June 27, 2018

ALL-COUNTY LETTER NO: 18-77

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY IN-HOME SUPPORTIVE SERVICES PROGRAM MANAGERS

SUBJECT: IMPLEMENTATION OF THE LESBIAN, GAY, BISEXUAL, AND TRANSGENDER DISPARITIES REDUCTION ACT [ASSEMBLY BILL (AB) 959]

REFERENCE: ASSEMBLY BILL (AB) 959 (CHAPTER 565, STATUTES OF 2015); CALIFORNIA GOVERNMENT CODE SECTION 8310.8

PURPOSE

This All-County Letter (ACL) provides counties with information and instructions for implementing the provisions of Assembly Bill (AB) 959 (Chapter 565, Statutes of 2015), the Lesbian, Gay, Bisexual, and Transgender Disparities Reduction Act in the In-Home Supportive Services (IHSS) program.

BACKGROUND

The intent of AB 959 is to understand the full diversity of state program recipients and to collect accurate data to effectively implement and deliver critical state services and programs.

The AB 959 requires four specific state departments, including the Department of Social Services (CDSS), the Department of Health Care Services (DHCS), Department of Public Health (DPH), and the Department of Aging (CDOA), to begin collecting voluntary self-identification information pertaining to sexual orientation and gender identity when collecting, directly or by contract, other required demographic data. This
information will be used only for demographic analysis, coordination of care, quality improvement of services, conducting approved research, fulfilling reporting requirements, and guiding policy or funding decisions. The intent of collecting this demographic data is to gather accurate information to understand, compare, report, and apply that data to the enhancement and improvement of public services.

The effective date of implementation of AB 959 provisions is July 1, 2018.

CHANGES TO THE APPLICATION FOR IN-HOME SUPPORTIVE SERVICES (SOC 295)

Pursuant to AB 959, the State will be required to collect voluntary information about applicants’ sexual orientation and gender identity. To comply with this bill, the State will be collecting this new demographic information through the SOC 295, the Application for In-Home Supportive Services (IHSS) form. Changes have been made to the SOC 295 to appropriately capture this new information in the new Sexual Orientation and Gender Identity section. The terminology for sexual orientation and gender identity in this section is consistent with the terminology used by the DHCS for the application for Medi-Cal benefits.

Although counties are required to ask applicants for this new information, applicants are not required to provide responses. Any responses to the questions shall not be used in any manner that connects the personal information to the individual to whom the information pertains.

Additionally, the collection of this new information will only apply to applicants who apply for IHSS beginning July 1, 2018. Counties will not be required to collect this information from recipients currently receiving IHSS.

Modifications will be made to the Case Management, Information and Payrolling System (CMIPS) II to allow for entry of the sexual orientation and gender identity information for purposes of collecting and reporting as required. A forthcoming All-County Information Notice (ACIN) addressing these modifications will be released by the CDSS, Adult Programs Division, Systems and Administrative Branch.

Other Changes to the SOC 295

Additional revisions to the SOC 295 have also been made to reflect recent updates to procedures:

- The Household Information section has been revised to capture members living in the home rather than exclusively family members. A new check box labeled “non-relative” has been added to this section to capture individuals living in the home who are not related to the applicant.
The Ethnic and Language Information section has been changed to include two separate questions to appropriately capture what language applicants prefer to read and what language applicants prefer to speak. The list of Ethnic Codes has been revised to include two new options: “Other” and “Mixed Ethnicity.” These capture individuals who identify as an ethnicity other than what is listed on this form or whether the applicant identifies with multiple ethnicities.

Since the development and implementation of the Electronic Timesheet System (ETS) which allows providers an option to submit timesheets online using a tablet, smartphone, laptop or computer, the Communication Accommodations section on the SOC 295 has been revised to include this new ETS option, including the website to register for ETS.

The “For Agency Use Only” section has been expanded to include additional boxes to capture Medi-Cal Aid Code and Modified Adjusted Gross Income (MAGI) Eligible Recipient status. Additionally, a Notes section has been added for counties to record any information pertinent to the applicant, such as potential eligibility status information or applicants’ preferred pronoun as related to the Sexual Orientation and Gender Identity section.

COUNTY RESPONSIBILITIES

Upon release of this ACL, counties shall use the attached revised SOC 295 for IHSS applicants to collect information regarding an IHSS applicant’s sexual orientation and gender identity. Counties have a responsibility to inform all applicants that responses to questions regarding applicants' sexual orientation and gender identity are optional and will be used for statistical purposes only; responses shall not be used in any manner that will connect them to applicants. Additionally, counties must inform applicants that any information provided in the Sexual Orientation and Gender Identity section of the form will not affect an applicant’s IHSS eligibility determination.

STATE RESPONSIBILITIES

CDSS will be responsible for compiling this new demographic data collected in CMIPS and report this information to the legislature.

CDSS will update the social worker training modules to provide guidance to county social workers in the collection of information related to AB 959. The training modules are expected to include information on how counties will present and discuss the collection of this new data information with applicants.
FORMS ACCESS

Counties will be able to access the revised SOC 295 on the CDSS Forms/Brochures web page.

Upon completion of translations, CDSS will post Armenian, Chinese and Spanish versions of the form on the Translated Forms and Publications webpage.

The designated Forms Coordinator for your county must distribute translated forms to each program and location. Each county shall provide bilingual/interpretive services and written translations to non-English or limited-English proficient populations, as required by the Dymally-Alatorre Bilingual Services Act (California Government Code section 7290 et seq.) and by state regulation (CDSS Manual of Policies and Procedures [MPP] Division 21, section 115, Civil Rights Nondiscrimination).

It is the county’s responsibility to provide bilingual/interpretive services if an applicant or recipient requests it or when an applicant or recipient does not understand English. This requirement may be met through utilization of paid interpreters, qualified bilingual employees, and qualified employees of other agencies or community resources.

Counties are also reminded that minors are not appropriate translators in situations where translating is required, unless explicitly requested by the applicant or recipient. Individuals who have been designated as Authorized Representatives (AR) for purposes of IHSS by the applicant or recipient may assist in translations at the applicant’s or recipient’s request. Bilingual/interpretive services shall be provided free of charge to the applicant/recipient. More information regarding translations can be found in MPP Section 21-115.

Questions about accessing the forms may be directed to the Forms Management Unit at fmudss@dss.ca.gov. Questions about translations may be directed to the Language Services Unit at LTS@dss.ca.gov.

If you have any questions about this ACL, please contact the Adult Programs Division, Policy and Quality Assurance Branch, Policy and Operations Bureau at (916) 651-5350.

Sincerely,

*Original Document Signed By:*

DEBBI THOMSON
Deputy Director
Adult Programs Division

Attachment
APPLICATION FOR IN-HOME SUPPORTIVE SERVICES

To the Applicant: All sections of this form must be completed. Information provided is subject to verification.

NOTE: Retain your copy of your completed application. Regarding your Social Security Number, it is mandatory that you provide your Social Security Number(s) as required in 42 USC 405, or that you apply for a Social Security Number(s) with the Social Security Administration. This information will be used in eligibility determination and coordinating information with other public agencies.

<table>
<thead>
<tr>
<th>Date of Application:</th>
<th>Case Number (if known):</th>
</tr>
</thead>
</table>

Section 1 – Personal Information

<table>
<thead>
<tr>
<th>Name of Applicant:</th>
<th>Social Security Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address:</td>
<td>City:</td>
</tr>
<tr>
<td>State:</td>
<td>Zip Code:</td>
</tr>
<tr>
<td></td>
<td>Telephone:</td>
</tr>
<tr>
<td></td>
<td>Email:</td>
</tr>
</tbody>
</table>

| Date of Birth: | Gender: □ Male □ Female □ Transgender: male to female □ Transgender: female to male |

Section 2 – Sexual Orientation and Gender Identity (Optional)

Providing responses in the sections below is optional and confidential. Any information you provide in this section will not be used in your eligibility determination.

How do you identify your gender identity?
(check the box that best describes your current gender identity)

□ Female □ Male □ Transgender: male to female □ Transgender: female to male □ Non-Binary (neither male nor female) □ Another gender identity □ Decline to state
**What sex was listed on your original birth certificate?** □ Female □ Male

**How do you identify your sexual orientation?**
Select one answer.

- □ Straight/heterosexual
- □ Gay or lesbian
- □ Bisexual
- □ Queer
- □ Another sexual orientation
- □ Unknown
- □ Decline to state

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### Section 3 – Veteran Information

<table>
<thead>
<tr>
<th>Are you a Veteran?</th>
<th>Are you a Spouse/Child of a Veteran?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

If YES, give Veteran name and Claim Number:

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### Section 4 – SSI/SSP Information

<table>
<thead>
<tr>
<th>Do you receive SSI/SSP benefits?</th>
<th>□ Yes □ No</th>
</tr>
</thead>
</table>

If yes, check your type of living arrangement:

- □ Independent Living
- □ Board and Care
- □ Home of Another

**Services being requested:**

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### Section 5 – Past IHSS Information

<table>
<thead>
<tr>
<th>Have you received In-Home Supportive Services (IHSS) in the past?</th>
<th>□ Yes □ No</th>
</tr>
</thead>
</table>

If Yes, complete the following.
Date and county where service was last received:

<table>
<thead>
<tr>
<th>Total Monthly Hours:</th>
<th>Name Used (if different from above):</th>
</tr>
</thead>
</table>
Section 6 – Household Information

List Household Members:

<table>
<thead>
<tr>
<th>Name of Spouse:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birthdate:</td>
</tr>
<tr>
<td>Name of: □ Parent □ Child □ Other Relative □ Non-Relative</td>
</tr>
<tr>
<td>Birthdate:</td>
</tr>
<tr>
<td>Name of: □ Parent □ Child □ Other Relative □ Non-Relative</td>
</tr>
<tr>
<td>Birthdate:</td>
</tr>
<tr>
<td>Name of: □ Parent □ Child □ Other Relative □ Non-Relative</td>
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<tr>
<td>Birthdate:</td>
</tr>
<tr>
<td>Name of: □ Parent □ Child □ Other Relative □ Non-Relative</td>
</tr>
<tr>
<td>Birthdate:</td>
</tr>
</tbody>
</table>

Section 7 – Ethnic and Language Information

The law requires that information on ethnic origin and primary language be collected. If you do not complete this section, social service staff will make a determination. The information will not affect your eligibility for service.

A. My Ethnic Origin is:
   Please choose one
   (See Page 8 for a list of Ethnicities and Codes)

B1. What language do you prefer to read?
   Please choose one

B2. What language do you prefer to speak?
   Please choose one
   (Please choose one from the list of languages and codes on Page 8)
Section 8 – Communication Accommodations
To accommodate blind or visually-impaired applicants, IHSS information is available in the following alternative formats. Please indicate which format you would prefer, if applicable. Providing information in this section will not affect your eligibility for services.

I am Blind: □ Yes □ No

If yes, please choose one of the following for each of the three types of Department of Social Services (DSS) documents listed.

For Notices of Action: □ No accommodation is needed □ Braille Documents □ Audio CD □ Data CD □ County Support
(If County Support, describe requested support)

For IHSS Required forms: □ No accommodation is needed □ Braille Documents □ Audio CD □ Data CD □ County Support
(If County Support, describe requested support)

For Timesheets: □ No accommodation is needed □ Telephonic System (4 Digit RAN: ) □ County Support
□ Electronic Timesheet System (ETS) (Applicants and providers must first register at https://www.etimesheets.ihss.ca.gov)
(If County Support, describe requested support)

I am Visually Impaired: □ Yes □ No

If yes, please choose one of the following for each of the three types of Department of Social Services (DSS) documents listed.
For Notices of Action: □ No accommodation is needed
□ 18 point font documents □ Audio CD □ Data CD □ County Support
(If County Support, describe requested support)

For IHSS Required forms: □ No accommodation is needed
□ 18 point font documents □ Audio CD □ Data CD □ County Support
(If County Support, describe requested support)

For Timesheets: □ No accommodation is needed
□ Telephonic System (4 Digit RAN: )
□ 18 point font documents □ County Support
□ Electronic Timesheet System (ETS) (Applicants and providers must first register at https://www.etimesheets.ihss.ca.gov)
(If County Support, describe requested support, including blind-only services)

Section 9 – Affirmation
I affirm that the above information is true to the best of my knowledge and belief. I agree to cooperate fully if verification of the above statements is required in the future.

I also understand that as the employer of my IHSS provider(s) I am responsible for:

1. Hiring, training, supervising, scheduling and, when necessary, firing my provider(s).
2. Ensuring the total hours reported by all providers who work for me do not exceed my IHSS authorized hours each month.
3. Referring any individual I want to hire to the County IHSS office to complete the provider eligibility process.
4. Notifying the County IHSS office within 10 days when I hire or fire a provider.
In addition, I understand and agree to the following terms and limitations regarding payment for services by the IHSS program:

1. In order for any individual to be paid by the IHSS program, they must be approved as an IHSS eligible provider.
2. If I choose to have an individual work for me who has not yet been approved as an eligible IHSS provider, I will be responsible for paying him/her if he/she is not approved.
3. The IHSS program will not pay for any services provided to me until my application for services is approved and then will only pay for those services that are authorized for me to receive by the IHSS Program.
4. I will be responsible for paying for any services I receive that are not included in my IHSS authorization.
5. I will be responsible for paying my Share-of-Cost (SOC) and informing my individual provider(s) of that SOC.

I also understand and agree to cooperate with the following as a part of my eligibility for IHSS:

To promote program integrity and quality assurance, I may be subject to (un)announced visits to my home and that I or my provider(s) may receive letters identifying program requirement concerns from the State Department of Health Care Services (DHCS), California Department of Social Services (CDSS) and/or the County in which I receive services.

The purpose of the visits and letters is to ensure that program requirements are being followed and that the authorized services are necessary for you to remain safely in your home. The visit will also verify that the authorized services are being provided, that the quality of those services is acceptable, and that your well-being is protected.

If it is found that IHSS services are not required or not being properly provided, you and/or your provider may be subject to a Medi-Cal fraud investigation. If fraud is substantiated, you and/or your provider will be prosecuted for Medi-Cal fraud.
Section 10 – Signature(s)

<table>
<thead>
<tr>
<th>Signature of Applicant:</th>
<th>Date:</th>
</tr>
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<table>
<thead>
<tr>
<th>Signature of Applicant’s Representative (only if applicable):</th>
<th>Date:</th>
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<table>
<thead>
<tr>
<th>Representative’s Relationship to Applicant (only if applicable):</th>
<th>Representative’s Telephone Number (only if applicable):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Representative’s Address (only if applicable):</th>
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</thead>
</table>

To report suspected fraud or abuse in the provision or receipt of IHSS services, please call the fraud hotline at 1-800-822-6222, email at stopmedicalfraud@dhcs.ca.gov, or go to http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx.

FOR AGENCY USE ONLY

<table>
<thead>
<tr>
<th>Income Eligible:</th>
<th>Status Eligible:</th>
<th>Medi-Cal Aid Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
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<table>
<thead>
<tr>
<th>MAGI Eligible Recipient:</th>
<th>Verification:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Disabled 12 months or longer</td>
<td></td>
</tr>
<tr>
<td>☐ At risk without IHSS</td>
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<tr>
<th>Notes:</th>
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</table>

<table>
<thead>
<tr>
<th>Signature of Social Worker or Agency Representative:</th>
<th>Telephone Number:</th>
</tr>
</thead>
</table>

SOC 295 (6/18)
Ethnic Codes:

A. White.
B. Hispanic.
C. Black.
D. Other Asian or Pacific Islander.
E. American Indian or Alaskan Native.
F. Filipino.
G. Chinese.
H. Cambodian.
I. Japanese.
J. Korean.
K. Samoan.
L. Asian Indian.
M. Hawaiian.
N. Guamanian.
O. Laotian.
P. Vietnamese.
Q. Other.
R. Mixed Ethnicity.

Language Codes:

1. American Sign Language (AMISLAN or ASL).
2. Spanish - NOA will be issued in Spanish.
3. Cantonese.
5. Korean.
6. Tagalog.
7. Other non-English.
8. English.
9. Spanish - NOA will be issued in English.
10. Other Sign Language.
11. Mandarin.
12. Other Chinese Languages.
13. Cambodian.
15. Ilacano.
17. Hmong.
18. Lao.
19. Turkish.
22. Polish.
23. Russian.
25. Italian.
26. Arabic.
27. Samoan.
28. Thai.
29. Farsi.
30. Vietnamese.