	-2.81	3.12
PERCEIVED STRESS LEVELS						
Baseline	7.86	7.73	0.13	0.44	-0.90	0.83
6 months	7.56	7.89	-0.33	0.36	-0.82	0.59
12 months	7.26	7.85	-0.59	0.37	-0.92	0.54
18 months	6.95	7.91	-0.96	0.47	-1.20	0.65
KESSLER PSYCHOLOGICAL DISTRESS						
Baseline	22.85	22.96	-0.11	1.3	-2.31	2.81
6 months	22.71	22.84	-0.13	1.1	-2.28	1.85
12 months	23.29	24.54	-1.25	1.2	-2.81	1.72
18 months	23.25	25.07	-1.82	1.4	-3.56	1.90
CHAOS						
Baseline	30.71	29.98	0.73	1.08	-1.86	2.35
6 months	30.95	31.27	-0.32	1.10	-2.99	1.32
12 months	30.85	32.26	-1.41	1.80	-2.82	1.80
18 months	31.27	33.28	-2.01	1.96	-3.44	1.25

OUTCOME	TREATMENT	CONTROL	ESTIMATED IMPACT	STANDARD ERROR	95% CI LOWER	95% CI UPPER
AVERAGE GENERAL HEALTH						
Baseline	57.55	57.69	-0.14	3.76	-7.39	7.18
6 months	57.18	59.73	-2.55	2.56	-7.93	2.12
12 months	57.95	53.85	4.10	2.96	-4.66	6.93
18 months	53.23	53.77	-0.54	2.60	-6.20	3.97
SF-36 PHYSICAL						
Baseline	57.67	56.15	1.52	6.06	-14.66	9.11
6 months	57.78	56.73	1.05	6.23	-13.44	10.99
12 months	61.70	49.18	[12.52]*	6.32	0.49	25.26
18 months	53.52	48.51	5.01	6.34	-8.91	15.96
SF-36 HEALTH LIMITS						
Baseline	78.36	75.92	2.44	3.51	-5.08	8.69
6 months	76.89	73.90	2.99	3.34	-6.57	6.51
12 months	78.05	68.63	[9.42]*	3.29	0.29	13.21
18 months	74.00	70.02	3.98	2.90	-4.89	6.49
AGENCY						
Baseline	20.86	22.30	-1.44	0.80	-2.84	0.30
6 months	22.43	21.13	[1.3]***	0.74	0.94	3.83
12 months	22.54	21.46	[1.08]**	0.76	0.49	3.46
18 months	22.07	21.00	[1.07]**	0.76	0.63	3.61
PATHWAY						
Baseline	23.09	23.92	-0.83	0.73	-1.83	1.05
6 months	24.47	23.17	[1.3]**	0.71	0.57	3.35
12 months	24.15	22.85	[1.3]*	0.79	0.03	3.15
18 months	24.36	22.81	[1.55]**	0.69	0.46	3.18

OUTCOME	TREATMENT	CONTROL	ESTIMATED IMPACT	STANDARD ERROR	95% CI LOWER	95% CI UPPER
ADULT HOPE - TOTAL						
Baseline	43.95	46.22	-2.27	1.39	-4.39	1.07
6 months	46.90	44.30	[2.6]***	1.23	1.93	6.77
12 months	46.69	44.32	[2.37]**	1.34	0.93	6.20
18 months	46.44	43.81	[2.63]***	1.24	1.52	6.37
AWARENESS						
Baseline	30.04	30.34	-0.30	0.92	-2.37	1.22
6 months	30.59	29.72	0.87	0.78	-0.29	2.75
12 months	29.26	28.11	1.15	0.91	-0.29	3.26
18 months	29.96	28.62	[1.34]*	0.82	0.28	3.49
IMPORTANCE						
Baseline	36.26	36.69	-0.43	1.13	-2.18	2.25
6 months	36.99	34.90	[2.09]*	0.89	0.10	3.57
12 months	36.00	34.91	1.09	0.94	-0.92	2.76
18 months	36.41	35.48	0.93	0.88	-0.94	2.51
RELIANCE						
Baseline	24.22	23.54	0.68	0.61	-1.11	1.28
6 months	24.27	23.20	1.07	0.65	-0.46	2.09
12 months	24.12	22.69	1.43	0.62	-0.24	2.19
18 months	24.32	23.04	[1.28]*	0.59	0.11	2.24

Footnotes:

Baseline Mean: Adjusted average score prior to any intervention

6/12/18-month Mean: Adjusted average score at the respective time mark

Estimated Impact: The Mean difference between the treatment and control groups

Robust Standard Error: Indicates the precision of the impact estimates

95% CI Lower/Upper: Bounds of the 95% confidence interval for the impact estimate

* Indicates statistical significance: * $p<0.05$, ** $p<0.01$, *** $p<0.001$

Appendix B

Table 9: Racial/Ethnic Distribution of Housing Cost Voucher Recipients in Ithaca, NY

	% HCV
Black or African American	27
American Indian and Alaska Native	1
Asian/Native Hawaiian and other Pacific Islander	3
Hispanic or Latino origin (of any race)	8
White alone, not Hispanic or Latino	61

Appendix C

Table 10: Sample Attrition

TIME PERIOD	TREATMENT	CONTROL	OVERALL ATTRITION (%)	DIFFERENTIAL ATTRITION (%)
Baseline	110	130		
6 months	99	92	20.42	19.23
12 months	103	83	22.50	29.79
18 months	82	68	37.50	22.24