County Quality Assurance:

- Any QA desk reviews and home visits completed with findings and finalization of the remediation process.
- Any referrals made, including the date and the name of the entity.

Spouse Provider Eligibility:

- Eligibility of spouse provider and reference to the existing regulations and Welfare and Institutions Codes (W&IC).
- The status of the recipient's spouse (e.g., Able and Available, Unable and Available, etc.), and include any pertinent details regarding the spouse's ability and availability.

Parent Provider Eligibility:

- Eligibility of parent provider(s) and reference to existing regulations and W&IC.
- Discuss and document the employment and/or educational schedule of parent(s).
- If the parent is not employed full-time, ask and document the reason.

Minor Recipient Eligibility:

- The application of Age Appropriate Guidelines.
- All services received at school or from other sources.
- For Protective Supervision eligibility, document all four requirements necessary in determining eligibility for minors:
  - Minor is nonself-directing due to the mental impairment/mental illness**;**
  - Minor is likely to engage in potentially dangerous activities**;**
  - Minor also needs more supervision than a minor of comparable age who is not mentally impaired/mentally ill pursuant to Garrett v. Anderson**;**
  - 24 hours-a-day supervision is needed in order for the minor to remain at home safely.

Provider Information:

- Verify the providers actively working for the recipient; include the names and verification that a valid IHSS Recipient Designation of Provider form (SOC 426A) is on file.
- The relationship(s) of provider(s) to the recipient.

Critical Incidents/Referrals:

- All critical incidents, including type, date, referrals made, and resolution, if known.
- Any fraud referrals made to the appropriate parties.

Forms:

- All forms that were utilized.
- Confirm that the pamphlet titled, Your Rights Under California Welfare Programs (PUB 13), and Voter Registration were provided to the recipient.
- All reasons why forms are missing, not signed, refused, and/or incorrectly completed and the necessary steps taken to rectify the issue.

State Administrative Hearings:

- Any details and outcomes of past State hearings for use in determining continued eligibility for services.

Additional Information:

- Any additional comments needed to support the recipient's case (e.g. inter-county transfer details, change in services/hours due to the recipient's health, etc.).

Case Disposition:

- The case approval or denial including date of action, justification for the approval/denial, and the total number of monthly authorized hours.

If you have any questions, please contact **CDSS Adult Programs Division** at (916) 651-3494 or email IHSS-Training@dss.ca.gov for more information.

CDSS In-Home Supportive Services

IHSS Quality Assurance Case Narrative Guide

This guide identifies key elements necessary to document the assessment and authorization of In-Home Supportive Services (IHSS). The inclusion of all the information specified below in a recipient's case file will help create comprehensive case documentation and consistency necessary for quality assessments.

Using this guide to document recipients' needs will assist social workers in preparing for state hearings and responding to inquiries from management or other organizations that are responsible for coordinating the authorization of services, such as Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP), or Managed Health Care Plans. In addition, providing thorough documentation assists other social workers who may later assume responsibility for an existing case or when Inter-County Transfers occur.

General Information:

- Date of the home visit.
- Start and end time of the home visit.
- List those present at the home visit.
- Assessment Type: Initial, Reassessment, Inter-County Transfer (ICT), Change Assessment (proration or increase/decrease in authorized hours), or Quality Assurance (QA) Findings & Recommendations.
- Living Situation: type of home [e.g., apartment, Single Room Occupancy (SRO), single story house, etc.].
- Living Arrangement: If the recipient resides in a shared living arrangement, indicate the number of rooms used solely by the recipient and/or shared with other residents in the household. If others live in the home, verify and document the living arrangement and the relationship(s) to the recipient, i.e. spouse, roommate, relative, etc. Also, if a shared living arrangement exists, note whether any of the following apply: live-in provider, recipient moved into a relative's home primarily for the purposes of receiving services, landlord/tenant, etc.
- Recipient's authorized representative (AR) (if applicable, e.g., power-of-attorney, conservator, guardian, etc.), provider, family members, etc.
- Companion case(s): names and case numbers.
- Names of persons other than the recipient/AR participating in the assessment; include information about relationship to recipient or agency affiliation.

Recipient Information:

- Age and gender of the recipient.
- Recipient's primary language and translator information, if applicable.

Social Worker Observations:

- Appearance of the recipient (include physical well-being, signs of abuse and/or neglect).
- Functional abilities and limitations demonstrated and/or reported by the recipient.
- Physical limitations such as blind, deaf, or nonverbal.
- Mental abilities/limitations.
- Appearance of the home: identification of risks or safety issues, strong odors, visible Durable Medical Equipment (DME), oxygen equipment/use, etc.
- Safety concerns within the home: indicate safety issues and/or barriers.
- Any other general observations which may contribute to the assessment of the recipient's need for IHSS, or need for referrals to other organizations.

Functional Abilities/Limitations:

- Recipient's statements of abilities to safely perform Activities of Daily Living (ADLs)/Instrumental Activities of Daily Living (IADLs) and any functional limitations that prevent the recipient from performing ADLs and IADLs.
- Availability and use of Durable Medical Equipment (DME).

Recipient Health Information:

- All healthcare providers and details about frequency and duration of visits.
- Any authorized medical accompaniment and wait times, and if the optional IHSS Program Accompaniment to Medical Appointment form (SOC 2274) was utilized.
- Any emergency room visits and/or hospitalizations since last reassessment or since the intake assessment.
- Medical conditions including diagnoses, current symptoms, reported ailments, and treatments.
- Include any information provided on the IHSS Health Care Certification form (SOC 873) or other documents signed by healthcare professionals (primary conditions relating to functional limitations).
- Any discrepancies identified between the recipient or the AR's statements and documentation from healthcare professionals.
- Changes in condition since the last assessment.
- List of medications.
- Any in-home nursing/medical care information.
- Recipient's statement of why he/she feels unable to remain safely in his/her own home without IHSS.
- Whether or not the recipient would need skilled-nursing facility care if he/she were unable to remain at home.
- Disaster Preparedness Code.

IHSS Service Information:

- Description of necessary services per Functional Index (FI) rankings and assessed hours.
- All calculations of time per tasks.

Paramedical:

- Approval of Paramedical Services: details about the recipient's reported needs and the reported needs on the Request for Order and Consent – Paramedical Services form (SOC 321) and details about any contact(s) made with the recipient's healthcare professional to clarify the recipient's needs and the appropriate amount of authorized Paramedical Service hours.
- Denial of Paramedical Services: details about the denial of Paramedical Services including any supporting documents.

Protective Supervision Documentation:

- Reported incidents in which the recipient placed himself/herself in any harm and/or danger and any precautions taken to prevent future risks (ask if there have been any incidents during the previous year regarding quality of care).
- All supporting evidence of need for Protective Supervision and details on how the 24-hour need is met.
- The re-evaluation for Protective Supervision and the Protective Supervision 24-Hours-a-Day Coverage Plan form (SOC 825) or care plan were completed during each reassessment.
- Social worker's attempt to obtain the Assessment of Need for Protective Supervision for IHSS Program form (SOC 821).
- Information from collaborative sources that support the authorization of Protective Supervision, such as an Individual Education Plan (IEP), Alta Regional Center reports, mental health reports, etc.
- All evidence that supports the denial of Protective Supervision services, include regulations as appropriate.
- Update Disaster Preparedness Code during reassessment.

- If the recipient's FI rank is 5 in Ambulation/Transfer, provide documentation to justify how the client is eligible for Protective Supervision.
- IHSS Individualized Back-up Plan and Risk Management form (SOC 864) should be completed for IPO and CFCO recipients.

Unmet Need(s):

- Any efforts to seek/offer resources, which may address any unmet needs.
- If resources are already in place, document the details of the resources.
- Any safety issues and referrals made to the appropriate agency.
- Discussion with recipient regarding whether he/she can remain safely in his/her own home given there are unmet need hours and the associated risks of not having these needs met.

Alternative Resources:

- Social worker explored the availability of alternative resources.
- All services from formal alternative resources, including the source of the services, the services provided, frequency, and duration. Include services such as CBAS, MSSP, services received at school, Regional Center services, any in-home nursing services, etc.
- All informal resources, such as family, friends, and neighbors. Document services provided, including the frequency and duration. If the individual is eligible to be paid by IHSS for providing services, document the request for and the receipt of the Voluntary Services Certification form (SOC 450).
- If the recipient receives Medi-Cal In-Home Operations (IHO) services, document the hours received and services provided.

Independent Choices:

- Details regarding the recipient's choice of where he/she lives.
- Recipient having the choice and control of his/her daily schedules.
- Recipient having the choice to participate in community activities (e.g. going to the library, attending church, shopping, etc.).
- Recipient having the choice to seek employment, if desired.