

2013

IN-HOME SUPPORTIVE SERVICES (IHSS)

Uniform Statewide Protocols



CDSS

California Department of Social Services
Adult Programs Division



EXECUTIVE SUMMARY

In 2009, budget trailer bill legislation was enacted that, among other things, put into law new requirements intended to improve recipient health and safety, and intergovernmental coordination, in the In-Home Supportive Services (IHSS) program. Specifically, the new law required the development of protocols for unannounced home visits and directed mailings to IHSS providers and recipients, and the delineation of roles and responsibilities across entities at all levels of government for the appropriate expenditure of public funds.

These Uniform Statewide Protocols fulfill those requirements. These protocols reflect three years of work with state and county governments and the public. We are grateful to the many participants in this process for their time, efforts, contributions, and demonstrated respect for often-divergent points of view on the various issues that are reflected in these protocols.

The workgroup that developed these protocols began meeting in March 2010. In various meetings, subcommittees and subgroups, and public forums, participants in the development of these protocols ultimately included representatives from the CDSS, the California Department of Health Care Services (DHCS), the California Department of Justice's (DOJ) Bureau of Medi-Cal Fraud and Elder Abuse, county welfare departments and human services agencies, county district attorneys, public authorities, labor organizations, IHSS recipients, advocates for seniors and persons with disabilities, staff from the Legislature, and members of the public. The workgroup used the principles listed in the box below to guide its work on the protocols:

Common Themes

These IHSS Uniform Statewide Protocols reflect the workgroup's guiding principles:

- process transparency
- recipient well-being
- recipient and provider dignity
- emphasizing program education and prevention
- safe and respectful mitigation (stopping a problem before it starts)
- a commitment to ensuring that no one is unfairly targeted
- cooperation, and
- minimal disturbance or confusion caused to the vulnerable members of the IHSS community.

In December 2012, a public meeting was held to accept final input on the draft protocols. The draft protocols were web-posted and widely disseminated for public comment for a number of months before the December meeting. The final protocols differ from the draft protocols mainly in their final formatting. What follows is a brief description of each protocol:

Unannounced Home Visits

Trained county IHSS staff will conduct a visit to the home of a recipient. The date and time of the visit will not be announced to the recipient or the provider. In the course of the visit, county staff will verify the receipt and quality of services, verify the recipient's well-being, and briefly discuss any concerns with the recipient. If a recipient is unable, unavailable, or unwilling to participate in an unannounced home visit, the county will follow up with at least two more visit attempts, at least two phone calls, and send a letter over the next 45 to 60 days. *These visits only will be conducted as the result of a specific, articulable program integrity concern, never at random.*

[Note: The IHSS program is a benefit program within the larger Medi-Cal program. Also, in many cases IHSS recipients also receive other public benefits or services as well. In the context of receiving those other benefits or services, the home of an IHSS recipient may be visited subject to the rules and requirements of those programs. These protocols apply only to the IHSS program.]

Statewide Coordination and Communication

State and county agencies will follow a standardized process for reviewing IHSS program integrity complaints and forward them for investigation, if appropriate. County IHSS agencies will establish a designated point of contact to review complaints and determine which complaints merit investigation. Counties who enter into memoranda of understanding (MOU) with the DHCS may conduct their own investigations in accordance with those MOUs. Counties without MOUs will forward complaints to DHCS for investigation. *Every consideration was given to minimizing duplication between agencies and to reducing the exposure of IHSS recipients and providers to redundant interactions with different investigative entities.*

Directed Mailings

Counties will conduct at least one mailing annually, directed to a county-identified subset of IHSS providers. The mailing will be conducted using a standard template, with the reason for the mailing, and county government contact information, added. To provide context for providers, the template letter includes a list of common program integrity concerns.

Now that the protocols have been finalized, CDSS will begin the next steps of disseminating them to relevant state and county government entities via CDSS' existing all-county letter process. This dissemination will be followed by the development of formal regulations that reflect the protocols, consistent with the requirements of the 2009 law and California's Administrative Procedures Act.

We again want to thank the many people who contributed to the development of these protocols. As a result of their time, energy, and thoughtful participation, these protocols now are available for use in the IHSS program. The protocols will guide how data and information is shared amongst government departments and agencies, how home visits and program communications are utilized to ensure IHSS recipient health and safety, and to assure the public that our best efforts are in place to ensure the responsible use of public funds for their intended purposes.

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Attachment C Important Program Integrity Information from the In-Home Supportive Services (IHSS) Program
Attachment D IHSS Complaint of Suspected Fraud Form (SOC 2248)
Attachment E Department of Health Care Services Memorandum of Understanding (SAMPLE)
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OVERVIEW

WIC Section 12305.82(b)

(1) The department, in consultation with county welfare directors and other stakeholders, as appropriate, shall develop uniform statewide protocols for acceptable activities to be performed and acceptable measures to be taken by the department, the State Department of Health Care Services, and the counties for purposes of fraud prevention.

PURPOSE

The purpose of these protocols is to establish the basis for State and county policies, procedures, and timelines, and to provide instructions regarding acceptable activities to be performed, and acceptable measures to be taken for the purposes of fraud prevention, detection, and coordinated investigation and prosecution in the In-Home Supportive Services (IHSS) Program. These protocols are designed to assist counties in developing and implementing policies and procedures to ensure consistency.

APPLICABILITY

These protocols apply to the California Department of Social Services (CDSS), county welfare departments, and any other agencies operating under the authority established in the California Welfare and Institutions Code (WIC) Sections 12305.7(e)(2), 12305.7(h), 12305.71(c)(3), 12305.71(c)(5), or 12305.82. These protocols are not intended to limit in any way the jurisdiction or ability of law enforcement agencies operating under separate authority.

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THE MEASURES

Unannounced Home Visits

Directed Mailings

Statewide Coordination and Communication

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Unannounced Home Visits

WIC Section 12305.71(c)(3)

(A) As appropriate, in targeted cases, to protect program integrity, this monitoring may include a visit to the recipient's home to verify the receipt of services.

(B) The exact date and time of a home visit shall not be announced to the supportive services recipient or provider.

(C) The department, in consultation with the county welfare departments, shall develop protocols for followup home visits and other actions, if the provider and recipient are not at the recipient's home at the time of the initial home visit. The protocols shall include, at a minimum, all of the following:

(i) Information sent to the recipient's home regarding the goals of the home visit, including the county's objective to maintain program integrity by verifying the receipt of services, the quality of services and consumer well-being, and the potential loss of services if fraud is substantiated.

(ii) Additional attempted visits to the recipient's home, pursuant to subparagraph (A).

(iii) Followup phone calls to both the recipient and the provider, if necessary.

WIC Section 12305.82

(f) The failure of a provider or a recipient to comply with program requirements may result in termination of his or her participation in the In-Home Supportive Services program, subject to all applicable federal and state due process requirements.

Definition

An unannounced home visit (UHV) is an unscheduled visit conducted by trained county IHSS staff in the home of an IHSS recipient who has been selected using specific indicators.

Purpose

The purpose of the UHV by county staff is to ensure that the services authorized are consistent with the recipient's needs at a level which allows him/her to remain safely in his/her home, and to validate the information in the case file. It is a monitoring tool to safeguard recipient well-being by verifying the receipt of appropriate levels of services, and to ensure program integrity by reminding recipients of program rules and requirements and the consequences for failure to adhere to them, including the potential loss of services.

The intent of the protocols is to ensure that the UHVs are conducted in a consistent and coordinated manner over a reasonable time frame, and performed in a manner that is respectful of each recipient's unique needs and circumstances.

Procedures

General

The UHVs will be conducted in a professional manner by designated county staff that have completed appropriate training, and must be based upon recipient well-being, Quality Assurance (QA) or program integrity concerns, indicators of risk for abuse and/or fraud, or referrals. These protocols are designed to assist the counties in developing and implementing individual policies and procedures to ensure consistency.

In the event of suspected maltreatment or neglect, per Mandated Reporter protocols, all UHV staff are required to contact Adult Protective Services (APS) and/or Child Protective Services (CPS). In cases of urgent endangerment, UHV staff must contact law enforcement (911). In the event that fraud is suspected, referral of the case to the appropriate investigating agency will occur per established protocols.

Following are the process, timeframes, and roles and responsibilities for conducting UHVs; a standardized follow-up letter to recipients; the UHV Reporting form, and instructions for documenting UHV activities.

Preparation

Prior to conducting the home visit, county UHV staff shall review the case file and note pertinent information such as specific conditions or needs of the recipient. This may include physical/mental disabilities or documented circumstances that may place the UHV staff at risk. UHV staff is encouraged to consult with the IHSS caseworker or supervisor as appropriate. The UHV shall, to the extent possible, be conducted in the documented primary language of the recipient. If it is not possible to conduct the UHV in the recipient's primary language, an interpreter must be used at no cost to the recipient.

Communication and Coordination: Counties shall ensure that IHSS caseworkers (or supervisors) are notified prior to all UHVs of their assigned cases (unless there is a specific need for confidentiality) in order to avoid duplication of efforts and ensure that the recipient's unique needs are taken into consideration. Counties may also notify the Department of Health Care Services (DHCS) and county investigative staff.

Identity Verification: Counties shall ensure that all persons conducting UHVs possess and present/display photo identification issued by their department upon requesting entry to the home. UHV staff shall carry telephone contact information for the county designated UHV contact person. If the recipient requests to verify the visit/staff identity, telephone contact information shall be provided to the recipient and a telephone call to the designated UHV contact person shall be allowed. If the county is not able to verify the identity of the UHV staff person, the UHV may be delayed at the recipient's request. If the recipient denies entry to the UHV staff person based on a lack of proper identification, or based on county inability to verify the UHV, that UHV shall not be counted towards the three UHV attempts to which recipients are entitled.

The UHV

Entry Granted: Counties shall ensure that when entry is granted, the UHV staff informs the recipient of the purpose of the UHV and provides general and/or specific information regarding program requirements and the consequences for failure to adhere to them. The UHV staff shall also ask questions regarding the recipients' services and the quality of those services. Using the IHSS UHV Findings Report, UHV staff shall observe plain-view areas of the home to help determine whether the recipient is receiving appropriate levels of quality care to remain safely in the home.

No Contact or Entry Denied: In the event that contact is not made or entry is denied, UHV staff must perform all of the following activities to make contact within 45-60 calendar days from the date of the initial UHV attempt:

- A minimum of two additional UHVs not conducted on the same day.
- A minimum of two telephone calls to the recipient, not conducted on the same day. Additional phone calls may be made to the provider or the recipient's emergency contact at the county's discretion.
- A UHV follow up letter sent to the recipient's home stating the purpose of the UHV and stating that unsuccessful attempts were made to contact the recipient at home and/or by telephone (*Attachment A*).

Counties shall ensure that the minimum requirements above are completed within the required timeframe. Additional methods of contact may be conducted at the county's discretion.

If, after all required attempts of contact have been made, no UHV has been conducted, counties shall send the recipient a Notice of Action (NOA) indicating that the recipient's IHSS is being discontinued, as failure to participate in a UHV constitutes a recipient's failure to comply with program requirements.

The NOA shall contain the reason for the discontinuation of services and the applicable law. Once the NOA is issued, the process continues to termination. Counties shall ensure that the IHSS caseworkers (or supervisors) are notified that the NOA has been issued. Counties shall ensure that there are policies and procedures in place to address the timely documentation and termination of services to prevent an overpayment from occurring. Counties shall also ensure that once the NOA has been issued, the recipient cannot stop the process or restart services by contacting the county.

Aid Paid Pending: All guidance concerning State hearings and aid paid pending a State hearing remains in full effect.

Follow-up and Reporting

Counties shall ensure that all of the following reporting requirements are completed:

- The UHV staff shall document all UHV attempts and visits on the IHSS UHV Findings Report (*Attachment B*).
- The county shall communicate UHVs conducted and the outcomes to CDSS by completing the UHV list that they receive from CDSS, and attaching copies of completed UHV Findings Reports.
- The county shall initiate any required administrative actions subsequent to UHVs including reassessments, referrals, and notices of termination of services.

Roles and Responsibilities

CDSS shall:

- Develop and distribute to counties a list of IHSS recipients who have been identified to receive a potential UHV based on targeted indicators reviewed by the State. Instructions for completing and documenting the UHV will accompany the list.
- Review county actions/findings upon the completion of the UHVs and conduct a post UHV follow-up review of targeted cases in Case Management Information and Payrolling System (CMIPS) to evaluate outcomes.

- Serve as the central repository for all UHV tracking data.
- Establish reporting requirements.
- In select cases, CDSS staff may accompany county UHV staff upon State or county request.

County Agencies shall:

- Use these protocols to develop and implement policies and procedures for conducting UHVs. The policies and procedures must include the adoption of forms/letters, establishment of minimum requirements, conducting of follow-up activities and reporting, and training in proper UHV protocols.
- Conduct UHVs.
- Use the CDSS list of identified potential recipients as well as any additional recipients identified by the county for whom an UHV would be appropriate based on targeted indicators.
- Prepare for the UHV in accordance with “Preparation” section listed above in Procedures.
- Clearly document the reasons why the county, based on specific knowledge or understanding of the staff caseload, has *not* conducted a UHV on an identified recipient and include that reasoning in the completed report.
- Notify CDSS of additional UHVs identified and performed.
- Document outcomes/findings and perform follow-up activities.
- Coordinate with CDSS on county directed UHVs and include them in the reports.
- Designate staff to conduct UHVs.
- Ensure staff training requirements are met.
- Make training available to outside staff (i.e. law enforcement) at county discretion.

Law Enforcement:

May accompany UHV staff upon county request, document outcomes/findings of the UHV and consult UHV staff regarding resulting fraud referrals.

Forms and Letters

A UHV Follow-Up Letter and Findings Report (SOC 2247) with instructions are attached.

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Directed Mailings

WIC Section 12305.7

(h) The department, in consultation with the county welfare departments and other stakeholders, as appropriate, shall develop protocols for the implementation of targeted mailings to providers, to convey program integrity concerns.

WIC Section 12305.71(c)

(5) In accordance with protocols developed pursuant to subdivision (h) of Section 12305.7, distribute targeted program integrity mailings to providers. The purpose of the targeted program integrity mailings is to inform providers of appropriate program rules and requirements and consequences for failure to adhere to them.

Definition

A directed mailing is a standard template letter with required information and customizable areas, including a plain-English reason why the provider received the letter, and county contact information.

Purpose

The purpose of directed mailings is to convey program integrity concerns, inform IHSS providers of appropriate program rules and requirements, and express the consequences for failing to adhere to them. The goal is to increase the participants' knowledge and create a better informed provider of IHSS services in an effort to reduce errors, fraud, and abuse in the IHSS program.

The intent of these protocols is to ensure that the directed mailings are conducted in a consistent and coordinated manner and that there is an established process, including the selection, mailing, and post-mailing data analysis in place to inform providers of the appropriate program rules and requirements and the consequences of the failure to adhere to them. These protocols are designed to assist the counties in developing and implementing individual policies and procedures to ensure consistency.

Procedures

The directed mailing is sent to a specific group of IHSS providers based on some attribute (indicator) that they share, such as providers who claim excessive hours of services per month, providers who are also recipients, or providers who submit timesheets inconsistently. By directing the mailers to specific groups, information is sent to the appropriate audience.

General

Counties shall select indicators from the indicator list provided by CDSS (distributed under separate cover), and conduct data pulls to determine each mailing group and create a directed mailing list of providers who all share the indicator.

Preparation

- Counties shall send CDSS the list of providers to receive the directed mailings electronically (Excel spreadsheet format) prior to mailing.

- CDSS shall cross reference the county mailing list against previous mailings, and ensures that the county is aware of any duplication or repeat mailings.
- Counties shall review the returned list and determine, for each repeat name, whether or not to include in the mailing.
- Counties shall customize the letter (*Attachment C*) to include a reason for the mailing from the reasons list and county contact information, and then conduct the mailing.

Mailing

Counties shall ensure that the directed mailings containing the required elements are sent to all providers in the directed mailing group, and that a copy of the directed mailing is sent to each recipient assisted by those providers.

Communication and Coordination

In order to coordinate and track the mailings and minimize unintentional duplication, counties shall electronically (Excel spreadsheet format) send CDSS a final list of providers and recipients who were sent directed mailings for tracking and analysis.

Follow-up and Reporting

Counties shall conduct a minimum of one directed mailing to a specific group of IHSS providers per year.

CDSS shall conduct periodic post-mailing analysis and issue annual reports tracking any measurable impact of the directed mailings.

Procedural Exceptions

Unforeseeable Circumstances

If a county experiences an unforeseeable emergency which prevents it from conducting a data pull or its required annual directed mailing, it may request that CDSS conduct the data pull or directed mailing on its behalf. Counties may request a data pull based on a specific indicator, or leave it to CDSS to select an indicator. CDSS will, to the extent possible, conduct data pulls and directed mailings within a reasonable timeframe upon county request.

Zero-Result Data Pulls

If a county conducts a data pull and gets no results, it shall conduct a second data pull based on a different indicator, or different combination of indicators. If the second data pull also returns no results, the county shall conduct a third data pull using an indicator or a combination of indicators which have not yet been tried. If the third pull results in no matches, the county shall notify CDSS. CDSS will evaluate the obligation of that county to send a directed mailing for that year, and *may* conduct a data pull for the county at its discretion. On the second consecutive year that a county conducts three zero-result data pulls, CDSS *shall* conduct a data pull and send the resulting set to the county, who shall use the set to conduct a directed mailing.

Roles and Responsibilities

CDSS shall:

- Function as the central repository for all directed mailing data.
- Upon request and as able, assist counties with data mining and mailing as appropriate.

County Agencies shall:

- Use these protocols to develop and implement policies and procedures for conducting directed mailings. The policies and procedures must include the adoption of forms/letters, establishment of minimum requirements, conducting of follow-up activities and reporting, and training in proper protocols.
- Prepare directed mailing lists, and coordinate with CDSS to match against previous lists prior to mailing to avoid unintentional duplication.
- Report directed mailings and any outcomes to CDSS.
- Ensure staff training requirements are met.
- Request CDSS assistance when appropriate.

Forms/Letters

A Directed Mailings Letter and a sample of Directed Mailings Letter Reasons are attached.

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Statewide Coordination and Communication

WIC Section 12305.82

(a) In addition to its existing authority under the Medi-Cal program, the State Department of Health Care Services shall have the authority to investigate fraud in the provision or receipt of in-home supportive services. Counties shall also have the authority to investigate fraud in the provision or receipt of in-home supportive services pursuant to the protocols developed in subdivision (b). The department, the State Department of Health Care Services, and counties, including county quality assurance staff, shall work together as appropriate to coordinate activities to detect and prevent fraud by in-home supportive services providers and recipients in accordance with federal and state laws and regulations, including applicable due process requirements, to take appropriate administrative action relating to suspected fraud in the provision or receipt of in-home supportive services, and to refer suspected criminal offenses to appropriate law enforcement agencies for prosecution.

(b) (1) The department, in consultation with county welfare directors and other stakeholders, as appropriate, shall develop uniform statewide protocols for acceptable activities to be performed and acceptable measures to be taken by the department, the State Department of Health Care Services, and the counties for purposes of fraud prevention.

(2) The State Department of Health Care Services, the department, and the county may share data with each other as necessary to prevent fraud and investigate suspected fraud pursuant to this section. The information shall only be used for purposes of preventing and investigating suspected fraud in the In-Home Supportive Services program, and shall otherwise remain confidential.

(c) If the State Department of Health Care Services concludes that there is reliable evidence that a provider or recipient of supportive services has engaged in fraud in connection with the provision or receipt of in-home supportive services, the State Department of Health Care Services shall notify the department, the county, and the county's public authority or nonprofit consortium, if any, of that conclusion.

(d) If a county concludes that there is reliable evidence that a supportive services provider or recipient has engaged in fraud in connection with the provision or receipt of in-home supportive services, the county shall notify the department and the State Department of Health Care Services of that conclusion.

(e) Notwithstanding any other provision of law, a county may investigate suspected fraud in connection with the provision or receipt of supportive services, with respect to an overpayment of five hundred dollars (\$500) or less.

(f) The failure of a provider or a recipient to comply with program requirements may result in termination of his or her participation in the In-Home Supportive Services program, subject to all applicable federal and state due process requirements.

Definitions

Complaint: Any program integrity concern/allegation identified or received by the State or county.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Triage: The process whereby designated county staff reviews a complaint of suspected fraud and determines whether or not the complaint becomes a fraud referral.

Fraud Referral: A complaint that has been triaged by designated county staff and referred to a law enforcement agency for fraud investigation.

Purpose

The purpose of statewide coordination and communication is to develop a coordinated and standard process for fraud referrals and investigations that fosters collaborative working relationships across jurisdictions. This includes a standard for deciding when to refer a case for fraud investigation.

Fraud Referral Procedures

The intent of the guidelines below is to provide a framework to enable CDSS, DHCS, the Department of Justice (DOJ), county welfare departments, county district attorney offices and any agency that may be involved in the IHSS program and/or fraud detection and prevention related to the program, to work together on fraud referrals and investigations.

This joint/collaborative effort will include implementing uniform statewide protocols in order to avoid duplication of effort, and coordinate fraud detection and prevention activities. These protocols address case referrals, a county's authority to investigate, data sharing, and authority to terminate a provider or recipient's participation in the IHSS program. The county must designate staff

who will review the fraud complaint and determine if it is appropriate for investigation. These protocols are designed to assist the counties in developing and implementing individual policies and procedures to ensure consistency.

Fraud Complaint

Counties shall use the Complaint of Suspected Fraud form (SOC 2248) (*Attachment D*) to report any incident of suspected or reported fraud in the IHSS program. County IHSS workers at all levels are responsible for reporting any incident of suspected or reported fraud (at this stage referred to as the fraud complaint) and must complete sections A through D of the Complaint of Suspected Fraud form as completely as possible. The county agency worker who discovers, receives, or is assigned to the complaint shall be responsible for:

- reviewing the form for accuracy and completion,
- gathering any missing information from the Reporting Party,
- filling in any additional information obtained, and
- gathering any relevant supporting documentation such as copies of any time sheets and paid warrants for the period in question.

The agency worker shall submit the form and supporting documentation, referred to as the fraud complaint package to the designated county staff for triage.

Fraud Referral

The county must identify staff to conduct triage on fraud complaints, complete Section E of the Complaint of Suspected Fraud form, and refer cases to law enforcement for investigation when appropriate. The fraud complaint package must be sent for triage as soon as is practical. Any follow up correspondence, proof of mailing etc. should be kept with a copy of the package in the case file. Once a complaint has been triaged, it will either be determined appropriate for referral, or not appropriate for referral. Those complaints determined not appropriate for investigation will be returned to the originating county agency for possible administrative action. Complaints determined appropriate for

investigation will become fraud referrals, and follow one of two paths, depending on whether or not the county has a Memorandum of Understanding (MOU) with DHCS.

Counties without an MOU with DHCS shall send all IHSS fraud referrals over \$500 directly to DHCS for investigation. If a county receives a complaint which appears to be under \$500, refers the complaint for county investigation and it is subsequently determined to involve over \$500 in fraud, the county will confer with DHCS to decide jurisdiction for the continued investigation.

Counties who have a MOU with DHCS will abide by the terms of that MOU. A sample MOU is included (*Attachment E*).

Fraud Investigation

The law enforcement agency shall conduct an investigation and determine the outcome, and either: (1) forward the completed investigation for prosecution; or (2) return it to the originating county agency for possible administrative action as appropriate. Please refer to the Fraud Referral Process Flowchart (*Attachment F*).

Roles and Responsibilities

CDSS shall:

- Refer all complaints to DHCS.
- Define required elements of statistical data reporting.
- Collect, analyze and report on data from counties, DHCS, and DOJ on a routine basis.

DHCS shall:

- Act as a resource to counties.
- Ensure the timely investigation of cases referred by counties.
- Report findings/outcome of investigations to originating county.
- Audit county investigations as appropriate.
- Reserve the right to take any case involving suspected fraud in an amount over \$500.
- Report statistical data to CDSS on a quarterly basis.

DOJ, Bureau of Medi-Cal Fraud and Elder Abuse shall:

Assist counties with investigations/prosecutions of provider fraud, at the request of the county or DHCS.

Counties with MOUs shall:

- Agree to all stipulations and meet the requirements outlined in their MOU.
- Maintain copies of all complaints, referrals and reports for three years from the last date of aid or services.
- Make copies available to DHCS upon request.
- Report statistical data to DHCS and CDSS on a quarterly basis. Effective FY 2011/12, all counties are required to submit fraud data to CDSS quarterly using the IHSS Fraud Data Reporting Form (SOC 2245) (*Attachment G*).

Counties without MOUs shall:

- Use these protocols to develop and implement policies and procedures for conducting the fraud referral process. The policies and procedures must include the adoption of forms/letters, establishment of minimum requirements, conducting of follow-up activities and reporting, and training in proper protocols.
- Maintain copies of all complaints, referrals and reports for three years from the last date of aid or services.
- Send all complaints that become referrals to DHCS.

- Cooperate with DHCS investigations.
- Report statistical data to CDSS on a quarterly basis using the IHSS Fraud Data Reporting Form (SOC 2245).
- Ensure staff training requirements are met.

All Counties shall:

Ensure that the fraud reporting process and contact information is clearly visible on their website.

Forms/Letters

An IHSS Complaint of Suspected Fraud Form (SOC 2248) with instructions and a DHCS sample MOU are attached.

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**Unannounced Home Visit
Follow-Up Letter**

Mr. John Smith
1234 Main Street
Anytown, CA 90123-4567

Dear Mr. Smith:

We tried to visit you at your home on **<insert date of attempted home visit here>** at **<insert time of attempted home visit here>**. You were either not home or did not allow the county staff to enter your home. The purpose of the visit is to make sure that you are getting your IHSS services, verify the quality of those services, and to check on your well-being. We also go over some program rules and requirements.

You are responsible for managing your provider and making sure you get your needed services. Our goal is to increase your knowledge so that you will become a better-informed recipient to make sure you have the best outcome for your health and well-being.

Please be reminded that you must cooperate with home visits as a condition for getting your benefits. Some visits may be announced and other visits may be unannounced. If we are unable to do a home visit or find out why we could not do one, your benefits could end. You would get a notice before that happens.

Following program rules can help prevent you owing us for overpayments, prevent the loss of services, and protect you from civil or criminal legal actions.

In addition to cooperating with home visits, please remember to do the following:

- Only sign your own name on each timesheet, unless you are authorized to sign for someone else.
- Make sure to tell your worker if your level of need goes UP or DOWN so you can get the correct amount of services.
- Only put the hours that were actually worked on the timesheet. Do not list all of the approved hours if they were not worked.
- (Hours while you are in the **hospital** or **nursing home**, unless authorized by your caseworker, or if you are **incarcerated** cannot be paid for).
- Always report all members living in your household.
- Report if you are going to be out of your home for an extended period of time.

Please call **<insert designated representative name and phone here>** to verify your address, phone number, availability, and best way to contact you. This will help us to complete the visit. The person making the unannounced home visit will be trained county staff, will have a county badge or ID, and must show this to you before you permit entry into your home.

If you feel that you have been mistreated or discriminated against, contact **<insert contact information here>**. If you suspect fraud occurring in the IHSS program, please contact the Department of Health Care Services fraud hotline at 1-888-717-8302.

General Information

IHSS recipient name:		County:	
Case no.:		UHV staff name:	
Recipient phone no.:		UHV staff phone no.:	
Alt. phone no.:		Reason for UHV:	

(Attach additional sheets if necessary)

A. Case File Information

Primary language:		No. of providers:	
No. in household:		Date of last Face-to-Face(F2F):	
Authorized no. hours:		Who conducted last F2F:	

☐ Severely Impaired
 ☐ Minor

☐ Protective Supervision

☐ FI rank 5 service(s) (specify): _____

☐ Case/Narrative notes reviewed

B. Record of Attempts to Contact the Recipient *(Provide details in Section E)*

Visits			Phone calls to recipient		Completed visit	
1st	(date)	(time)	1st	(date)	(time)	<input type="checkbox"/> Recipient ID verified <input type="checkbox"/> Provider present <input type="checkbox"/> Provider ID verified Provider name: _____
2nd	(date)	(time)	2nd	(date)	(time)	
3rd	(date)	(time)				
			Letter	NOA		
			(date)	(date)		

C. Findings of the UHV *(Provide details in Section F)*

☐ Program Integrity concerns unsubstantiated (check ONLY if ALL statements below are correct)

- ☐ It appears that all authorized services are being provided to the recipient
- ☐ It appears that all authorized services are provided at an acceptable quality
- ☐ It appears that the recipient is receiving adequate care

☐ Program Integrity concerns appear valid

- ☐ Services appear to be authorized beyond need
- ☐ Services appear to be authorized below need
- ☐ Authorized services appear to not be sufficiently provided

D. Report of Recommendations *(Provide details in Section F)*

- ☐ Recommend reassessment to:
- ☐ Increase hours ☐ Decrease hours ☐ Terminate services
- ☐ Provided Information and/or Referral (specify): _____
- ☐ Overpay recovery / Administrative action
- ☐ Refer IHSS complaint to: Against:
- | | | |
|---------------------------------|--------------------------------|--|
| <input type="checkbox"/> APS | <input type="checkbox"/> DHCS | <input type="checkbox"/> Recipient |
| <input type="checkbox"/> CPS | <input type="checkbox"/> DOJ | <input type="checkbox"/> Provider (number) |
| <input type="checkbox"/> DA/SIU | <input type="checkbox"/> Other | <input type="checkbox"/> Other: |
- ☐ Termination for non-compliance with program requirements
- ☐ Other follow-up (specify in Section F)
- ☐ No further action

UHV staff signature: _____

Date of report: _____

E. Case File and Visit Summary**F. Findings and Recommendations**

IHSS UHV FINDINGS REPORT INSTRUCTIONS

General Information

IHSS recipient name:	Enter the name of the recipient being visited.
Case no.:	Enter the IHSS case number.
Recipient phone no.:	Enter the phone number on file for the recipient.
Alt. phone no.:	Enter an alternate phone number for the recipient, if there is one on file.
County:	Select the county conducting the UHV.
UHV staff name:	Enter the name of the person conducting the UHV.
UHV staff phone no.:	Enter the phone number of the person conducting the UHV.
Reason for UHV:	Enter the reason for the UHV. Please provide details in Section E as needed.

A. Case File Information

Primary language:	Select the primary language of the recipient as listed in the case file.
No. in household:	Enter the total number of people living in the household including the recipient.
Authorized no. hours:	Enter the number of hours authorized for purchase.
No. of providers:	Enter the number of eligible providers on file for this recipient.
Date of last Face-to-Face (F2F):	Enter the date of the last recorded face-to-face contact the county had with the recipient.
Who conducted the last F2F:	Enter the name of the person who conducted the last face-to-face with the recipient.
Severely Impaired:	Check if the recipient meets the Severely Impaired criteria.
Protective Supervision:	Check if the recipient is currently authorized Protective Supervision.

Minor	Check if the recipient is a minor.
FI rank 5 service(s):	Record any services for which the recipient is currently assessed a functional index ranking of 5. NOTE: This will indicate which services the recipient cannot perform on his/her own.
Case/Narrative notes reviewed:	Check if case file narrative or notes were reviewed prior to UHV. NOTE: Any case file information directly affecting the UHV should be noted in Section E.

B. Record of Attempts to Contact the Recipient

Visits

1st home visit:	Record the date and time the first UHV was attempted, whether or not it was completed.
2nd home visit:	Record the date and time the second UHV was attempted, whether or not it was completed.
3rd home visit:	Record the date and time the third UHV was attempted, whether or not it was completed.

Phone calls to recipient

1st Recipient Phone Call:	Record the date and time the first phone call was made to the recipient.
2nd Recipient Phone Call:	Record the date and time the second phone call was made to the recipient.
UHV Follow-up Letter:	Record the date the UHV Follow-up letter was sent.
NOA:	Record the date the Notice of Action was sent.

Completed Visit

Recipient ID Verified:	Check if the recipient ID was verified during the UHV.
Provider Present:	Check if the provider was present during the UHV.
Provider ID Verified:	Check if the provider ID was verified. Document the provider's name.

Use section E to provide details of section B.

C Findings of the UHV

Program Integrity Concerns Unsubstantiated:

Check if, in your opinion, based on the UHV, it appears that there are no Program Integrity concerns. Checking this box indicates that all three statements below are accurate. If one (or more) statements are not checked, provide details in Section F.

It appears that all authorized services are being provided to the recipient:

Check if it appears that all authorized services are being provided to the recipient.

It appears that all authorized services are provided at an acceptable quality:

Check if it appears that all authorized services are provided at an acceptable quality.

It appears that the recipient is receiving adequate care:

Check if it appears that the recipient is receiving adequate care.

Program integrity concerns appear valid:

Check if, in your opinion, based on the UHV, it appears that there may be Program Integrity concerns. Check if at least one of the following statements below is accurate. If it appears that there may be Program Integrity concerns not described in the following statements, check this box and provide details in Section F.

Services appear to be authorized beyond need:

Check if it appears that the authorized services documented in the case file are beyond the current need.

Services appear to be authorized below need:

Check if it appears that the authorized services documented in the case file are below the current need.

Authorized services appear to not be sufficiently provided:

Check if it appears that the recipient is not receiving the level of services that they are authorized.

Use section F to provide details of section C.

D. Report of Recommendations

Recommend reassessment to: Check if, based on the UHV, a reassessment is recommended.

Increase Hours: Check if a reassessment is recommended because it appears that the recipient's need exceeds the authorized hours.

Decrease hours: Check if a reassessment is recommended because it appears that the authorized hours exceed the recipient's need.

Terminate services: Check if, based on a completed UHV, a reassessment is recommended because it appears that the recipient does not need IHSS.

Information and/or referral provided: Check if information was provided and/or a referral for additional assistance was made or recommended. Specify all information or referrals provided during the UHV.

Overpay recovery/administrative action: Check if, based on the UHV, some administrative action such as overpay recovery is recommended.

Refer IHSS complaint to: (APS, CPS, DA/SIU, DHCS, DOJ, Other)
Check if you recommend that the case be forwarded for additional action by another agency. Check the box of the agency to which referral is recommended. Multiple agencies may be chosen. **NOTE:** Also check the box indicating who the complaint is against, if known. Both the provider and recipient may be checked if appropriate.

Termination for non-compliance: Check if the recommendation is the termination of the recipient's case for non-compliance with program requirements. For example, termination is recommended because the UHV was not conducted due to no contact made or entry denied.

Other follow-up: Check if it is necessary to follow-up on the case for any reason not mentioned above. Provide details in Section F.

No further action: Check if no further action on the case is necessary.

UHV staff signature report: The person who conducted the UHV should sign the report.

Date of report: Enter the date the report was completed.

Use section F to provide details of section D.

E. Case File and Visit Summary

For each contact, provide the date, time, and specific details; include all descriptions of interactions (including messages left on machines) from section B.

Add any other information from case file that seems relevant.

F. Findings and Recommendations

Record detailed findings and recommendations from section D.

Important Program Integrity Information from the In-Home Supportive Services (IHSS) Program

If you are an IHSS provider, you are getting this letter because we are providing program information to all providers **<insert reason here>**. This is an area in which we often find IHSS errors or confusion about the rules. Our goal is to reduce errors, fraud, and abuse within the program by giving you information about the program rules.

If you are an IHSS recipient, this is a copy of a letter we have sent to your provider. You got this letter for information *only*. This is not a change in your benefits or provider.

People who get IHSS are the employers of their providers. They are responsible for managing their services. Both providers and recipients must follow the program rules and requirements. Following program rules can help prevent overpayment of benefits, loss of services, and civil or criminal legal actions for breaking the rules on purpose.

Please remember that it is illegal to try, on purpose, to get more benefits, services, or wages than what is allowed. This is fraud. It is a crime. Some examples include:

- **Signing someone else's name** on a timesheet or paycheck, *unless you are authorized* to sign for that person.
- **Misrepresenting** an IHSS recipient's level of need.
- Claiming hours which were **not actually worked by the provider**. (If the approved providers cannot do the hours, call the caseworker right away to get approval for substitute workers.)
- Claiming hours worked while the recipient is in the **hospital** or **nursing home**, unless authorized by the caseworker, or **incarcerated**. (If the recipient has this happen, call the caseworker right away.)
- **Requiring the provider** to share the IHSS paycheck with the recipient.

If you have any questions or concerns about this letter, please contact **<insert the appropriate county contact information here>**.

If you suspect fraud in the IHSS program, please contact The Department of Health Care Services IHSS fraud hotline at **1-888-717-8302**.

Directed Mailings Letter

Reasons

Below are sample reasons for use in the Directed Mailing letter

"If you are an IHSS provider, you are receiving this letter because we are providing program information to all providers...

...who work so many hours."

...who work for more than one recipient."

...who live so far from their recipients."

...who submit timesheets inconsistently."

...who request more replacement timesheets than most."

...whose IHSS paychecks have been sent to an out of state address."

...who are also IHSS recipients."

Please fill in as much Information as possible

Provider relationship to recipient:		County:	
IHSS recipient name:		IHSS provider name:	
IHSS recipient SSN:		IHSS provider SSN:	
IHSS recipient DOB:		IHSS provider DOB:	
IHSS recipient address:		IHSS provider address:	

☐ Complaint against recipient ☐ Complaint against provider

A. Reporting Party

Name:		Date:	
Email:		Phone no.:	
Relationship to IHSS participant:		No. in household:	
How did you become aware of this information:		Name of person and Agency taking complaint:	

B. Reason for Complaint

☐ Deceased ☐ Recipient ☐ Provider ☐ Recipient residing in a care facility or hospital

Date of death: Name of facility:

☐ In Jail ☐ Recipient ☐ Provider ☐ Dates of stay:

Dates:

Provider Issues

☐ Being paid for services not provided ☐ Stealing from recipient ☐ Abuse/neglect/maltreatment of recipient

☐ County employee is IHSS provider ☐ Other (specify)

Recipient Issues

☐ Does not appear to Need Services

☐ Seen performing strenuous activities (such as yard work, sports, lifting heavy object, etc.)

☐ Seen driving

☐ Seen working If yes, where:

☐ Other (specify)

C. Narrative Description (Actions observed, date observed, etc)

D. Case File Information *(for County use ONLY)*

IHSS recipient name:

Authorized No. hours:

Case no.:

Date of last F2F:

No. in household:

Who conducted last F2F:

☐ Severly Impaired

 ☐ Protective Supervision

 ☐ Married

 ☐ SSN verified

Program service(s) in question:

Rank in service(s):

☐ Caseworker contacted for information

Name of person completing:

Enclosures:

☐ Pay warrants (copy of front and back) ☐ Other (specify) _____☐ Timesheets**E. Initial Referral** *(for County use ONLY)*☐ Sent to DHCS☐ Sent to DA/SIU for investigation☐ APS/CPS☐ No action (provide explanation in section G)☐ Sent for administrative action

Date referred:

Aproximate case amount \$:

If referred to other than DHCS: ☐ MOU with DHCS ☐ Under \$500**F. Determination** *(for County use ONLY)*☐ Administrative action☐ Reassessment

Date:

☐ Reduced hours

_____ hours reduced

☐ Termination of services

_____ hours saved in termination

☐ Overpayment recovery in the amount of:

\$ _____ -

☐ To DA for prosecution for violation of PC(s):☐ To DOJ for prosecution for violation of PC(s):☐ No action – Case not viable (provide explanation in section G)**G. Explanation of Non-Viability** *(Add information obtained that rendered case non-viable)*

Investigator signature: _____

Date: _____

Attach additional case file information.

Copy of complaint must be retained in county case file.

IHSS COMPLAINT OF SUSPECTED FRAUD FORM INSTRUCTIONS

- Provider relationship to recipient:** Enter the provider's relationship to the recipient if known.
- IHSS recipient name:** Enter the name of the recipient.
- IHSS recipient SSN:** Enter the recipient's social security number (SSN) if known.
- IHSS recipient DOB:** Enter the recipient's date of birth (DOB) if known.
- IHSS recipient address:** Enter the IHSS recipient's address if known.
- County:** Select the county where services are provided.
- IHSS provider name:** Enter the name of the provider. If the complaint is concerning more than one provider, indicate this in section C.
- IHSS provider SSN:** Enter the provider's SSN if known.
- IHSS provider DOB:** Enter the provider's DOB if known.
- IHSS provider address:** Enter the IHSS provider's address if known.
- Check one or both of the following options to indicate whom the complaint is against:** Complaint against recipient and/or complaint against provider.

A. Reporting Party

- Name:** Enter the name of the person filing the complaint.
- Email:** Enter the email address of the person filing the complaint.
- Relationship to IHSS participant:** Record the relationship of the person filing the complaint to the recipient.
- How did you become aware of this information:** Record how the person filing the complaint knows of the information they are reporting.
- Date:** Enter the date the complaint was taken.
- Phone no.:** Enter the phone number of the person filing the complaint.

No. in household: Enter the total number of people including the recipient that the complainant suspects are living in the household.

Name of person and agency taking complaint: Record the name of the person taking the complaint and the agency they are associated with (county agency, etc.)

B Reason for Complaint

Check the box that best represents the focus of the complaint. Specify details as applicable.

Deceased: Check if the reason for complaint is to report the death of recipient or provider and check the recipient or provider box as appropriate.

Date of death: Record the date of death.

Recipient residing in a care facility or hospital: Check if the reason for complaint is to report that the recipient is/was residing in a care facility or hospital.

Name of facility: Enter the name of the facility, in known.

Date of stay: Enter the dates of the stay of recipient in the facility, if known.

In jail: Check if the reason for complaint is to report that recipient or provider is/was in jail. Check the box of who is/was the person in jail.

Dates: Enter dates the person was in jail, if known.

Provider Issues:

Being paid for services not provided: Check if the reason for complaint is to report that the provider is/was being paid for services not provided.

Stealing from recipient: Check if the reason for complaint is to report that the provider is/was stealing from recipient.

Abuse/neglect/maltreatment of recipient: Check if the reason for complaint is to report that the provider is/was showing unacceptable

treatment such as abuse, neglect or any maltreatment to the recipient.

County employee is IHSS provider: Check if the reason for complaint is to report that the provider is a county employee.

Other (specify): Check if there is another reason for complaint that is not in the options. Specify the reason.

Recipient Issues:

Does not appear to need services: Check if the reason for complaint is to report that the recipient does not appear to need services.

Seen performing strenuous activities (such as yard work, sports, lifting heavy objects, etc.): Check if the reason for complaint is to report that the recipient was seen performing activities that he/she was reported unable to do because of his/her condition.

Seen driving: Check if the reason for complaint is to report that the recipient was seen driving.

Seen working: Check if the reason for complaint is to report that the recipient was seen working.

If yes, where: Specify where he/she is working, if known.

Other (specify): Check if there is another reason for complaint that is not in the options. Specify the reason.

C Narrative Description

Record any information pertinent to the complaint, things that were observed, dates, time, locations, etc.

D. Case File Information (for County use ONLY)

Use this section to provide the following information:

IHSS recipient name: Enter the name of the IHSS recipient.

Case no.: Enter the IHSS case number.

No. in household: Enter the total number of people living in the household

including the recipient.

Authorized no. hours: Enter the number of hours authorized for purchase.

Date of last Face-to-face (F2F): Enter the date of the last recorded face-to-face contact the county had with the recipient.

Person who conducted last F2F: Enter the name of the person who conducted the last face-to-face with the recipient.

Check any of the following applicable boxes:

Severely Impaired: Check if the recipient meets the Severely Impaired criteria.

Protective Supervision: Check if the recipient is currently authorized Protective Supervision.

Married: Check if the recipient is listed as married.

Minor: Check if the recipient is a minor.

SSN Verified: Check if Social Security Number was verified.

Program service(s) in question: Enter the services in question based on complaint.

Rank in service(s): Enter the Functional Index (FI) ranking of the services in question.

Caseworker contacted for information: Check if the caseworker was contacted for information.

Name of person completing: Enter the name of the person completing the case file information.

Enclosures:

Check the applicable boxes for any attached documents.

Pay warrants (copy of front and back): Check if pay warrants are attached to the complaint form.

Timesheets: Check if timesheets are attached to the complaint form.

Other (specify): Check if any other documents are attached. Specify what documents are attached.

E. Initial Referral (for County use ONLY):

Check the box for the action taken on the case.

Sent to DHCS: Check if the initial referral was sent to DHCS.
Sent to APS/CPS: Check if the initial referral was sent to APS/CPS.
Sent for administrative action: Check if the initial referral was sent for administrative action.
Sent to DA/SIU for investigation: Check if initial referral was sent to DA/SIU for investigation.
No action: Check if no action was taken and provide explanation in section G.

Date referred: Record the date the referral was made.

Approximate case amount: Record the estimated case amount in dollars.

If not sent to DHCS: Check one of the boxes for the reason the case was not sent to DHCS.

F. Determination

Check the box for the determined outcome of the case

Administrative action: Check if the case was determined by administrative action.
Reassessment: Check if the case was determined by reassessment.
Date: Record the date of the reassessment.
Reduced hours: Check if the case was determined to reduce hours. Enter the number of hours that were reduced.
Termination of services: Check if the case was determined to terminate services. Enter the number of hours saved in termination.
Overpayment recovery in the amount of: Check if the case was determined to recover overpayment. Enter the amount of overpayment recovered.

To DA for prosecution for violation of PC(s): Check if the case was determined by DA for prosecution for violation of PC(s). Record the penal code section.

To DOJ for prosecution for violation of PC(s): Check if the case was determined by DOJ for prosecution for violation of PC(s). Record the penal code section.

No action – Case not viable: Check if the case was determined as not viable and provide explanation in Section G.

G. Explanation of Non-Viability

Record information obtained that rendered the case non-viable.

Investigator Signature: Investigator must sign off on the case regardless of the action taken.

Date: Record the date the report was completed.

**Department of Health Care Services Memorandum of
Understanding (SAMPLE)**

I. PURPOSE

As part of the commitment to deter and prosecute fraud and maintain program integrity within the In-Home Supportive Services (IHSS) Program, a Memorandum of Understanding (MOU) must be executed between the California Department of Health Care Services (DHCS) and {FILL IN COUNTY} County.

The intent of this MOU is to ensure the county agrees to all stipulations and meets the requirements outlined below. Once this memorandum of understanding is fully executed, the county may investigate complaints received regardless of the dollar amount associated with the case. Its purpose is to form a working relationship promoting communication and coordination between the county and DHCS and a standard for investigating and prosecuting fraud.

This MOU sets out the responsibilities of all parties. The MOU identifies the work to be performed by the county and the DHCS. A work plan is identified in Attachment A.

II. RESPONSIBILITIES

County will:

1. Commit to a zero tolerance stance on fraud.
2. Follow a standard triage process for all complaints received.
 - a. This standard process will include review by a law enforcement entity.
3. Develop a plan for triaging, referring and investigating fraud that identifies staff and elements necessary to include in a referral.
4. Pursue cases criminally versus solely administratively whenever possible.
 - a. Administrative actions may include: overpay recovery, hour reductions, case terminations, etc.
5. Maintain copies of all complaints, referrals, reports and any other pertinent documents for three years from the last date of aid or services.
6. Provide quarterly statistical data to DHCS and California Department of Social Services (CDSS).
7. Maintain staff and procedures for investigating cases regardless of funding.
8. In the event the county is unable to operate according to the provisions in this MOU, they will utilize established DHCS referral modalities in accordance with statute.

California Department of Health Care Services will:

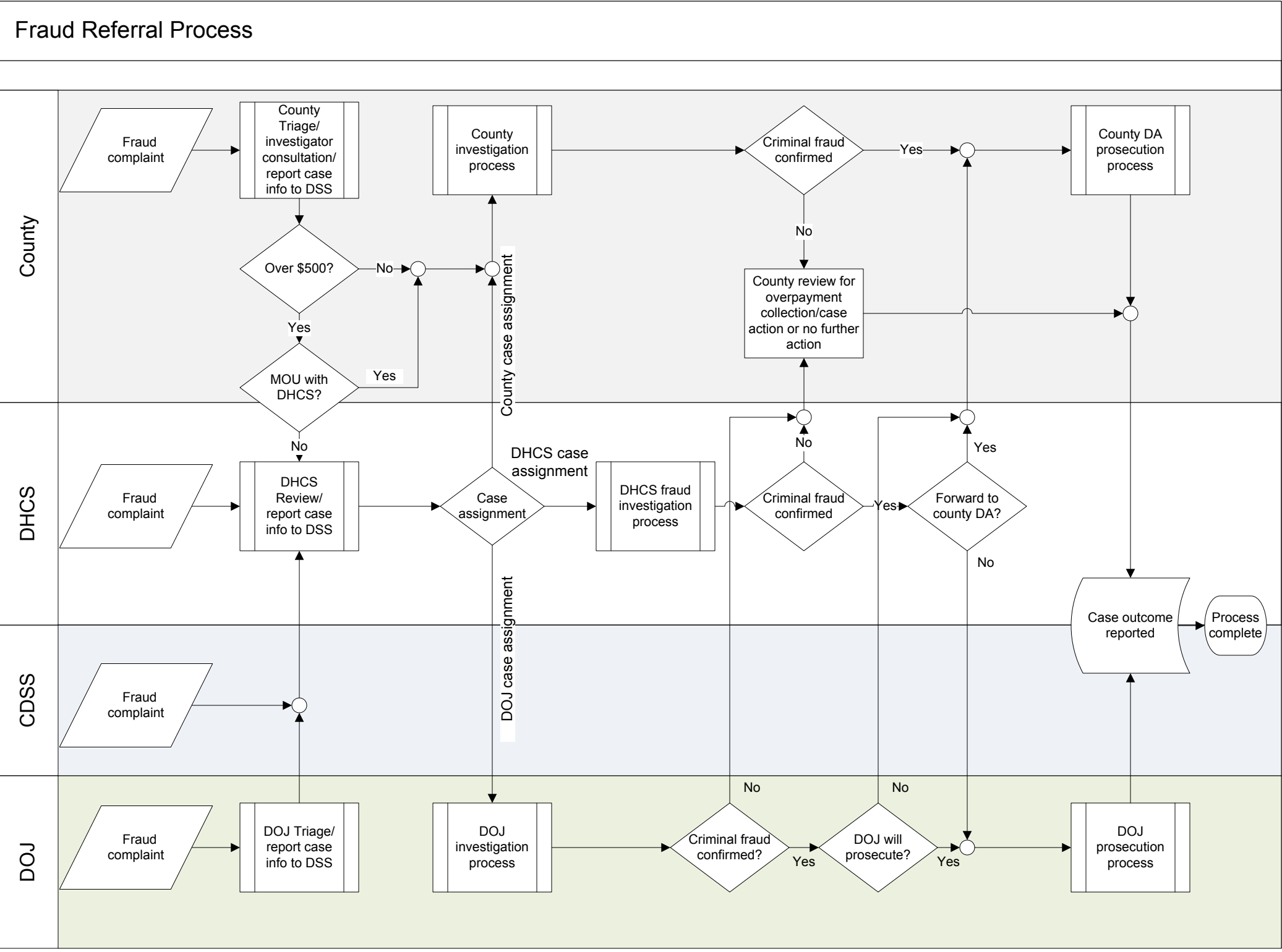
1. Be available to assist counties at any time.
2. Reserve the right to take any case over \$500 in the event the county fails to investigate/prosecute the case.
3. Establish standard documents to be included in referrals.
4. Provide quarterly statistical data to CDSS.

TITLE

Name:

Signature:

Date:



IN-HOME SUPPORTIVE SERVICES (IHSS) FRAUD DATA REPORTING FORM

County:	Select County Name
Reporting Quarter and State Fiscal Year:	Select Quarter and Year
Date Completed:	

Section I. Fraud Complaints

A	Total Number of Complaints Received	1
A.1.	Number of Complaints Received By Source	
	Recipient	2
	Provider	3
	Family member	4
	County staff	5
	Neighbor	6
	Data matches	7
	Anonymous- phone	8
	Anonymous- mail	9
	Anonymous- website	10
	Other (Explain in Comments- section VI.1.)	11
A.2.	Number of Complaints By Outcome - Initial Review	
	Referred for county investigation	12
	Referred for state investigation	13
	Referred for administrative action	14
	Referred to APS/CPS	15
	Dropped, no action	16

Section II. Early Detection Savings

A	Total Number of Cases Terminated/Reduced	17
A.1.	Number of Cases Terminated/Reduced as a Result of:	
	Data matches	18
	Entirely overstated disability	19
	Partially overstated disability	20
	Household composition/proration	21
	Misrepresented program eligibility	22
B	Total Number of Hours Terminated/Reduced	23
B.1.	Number of Authorized Hours Terminated/Reduced as a Result of:	
	Data matches	24
	Entirely overstated disability	25
	Partially overstated disability	26
	Household composition/proration	27
	Misrepresented program eligibility	28

Section III. Fraud Investigations - Completed

A	Total Number of Investigations Completed	29
A.1.	Number of Investigations By Type	
	Collusion (Provider & Recipient)	30
	Provider fraud	31
	Recipient fraud	32
	County staff	33
	Other (Explain in Comments - section VI.2.)	34

IN-HOME SUPPORTIVE SERVICES (IHSS) FRAUD DATA REPORTING FORM

A.2.	Number of Investigations By Outcome	
	Dropped, no action	35
	Referred for admin. action to IHSS	36
	Referred for prosecution to County DA	37
	Referred for prosecution to DOJ	38
A.3.	Amount Estimates by Outcome (\$)	
	Estimated amount referred for admin. action to IHSS	39
	Estimated amount referred for prosecution	40

Section IV. Prosecutions - County

A	Total Number of Cases Received for Prosecution	41
A.1.	Number of Cases by Outcome	
	Cases declined by DA	42
	Plea deal, no conviction	43
	Cases dismissed	44
	Number of cases - with convictions	45
	Number of felony convictions	46
	Number of misdemeanor convictions	47
	Number of defendants prosecuted	48
	Number of Referrals to suspended and ineligible list	49

Section V. Totals (\$)

A	Loss Identified to IHSS Program	50
B	Total Amount Identified for Collection through Court Ordered Restitution	51
C	Total Amount Identified for Collection through County Overpay Recovery	52

Section VI.1. Comments

53

Section VI.2. Comments

54

INSTRUCTIONS for completing the IHSS Fraud Data Reporting Form (SOC 2245)

General: County fraud data is reported to the California Department of Social Services (CDSS) quarterly using the SOC 2245 form. The data is due by the 15th of the first month following the reporting quarter.

Data entry: When entering data into the form, please enter numerical data only, there is no need to report “None” or “N/A.” If your county does not collect data for a particular reporting field, leave the field blank. Leave the field blank *only* if your county does not collect the appropriate data; if the data was collected and the answer is zero, please enter “0”.

If you inadvertently enter a number in a field for which your county does not collect data, exit the field, then single click or use the arrow keys to return to that field, and use the “Delete” key to clear the field.

Section I. Fraud Complaints

Definitions:

- **Complaint** – A complaint is any concern that comes in to the county; some will become referrals and some will not. Complaints may include a neighbor’s general suspicions, a family member’s concerns about the quality of a provider, or county staff’s suspicion of fraudulent behavior.
- **County Staff** – Any employee at the county level, this may include: Child Protective Services (CPS), Adult Protective Services (APS), social workers, county investigative staff, District Attorney’s Office, or others.
- **Data Matches** – Data matches may originate at the State or county level and may include death match, hospital match, jail match, etc.
- **Administrative Action** – any administrative action taken on a case and may include: overpay recovery, hour reduction, case termination, etc.

A. **Total Number of Complaints Received** – Record the total number of complaints received.

A.1. Number of Complaints Received by Source – The purpose of this section is to track where complaints are originating.

Record each complaint received during the reporting quarter in every applicable category. If the complaint was reported by a provider who is also a family member, record the complaint once for provider and once for family member. The total of A.1. must be greater than or equal to A.

A.2. Number of Complaints by Outcome – Initial Review – The action taken on the complaints after the initial review, grouped by outcome.

The review is conducted in accordance with your county’s process. These are initial outcomes determined this quarter regardless of when the complaint was received. Record each complaint reviewed during the reporting quarter in every applicable outcome category. If a complaint was referred for county investigation and had an overpay recovery action

initiated, mark “referred for county investigation” once and “referred for administrative action” once.

*Note: Counties must report all cases sent for investigation to the State, once received for investigation, the State will report on those cases separately. If the State sends the case back to the county for investigation or prosecution, the county must resume reporting on the case.

Section II. Early Detection Savings

Definitions:

- **Early Detection Savings** – Any future savings achieved by terminating or reducing hours on a case. Data is reported as hours saved in a single month.
- **Entirely/Partly Overstated Disability** – Recipient either completely or partially misrepresented his or her care needs.
- **Household Composition/Proration** – There was a misrepresentation regarding the people in the household or their usage of the household space.
- **Misrepresented Program Eligibility** – Recipient provided an incorrect citizenship status or misrepresented income/assets.

A. **Total Number of Cases Terminated/Reduced** – Record the total number of cases that were terminated or had authorized hours reduced during the reporting quarter as the result of a complaint.

A.1. Number of Cases Terminated/Reduced as the Result of: – Record each case that was terminated or had hours reduced during the reporting quarter in each category based on the cause for the termination/reduction.

B. **Total Number of Hours Terminated/Reduced** – Record the total number of monthly hours that were terminated or reduced as the result of being identified by a complaint.

B.1. Number of Hours Terminated/Reduced as the Result of: – Record the number of hours that were terminated or reduced in a single month in each category based on the cause for the termination/reduction.

Section III. Fraud Investigations – Completed

A. **Total Number of Investigations Completed** – Record the number of investigations that were completed this reporting period.

A.1. Number of Investigations by Type – The number of complaints investigated during the reporting quarter, grouped by the type of fraud suspected. Record each complaint by the person(s) suspected of committing fraud at the time the report is being completed. This may or may not be the same person(s) suspected when the original complaint was reported.

- A.2. Number of Investigations by Outcome – The result of the completed investigations, grouped by outcome.
- A.3. Amount Estimates by Outcome (\$) – The estimated amount of fraud involved in the cases investigated, grouped by outcome.

Section IV. Prosecutions – County

Definitions:

- **Cases Declined by the DA** – Cases sent to the DA for prosecution that the DA declines to prosecute.
- **Plea Deal, No Conviction** – Any cases that were plead out for restitution only, no conviction.

A. Total Number of Cases Received for Prosecution – Provide the number of cases that were received for prosecution in this reporting quarter.

- A.1. Number of Cases by Outcome – Provide the number of cases with completed prosecutions in the reporting quarter, grouped by outcome. 1) These will be county prosecuted cases only. 2) You may record a case more than once if, for example, it resulted in a conviction and a referral to the suspended and ineligible list, or if it resulted in both misdemeanor and felony convictions.

Section V. Totals (\$)

- A. **Loss Identified to IHSS Program** – Record the total overpay amount (gross) in all cases identified, whether or not they were sent for prosecution. This does not include extraneous costs such as court fees, hours for investigation, etc. Sections V.B. and V.C. do not need to equal V.A.
- B. **Total Amount Identified for Collection Through Court Ordered Restitution** – Record the total amount of restitution ordered for repayment to the IHSS program.
- C. **Total Amount Identified for Collection Through County Overpay Recovery** – Record the total net amount of overpayments identified as a result of a fraud investigation.

Section VI. Comments

1. and 2. Please use these sections to clarify if the “other” line is used in section I.A.1 and III.A.1.