

# **WELCOME TO THE IHSS TRAINING ACADEMY**

## ***CORE: IHSS 101***

The IHSS Training Academy provides courses that are designed to enhance the participant's skills in completing individual assessments and authorization of IHSS services.

This three-day training has been designed specifically for IHSS staff that have been newly hired, have limited IHSS experience, or require a refresher course. This course utilizes lecture, discussion, group, and individual activities to deliver course content.

Topics will include:

- Uniformity Overview
- Functional Rankings
- IHSS Program Background
- Regulations
- Eligibility
- IHSS Plus Option (IPO)
  - IPO Program and Philosophy
  - Self-Direction
  - Managing Risk
  - Completing the Individualized Back-Up Plan and Risk Assessment Form (SOC 864)
- Inter County Transfer
- Task Categories
- The Assessment
- The Home Visit
- The Interview
- Completing the Assessment Form (SOC 293)
- Shared Living
- Documentation
- Forms
- Providers
- Programs/Services that Interact with IHSS and How They Impact Assessments

### **Objectives:**

By the end of this training, participants will be able to:

1. Explain the purpose and importance of uniformity in IHSS.
2. Define the components of the functional index ranking and how they relate to the need for human assistance.
3. Demonstrate the ability to utilize the Annotated Assessment Criteria and IHSS regulations in determining the functional ranking for an IHSS consumer.
4. Explain the relationship between functional index scores and the authorization of IHSS services.
5. Identify the IHSS program goals, types of programs available, and eligibility criteria.

6. Describe the IPO program and philosophy, enhanced assessment requirements, and how to complete the mandatory Individualized Back-Up Plan and Risk Assessment Form (SOC 864).
7. Describe how to apply the Hourly Task Guidelines, including the definition of exceptions.
8. Describe why the home visit is important, and steps the social worker can take to obtain an accurate assessment.
9. Demonstrate the application of shared living regulations including the appropriate proration of services.
10. Become acquainted with IHSS program forms and recognize the importance and rationale for accurately completing forms and documenting in the case record.
11. Identify the order of the assessment process including the things to consider when an exception exists.
12. Have an understanding of the programs that interact with IHSS and how these programs affect the authorization of services.

**IHSS TRAINING ACADEMY**  
**CORE: IHSS 101**

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# IHSS TRAINING ACADEMY

## CORE: IHSS 101

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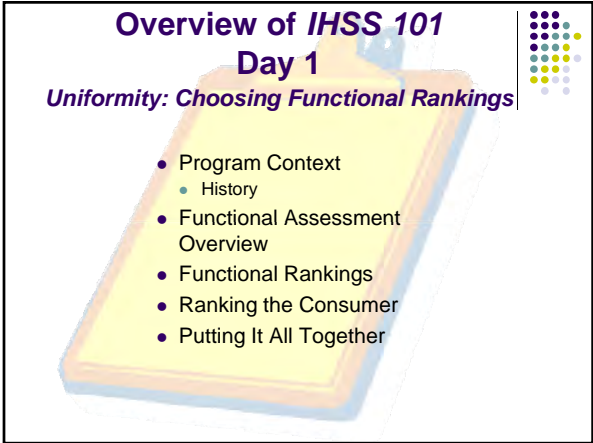
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**Overview of IHSS 101  
Day 1**  
*Uniformity: Choosing Functional Rankings*

- Program Context
  - History
- Functional Assessment Overview
- Functional Rankings
- Ranking the Consumer
- Putting It All Together

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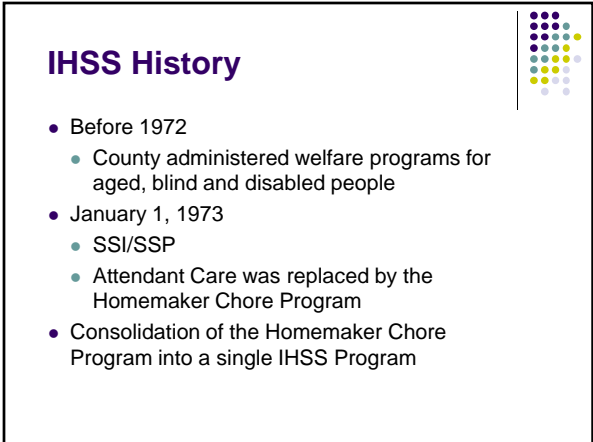
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**IHSS History**

- Before 1972
  - County administered welfare programs for aged, blind and disabled people
- January 1, 1973
  - SSI/SSP
  - Attendant Care was replaced by the Homemaker Chore Program
- Consolidation of the Homemaker Chore Program into a single IHSS Program

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## IHSS History



- Significant discrepancy in average hours authorized from county to county
  - Time per Task Standards for Domestic, Laundry, Shopping, and Errands
- CMIPS (Case Management Information and Payrolling System)
  - Payroll taxes
  - Help workers manage caseload
  - Collect program data

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## IHSS History



- Uniformity
  - A way to quantify the level of need,
  - Compare the level of impairment of consumers, and
  - Compare the average level of impairment between workers, units, and counties.
- 1993 PCSP (Personal Care Services Program)

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## Program Philosophy



- Program scope defined by regulations MPP §30-757.
- Covers persons who are aged, blind and disabled who meet eligibility requirements and need IHSS to avoid out of home care and remain safely in their homes.
- Doesn't provide for every need a person may have:
  - Friendly visiting
  - Socialization
  - 24-hour care

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## Demographic Changes



- Originally primarily aged
- Increase in disabled
- Increase in children
- Increase in hours per case

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## IHSS Today



- Three Programs
  - PCSP (Personal Care Services Program)
  - IPO (IHSS Plus Option)
  - Residual
- Quality Assurance Legislation
  - Quality Assurance Bureau
  - Program Integrity
  - Hourly Task Guidelines
  - IHSS Training Academy
- Fraud Legislation

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## Functional Assessment



- Consumers with similar needs should receive similar services.
- All consumers should have an equal opportunity to experience independence and safety.
- The same standards should be used with all consumers.

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## Functional Index Ranking



- Documents the social worker's assessment of the consumer's dependence on human assistance.
- Focus is on level of need, not services provided.
- Higher FI ranking may not indicate a need for more hours.
- Is based on individual need.

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## Functional Index Ranking



- Evaluates effect of recipient's physical, cognitive and emotional ability.
- Consumer's habits may differ from actual abilities.
- Medical diagnosis is an indicator, but does not dictate need.
- Assistive devices may improve functional ability.

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## Functional Index Scales Include



- Housework
- Laundry
- Shopping and Errands
- Meal Preparation/Cleanup
- Ambulation
- Bathing, Oral Hygiene, and Grooming/Routine Bed Bath
- Dressing/Prosthetic Devices
- Bowel, Bladder, and Menstrual Care
- Transfer
- Eating
- Respiration
- Memory
- Orientation
- Judgment

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## Assigning the Rank



- Consider consumer's:
  - Ability to perform needs independently and safely
  - Degree in which they need to rely on human assistance
  - Level of performance
  - Ability and safety, not speed of performance
  - Activities, responses, and environment

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## Questions to Consider



- Can the consumer perform the task independently and safely?
- If no, what type of human assistance is needed?
- What degree of assistance is needed?
- Would DME make the consumer more independent?
- Is the need daily or intermittent?

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**Myrtle**



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**Jewel**



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**Margaret and May**



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George



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Completing the H-Line:  
Joe



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End of Day 1



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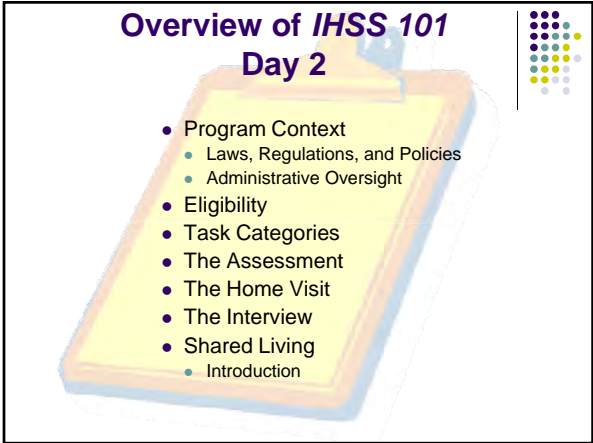
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**Overview of *IHSS 101*  
Day 2**

- Program Context
  - Laws, Regulations, and Policies
  - Administrative Oversight
- Eligibility
- Task Categories
- The Assessment
- The Home Visit
- The Interview
- Shared Living
  - Introduction

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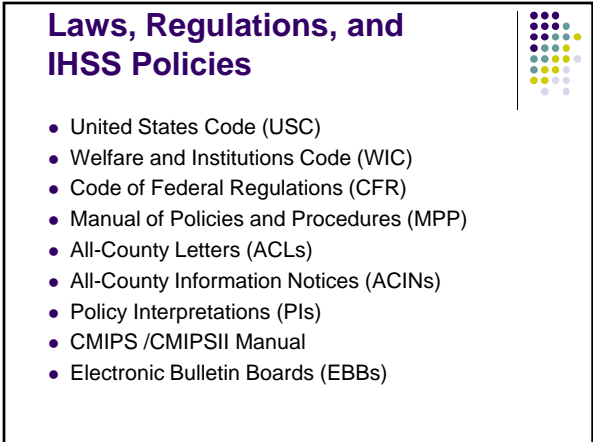
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**Laws, Regulations, and  
IHSS Policies**

- United States Code (USC)
- Welfare and Institutions Code (WIC)
- Code of Federal Regulations (CFR)
- Manual of Policies and Procedures (MPP)
- All-County Letters (ACLs)
- All-County Information Notices (ACINs)
- Policy Interpretations (PIs)
- CMIPS /CMIPSII Manual
- Electronic Bulletin Boards (EBBs)

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<http://www.cdss.ca.gov/agedblinddisabled/PG1296.htm>

Reference materials for workers

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## Regulations

- Laws (statutes) are sometimes very general.
- Regulations are needed to apply specificity and detail prior to implementation of laws.
- State agency that has jurisdiction writes regulations which must go through an administrative process which includes time for public comment.

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## Legal Remedies

- At times, consumers, advocates or advocacy agencies may disagree with laws or regulations, or decisions made on individual cases.
- Disagreements may be handled in several ways:
  - Locally
  - State hearing
  - Court case

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## IHSS Program Administration and Oversight



- Counties are responsible for administering on a local basis.
- CDSS is responsible for:
  - Overseeing how counties administer the program, and
  - Ensuring the applicable laws are followed.
- CDHCS is responsible for oversight and ensuring the integrity of programs that receive Federal Medicaid funding, including fraud investigation in IHSS.

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## IHSS Program Administration and Oversight



- Other State Oversight
- Federal Level
  - Centers for Medicare and Medicaid (CMS) is responsible for overseeing how states administer the Medicaid program.
  - In California, the Medicaid program is called Medi-Cal.

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## Who's Eligible?



- Aged, blind or disabled
- Financial (low income and resources)
  - SSI
  - Medi-Cal
- Own home
- Threshold level of need (at risk of placement)
- U.S. citizen or legal resident with certain restrictions
- California residence

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## Intake (ACL 12-36)



- Inquiry
  - Non person-specific call with informational inquiry regarding IHSS program
  - No action needed
- Referral
  - Person specific call by third party who does not have legal authority
  - Record contact information as referral
  - Follow up regarding need / desire for application
- Application
  - If desire stated must take application
  - Cannot deny or dissuade based on information communicated during a phone call or face-to-face visit
  - Assess for eligibility and NOA sent with county's determination

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## “Own Home”



*For IHSS purposes, an individual's own home is the place in which that individual chooses to reside except an acute care hospital, skilled nursing facility, intermediate care facility, community care facility, or board and care facility [MPP 30-701(o)], even if she/he chooses to live there.*

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## Other Things to Consider



- Inter County Transfer
- Temporary Absence from the State
- Institutionalization
  - Hospitalization
  - Incarceration
  - Board and Care
  - Skilled Nursing Facility (SNF)

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## Programs



- PCSP
- IPO
  - Restaurant Meal Allowance
  - Advance Pay
  - Consumer is minor child with parent provider, or spouse of consumer is provider
- Residual

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## IPO



- Federal program
  - Administered by CDSS
  - Medi-Cal funding
  - Eligibility
  - Promote independence
  - Program services change

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## IPO



Designed to allow individuals, or their representatives, to exercise decision-making authority in identifying, accessing, managing and purchasing their personal assistance options.

42 CFR §441.450(b)

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## IPO Definition of Self-Direction



The opportunity for consumers, or their representatives, to exercise choice and control over the budget, planning and purchase of self-directed personal assistance services (PAS), including the amount, duration, scope, provider and location of service provision.

42 CFR §441.450(c)

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## IPO Philosophy



- Self-direction
- Person-centered
- Participant directed care needs

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## IPO Enhanced Assessment Requirements



- Discussion of:
  - NOA
  - Process for changes in need
  - Right to request a state hearing
  - Voluntary disenrollment process
  - Available support at the county
- Completion of:
  - Individualized Back-Up Plan and Risk Assessment form (SOC 864)

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## Individualized Back-Up Plan and Risk Assessment Form (SOC 864)



What is important...

- Individuals are making informed decisions
- You have conversations about risk to ensure individuals are informed
- You document communication pertaining to risks, options, and supports utilizing this form

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## Completing the Individualized Back-Up Plan and Risk Assessment Form (SOC 864)



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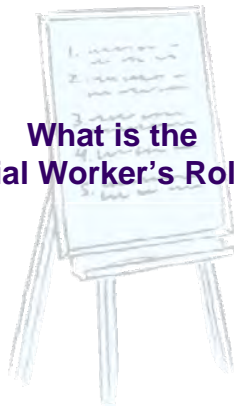
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## What is the Social Worker's Role?



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## Ultimate Goals of the Social Worker



- To assess needs and authorize hours and tasks needed for the consumer to stay safely in their home.
- To help the consumer implement and manage an appropriate care plan.
- To identify and make referrals to resources which may augment IHSS and contribute to their ability to remain safely in the home and/or reduce the need for IHSS.
- To identify risk factors and address the risk factors appropriately.

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## Activity: Task Categories




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Line	SERVICES
AA	Domestic Services
BB	Preparation of Meals
CC	Meal Clean Up
DD	Routine Laundry, Etc.
EE	Shopping for Food
FF	Other Shopping & Errands
GG	Heavy Cleaning
HH	Respiration
II	Bowel & Bladder Care
JJ	Feeding
KK	Routine Bed Baths
LL	Dressing
MM	Menstrual Care
NN	Ambulation
OO	Moving in and out of Bed (Transfer)
PP	Bathing, Oral Hygiene, Grooming
QQ	Rubbing Skin, Repositioning, Etc.
RR	Care and Assistance with Prosthesis
SS	Accompaniment to Medical Appt.
TT	Accompaniment to Alt. Resources
UU	Remove Grass, Weeds, Rubbish
VV	Remove Ice, Snow
WW	Protective Supervision
XX	Teaching & Demonstration
YY	Paramedical Services
ZZ	Meal Allowance



## Task Categories

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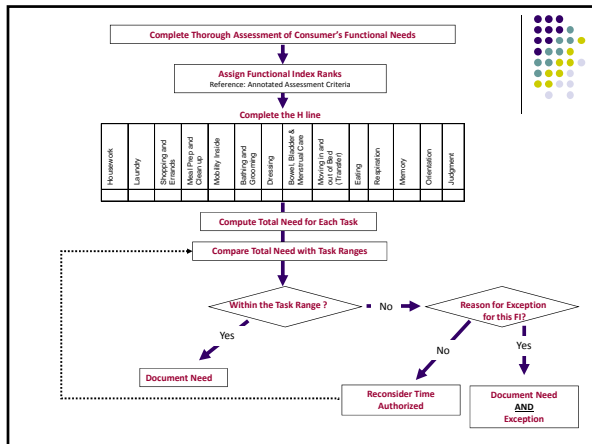
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## The Assessment

The assessment process should:

- Identify the degree of the consumer's ability to perform IHSS tasks independently and safely.
- Identify the degree of the consumer's need to rely on human assistance of some sort.
- Identify the frequency with which the task must be performed and how long it takes to perform the task.
- Include careful observation to ascertain information that most accurately identifies the consumer's *need*.

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## Assessment Timeframe

- Every 12 months
- Variable Assessments
  - Shorter than 12 months
  - 18-month option

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## The Home Visit



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## The Home Visit – Being Prepared



- Review all of the information that is available. Ask “Are there any missing pieces?”
- Determine if there are areas of concern that you want to address during the home visit based on available information.
- Make any preliminary contacts that may help you address any areas of concern or missing information.

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## The Home Visit – Being Prepared



- Gather any necessary forms.
- Use a checklist to help prepare.

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## Personal Safety for the Home Visit



- Be proactive
- Be prepared
- Be alert

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## Safety Considerations



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## Interviewing Skills



Purpose of the Initial Interview:

- Build rapport with the consumer.
- Explain the program and its components.
- Gain information about the consumer's situation, functional abilities, and limitations.

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*The interview is a two-way process. The consumer is looking at the SW for cues that they understand and care. The SW is looking for information to support service needs.*

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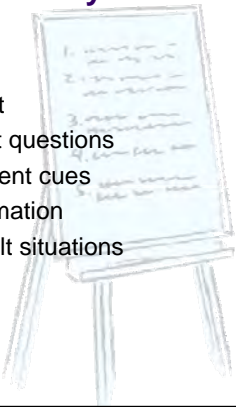
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**Teach Back Activity:  
Interview**



- Building rapport
- Asking the right questions
- Other assessment cues
- Clarifying information
- Handling difficult situations

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**Shared Living**

*Consumer resides in the same living unit with one or more persons.*

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## Proration



*Proration is the process of determining the consumer's individual need when the consumer has housemates. IHSS pays only for the consumer's share of services met in common with housemates.*

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## Shared Living



Some IHSS services must be prorated when the consumer is in a shared living arrangement. These services are:

- Domestic
- Laundry
- Meal Preparation and Cleanup
- Shopping for Food, Errands
- Heavy Cleaning, Yard Hazard Abatement, Snow Removal
- Protective Supervision, Teaching and Demonstration

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## Proration of Domestic



When prorating, consider rooms/areas used:

- In common
- Solely by consumer
- Solely by others

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## Proration of Related



When prorating, consider:

- Needs met in common
- The number of people sharing the service
- Whether practices differ on some days

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# End of Day 2



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**Overview of *IHSS 101*  
Day 3**

- Shared Living
  - Exceptions
  - Activity
- Completing the SOC 293
- Forms
- Documentation
- Putting It All Together
- Caring for Self

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**Shared Living *Exceptions...***

- Able and Available Spouse
- Live-In Provider
- Consumer moves in with a relative primarily to receive care
- Landlord – Tenant (consumer is Landlord)
- Landlord – Tenant (consumer is Tenant)
- Consumer is a child and lives with parent(s)
- Consumer has a child under the age of 14 who is not eligible and does not need IHSS

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## Documentation: SOC 293



- For all services that are prorated, the “**Total Need**” column of the SOC 293 means the total number of hours needed by *the entire household*, before any adjustments are made.
- For all services that are prorated, the “**Adjustments**” column of the SOC 293 means the total number of hours needed by *household members other than the consumer*.

Total Need	Adjustments	Individual Assessed Need	Alternative Resources	Auth to be Purchased

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## Exercise: Shared Living



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## SOC 293



- The SOC 293 is the standardized assessment tool referred to in MPP 30-761.27.
- The Case Management Information and Payrolling System
  - (CMIPS) Manual gives information regarding completion of the fields on the SOC 293.
  - CMIPS II has integrated help screens.

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## SOC 293



- Complete all portions of the SOC 293 accurately.
- Data from the SOC 293 can impact:
  - How services are authorized
  - Response to consumer in the event of a disaster
- Provides essential statistical information.

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## Completing the SOC 293



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## Completing the Grid Portion of the SOC 293



- Total Need
- Adjustments
- Individual Need
- Alternative Resources
- Authorized for Purchase
- Unmet Need
- Questions to find out specific needs
- Associated forms

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## Notice of Action (NOA)



- Timely and adequate notice
- Reason Codes
- How to count 10 days
- Exceptions to the 10-day notice

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## The IHSS Provider



- Provider Modes
  - Individual Providers (IP) selected by the consumer
  - Contractor
  - Homemaker
- Public Authority
- Provider Orientation Process

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## Completing the SOC 311



- Provider Eligibility
  - Puts providers into the CMIPS system
  - Links provider and consumer

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## Other Forms



What other forms must the social worker know about?

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## Being a Mandated Reporter



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## Activity: The Home Visit



Sarah

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## After the Home Visit



- Gather necessary information from other resources
  - Who else has important information?
- Health Care Certification
- Assign Functional Index (FI) rankings
- Referrals
- Alternative resources
- Durable Medical Equipment (DME)
- Documentation

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## Programs that Interact with IHSS



- Area Agencies on Aging (AAA)
- Multipurpose Senior Services Program (MSSP)
- County Case Management Programs
- Community Based Adult Services Program (CBAS)
- Alzheimer's Day Care Resource Center Program
- Regional Centers
- VA Aid and Attendance Program
- Waivers

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## Activity: Addressing Issues



**Sarah**

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## Authorization of Hours



- Need not assessed based on diagnosis
- Health Care Certification SOC 873
- Need versus practice
- Independence versus dependence
- Safety
- Apply Hourly Task Guidelines
  - Refer to regulations.
  - Compare to ranges.
  - Document Exceptions.

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## Exceptions



- Occur when needs require time for services that are outside of the Hourly Task Guidelines.
- Can be above or below the guideline.
- Are **expected** because assessments are individualized.
- Cannot be made due to inefficiency or incompetence of the provider.
- Must be documented in the case file.

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## Importance of Good Documentation



- Creates a visual picture of the social worker's visit.
- Provides historical record important for coverage when you are out in the field.
- Provides continuity for case transfers and inter-county transfers.
- Substantiates authorization at state hearings.
- Adherence to federal and state laws, regulations and policies.
- Aids in the investigation of potential fraud.



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## Documentation Tips



- Create a clear picture of the situation.
- Avoid documenting unnecessary information.
- Record the facts and avoid judging statements.
- Keep to the point and purpose of the visit.
- The files are open – all information may be read by the consumer and/or authorized representative.
- Do not document mental illness diagnosis unless it has been confirmed.

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## Activity: Authorization of Hours



Sarah

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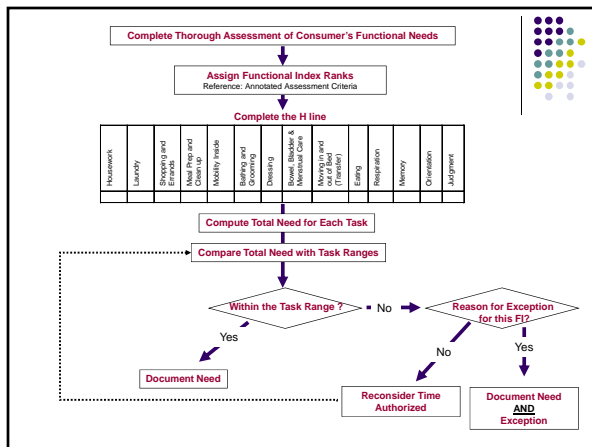
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## Caring for Self

*Why IHSS Matters*

*Why I Matter*

*Commitments*

- ★ Finding joy in the journey
- ★ Ways to make my work more meaningful
- ★ Finding play in every day
- ★ Steps to de-stress



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**Thank you for your participation!!**

# End of Day 3

**Please complete evaluation**



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# CASE STUDY – MYRTLE SPRIGGS

## ASSESSMENT WORKSHEET

While viewing the video, focus your attention on the following functions:

SCALES: \_\_\_\_\_  
Housework

\_\_\_\_\_   
Laundry

\_\_\_\_\_   
Meal Preparation & Cleanup

\_\_\_\_\_   
Mobility Inside

\_\_\_\_\_   
Bathing

\_\_\_\_\_   
Judgment

### H LINE

	Housework	Laundry	Meal Prep & Cleanup	Mobility Inside	Bathing & Grooming							Judgment
Self												
Group Consensus Score												



**REVIEW OF RELEVANT ASSESSMENT  
STANDARDS AND CRITERIA  
MYRTLE SPRIGGS**

**NOTES**

**Visual Observations: Environment, Actions and Responses**

Myrtle greets us from the front porch when we arrive. She is smiling, although she appears a bit strained. Her movement with her walker appears unbalanced and her gait is stiff. She uses her walker to move around her home. This assistive device has extended the consumer's independence.

Myrtle appears to genuinely enjoy her independence. She can wash some of her body. In bathing and grooming, the assistive device cannot compensate for her lack of balance, for her need for human assistance. Bathing completely alone would be unsafe for Myrtle.

She eagerly shows us several things we ask for. Her manual dexterity allows her to grasp and hold articles of different sizes and textures. Note her ability to open and close a water jar. She is able to reach things, even when standing with her walker, but notice that she nearly loses her balance when letting go of her walker and reaching to show the worker exercises they have her do at the Adult Day Health Center (ADHC). Her range of motion is limited, preventing her from reaching and lifting above the shoulder.

However, because of her strength and determination, she can manage some light laundry chores, including hand washing, folding, and putting clothes away in the dresser. She also tidies up after herself and manages other light household chores, like washing surfaces reachable from her walker. She uses the same skill and determination to prepare light meals and snacks that she applies to other self care in the home.

**Managing Her Environment**

She visits the local ADHC for her main meal and showering five days a week. The ADHC is an alternative resource, which, along with the assistive device, enhances her independence. Because Uniformity evaluates the consumer's dependence on human assistance, her overall functional rank is not changed in any area by this resource. Her functional ranking remains what it would be without the services.

**Consequences and Personal Choices: The Role of Consumer Judgment**

Myrtle's ability to care for herself is actually greater than it first appears. Her true needs are a little more difficult to assess, with her display of these attributes, preferable as they are. Her activity, affect and independent attitude enhance her physical ability, without putting her at risk. The case worker must weigh all the observations before determining the full extent of Myrtle's need. Since Myrtle participates in additional services that include social interaction, her insistence on independence displays good self management, rather than questionable judgment.

**DISCUSSION GUIDE  
MYRTLE SPRIGGS**

1. How did you rank Myrtle in housework? Why?
2. How did you rank Myrtle in laundry? Why?
3. How did you rank Myrtle in meal preparation and cleanup? Why?
4. How did you rank Myrtle in mobility inside? Why?
5. How did you rank Myrtle in bathing? Why?
6. How did you rank Myrtle in judgment? Why?
7. Where did you agree with your peers? Where did you disagree?

# CASE STUDY – JEWEL BROWN

## ASSESSMENT WORKSHEET

While viewing the video, focus your attention on the following functions:

SCALES: \_\_\_\_\_

Laundry

Meal Preparation & Cleanup

Dressing

Transfer

Eating

Memory

Orientation

H LINE

	Laundry	Meal Prep & Cleanup	Dressing	Transfer	Eating	Memory	Orientation
Self							
Group							
Consensus							
Score							

**REVIEW OF RELEVANT ASSESSMENT  
STANDARDS AND CRITERIA  
JEWEL BROWN**

**NOTES**

**Visual Observations: Environment, Actions and Responses**

Jewel meets us at the door with a walker. Her movements are slow and deliberate. She leads us into the house, which is a bit dusty, but tidy. Even though we see her tire easily, she keeps up with some light household chores. She has folded some dry laundry, and wet clothes are in the washer. Her kitchen is organized, with items put away in cupboards, refrigerator and on the counter.

Cooking must be handled by another person. Jewel reports a history of catching the kitchen on fire. This, her dependence on her walker, and her inability to release her grasp from the walker make her unable to take food out of the refrigerator or prepare snacks.

Jewel has good days and bad days. Functional ranking is based on her functioning on her bad days. Her medical condition makes Jewel unsafe, unless assisted with lifting and bending. Wet clothes are in the washer, because their weight is too great for her to lift. After chemotherapy and radiation treatments, she cannot lift, carry or walk outside, so shopping is limited. Because of weakness and infrequent blackouts, Jewel must be assisted getting into and out of the bathtub. When she gets into the tub to take a shower, she hangs onto the towel rack and never lets go. The towel rack is not a grab bar. That may compromise her safety. She could benefit from a shower bench. (She does report being able to bathe herself, giving herself “canary baths” without difficulty.) On her bad days, she needs a boost, but no more, to get in and out of chairs. We see her struggling to get out of a chair today.

In spite of these limitations, Jewel demonstrates her continuing ability to provide self care. Not only is she relatively independent for bathing, except for transfer, she’s also clean and well-groomed. Her face, teeth and clothing are clean today.

Her eating is affected by her reaction to chemotherapy and radiation treatments. And as a diabetic, Jewel must eat balanced meals at regular intervals. Yet, she often skips meals if she doesn’t feel like eating, especially after treatment. Skipping meals as a diabetic puts her at risk, although she needs no physical assistance to eat.

In mental function, Jewel shows some impairment in memory, such as forgetting her home address. The most important part of her memory problems, however, is that taking her medication slips her mind. Her orientation and judgment are realistic. She shows good judgment by limiting her activities as recommended by her doctor.

**Discriminating between Medically Diagnosed Conditions and Functional Limitations**

Jewel's several medical conditions limit her physical strength, stamina and range of motion. She is being treated for terminal bone cancer, diabetes and arthritis. She is also legally blind.

Her functioning is most impaired immediately following chemotherapy and radiation treatments for bone cancer. This is the level of ability at which she should be assessed. In several functional areas, she needs much more human assistance on days following treatment, than at any other time. For example, she can pull herself out of a chair on "good" days, whereas on "bad" days, she requires a boost.

**Discriminating between Value Judgment and Professional Assessment**

Assessing this consumer's need is an occasion for laying aside our own responses to her attitude. We might find Jewel admirable in her tenacity, particularly if we visited her on a good day. But to ensure an assessment in Uniformity to statewide standards, we must review the consumer's case in light of her functioning on her bad days.

**DISCUSSION GUIDE  
JEWEL BROWN**

1. How did you rank Jewel in laundry? Why?
2. How did you rank Jewel in meal preparation and cleanup? Why?
3. How did you rank Jewel in dressing? Why?
4. How did you rank Jewel in transfer? Why?
5. How did you rank Jewel in eating? Why?
6. How did you rank Jewel in memory? In orientation? Why?
7. Where did you agree with your peers? Where did you disagree?

# CASE STUDY – MARGARET IDELL

## ASSESSMENT WORKSHEET

While viewing the video, focus your attention on the following functions:

SCALES: \_\_\_\_\_

Mobility

Bathing & Grooming

Dressing

Bowel, Bladder & Menstrual

Transfer

Eating

H LINE

					Mobility Inside	Bathing & Grooming	Dressing	Bowel, Bladder & Menstrual	Transfer	Eating				
Self														
Group Consensus Score														

**REVIEW OF RELEVANT ASSESSMENT  
STANDARDS AND CRITERIA  
MARGARET IDELL**

**NOTES**

**Visual Observations: Environment, Actions and Responses**

Margaret's functioning is so limited as to be quite noticeable upon meeting her for the first time, but these limitations are due to more than her confinement in a wheelchair. In fact, she puts great effort into managing the wheelchair, using it to increase her mobility and independence. It's not that she has a problem moving around the home. In fact, she is quite independent in this regard, moving at will, however slowly, to attend to her personal needs as she can. But moving the wheelchair is made more difficult because her shoulders and arms are stiff with arthritis and partially paralyzed, so she moves with her one good arm and foot (her left side).

Margaret's confinement to the wheelchair and her difficulty grasping affect her ability to perform any housework other than light tasks and the preparation of light snacks and sandwiches.

She is able to dress herself, putting on and removing her house dress, and brace and shoes fastened with Velcro, without assistance.

Walking through the apartment, we can see the ways in which Margaret has learned to compensate for her difficulties in mobility and transferring. Note the position of her wheelchair in relation to the chair when she describes the transfer process. That is an accurate portrayal of her transfers in the bathroom because the wheelchair can only fit with the right side closer to the toilet. It would be a much safer transfer position if the wheelchair could approach from the other direction. The bedroom door jamb has been removed to accommodate Margaret's wheelchair. The toilet seat is raised to allow easier access from the wheelchair, and she has a bedside commode.

Since her fall five months ago when she broke her hip, Margaret has worn diapers to bed. She is afraid now of falling again, if she gets up in the night without help. Besides occasional help on and off the toilet, Margaret can care for herself by wiping and adjusting her clothing.

Although she is depressed, she has a good appetite and eats regularly. Margaret also has sufficient manual dexterity, in spite of her paralysis, to feed herself without assistance.

**Consumer Safety**

Margaret does a lot more than she can do safely. For example, during transfer, she is nearly independent and can transfer unassisted with difficulty, but needs assistance to transfer safely. Margaret is at risk during transfer and while engaged in other self-care and household care activities.

**DISCUSSION GUIDE  
MARGARET IDELL**

1. How did you rank Margaret in mobility? Why?
2. How did you rank Margaret in bathing and grooming? Why?
3. How did you rank Margaret in dressing? Why?
4. How did you rank Margaret in bowel, bladder & menstrual? Why?
5. How did you rank Margaret in transfer? Why?
6. How did you rank Margaret in eating? Why?
7. Where did you agree with your peers? Where did you disagree?



**CASE STUDY – MAY IDELL**

**ASSESSMENT WORKSHEET**

While viewing the video, focus your attention on the following functions:

SCALES: \_\_\_\_\_

Mobility Inside

Bathing & Grooming

Dressing

Eating

Respiration

**H LINE**

					Mobility Inside	Bathing & Grooming	Dressing			Eating	Respiration			
Self														
Group Consensus Score														

**REVIEW OF RELEVANT ASSESSMENT  
STANDARDS AND CRITERIA  
MAY IDELL**

**NOTES**

**Visual Observations: Environment, Actions and Responses**

Like her sister Margaret, May is quite safely mobile, being fully ambulatory and needing no reminding to step over or around her oxygen hose. She can walk safely to any room in the house that the hose can reach. However, the length of the hose only allows her to reach part of the living room and her own bedroom and bathroom. Because of this limitation and her extreme fatigue, May cannot perform any household chores.

May can contribute to her own personal hygiene, but is unable to meet total hygiene needs because she tires so easily. For example, she cannot complete a shampoo by herself. Her bed baths are incomplete and results in overexertion. She can brush her own teeth and move her body for another person to bathe her.

May can also dress relatively independently and shows common sense about her selection of clothing for the weather and the situation. She states that she sleeps in the nude to avoid overexertion. She also needs help with her shoes and socks since she can't reach her feet.

May is depressed, with an air of dejection and hopelessness. She replies politely, but does not show any eagerness about our visit and never makes eye contact. Her mood appears to affect her eating as well, since she is inclined to skip meals if she's not encouraged to eat. She and her sister have experienced recent, significant weight loss.

**Discriminating between Medically Diagnosed Conditions and Functional Limitations**

May's medical condition includes a very debilitating case of COPD (emphysema), which causes her to be severely fatigued. Because of the fatigue, she can only perform those tasks that are quick and simple. Any tasks that require repetitious movement, prolonged standing or any lifting are too tiring.

We see that May is unable to care for her oxygen unit independently. She is not strong enough to clean it or carry water to refill it. While the medical condition has necessitated the oxygen dependency, May's functional limitations keep her from caring for the unit.

We can observe the effect of her depressed attitude on her ability to care for herself. Her despondency causes her to choose not to use a portable oxygen unit, thus severely restricting her movement within her home.

**The Effect of Shared Housing on Assessment**

The two sisters' functioning must be evaluated independently of each other because the IHSS Program requires an individual assessment of need.

**DISCUSSION GUIDE  
MAY IDELL**

1. How did you rank May in mobility inside? Why?
2. How did you rank May in bathing and grooming? Why?
3. How did you rank May in dressing? Why?
4. How did you rank May in eating? Why?
5. How did you rank May in respiration? Why?
6. Where did you agree with your peers? Where did you disagree?

## CASE STUDY – GEORGE DAVIS

### ASSESSMENT WORKSHEET

While viewing the video, focus your attention on the following functions:

SCALES: \_\_\_\_\_

Housework

Shopping & Errands

Meal Preparation & Cleanup

Memory

Orientation

Judgment

H LINE

	Housework	Shopping & Errands	Meal Prep & Cleanup								Memory	Orientation	Judgement
Self													
Group													
Consensus													
Score													

**REVIEW OF RELEVANT ASSESSMENT  
STANDARDS AND CRITERIA  
GEORGE DAVIS**

**NOTES**

**Visual Observations: Environment, Actions and Responses**

George's apartment is cluttered and dirty. Unlike many hoarders who keep papers, George collects old equipment like fans, lamps and bikes. Walkways are blocked which doesn't seem to affect George's ability to maneuver around the apartment because he is agile on his feet. He lives in a second floor apartment building and has no difficulty carrying his bike up and down the stairs.

Clutter also includes macaroni and cheese caked on a plate that he says has been in the living room next to his chair for a couple of weeks. The sink is overflowing with dishes that also have food caked on them as does a pot on the stove. Though we don't see any, it's probable that he has rodents and cockroaches in his apartment.

George was referred to IHSS by his landlord because he is at risk of eviction because the landlord believes the apartment is a health hazard. Until pressed, George denies need. George seems comfortable entertaining visitors and with the condition of his apartment, since he willingly shows us through the apartment and makes no apology for the conditions.

George's clothes are clean and appear to have been pressed. He was not dirty, though his teeth were in bad shape. George indicates that he attends to his own personal hygiene.

A pivotal question in this case is whether George is making lifestyle choices that we might not agree with or if an impairment is affecting his ability to function safely. George seems to be physically unimpaired. The information available indicates that he had a lobotomy some time ago. Lobotomies were performed on people with mental illnesses to control aggressive, violent behavior. Though he does not seem aggressive during the interview, there are a few clues that he continues to have mental impairments that affect his functioning. He says that the barber in town won't shave him anymore. Further probing might give us information about his mental functioning. His interaction with the social worker during the interview was personable but joking, sometimes inappropriately. For example, he went to the kitchen to get the social worker something to drink. He came back with a bottle of Coke which was almost empty.

George claims to eat 3 or 4 meals a day. When the social worker goes to the kitchen, we see that his coffee pot is on, but his refrigerator is almost empty. That may be because it is the day before pay day. We wouldn't expect to see fruits or vegetables in the refrigerator because George says that he doesn't eat them. However, it's hard to tell what he will eat the rest of the day.

There were some hot dogs in the refrigerator and an open loaf of bread on the counter. From the video, we do not know how long the hot dogs have been in the refrigerator, but it is likely what he will eat the rest of the day. The landlord didn't complain that George isn't paying his rent, but he may have difficulty managing his money. Until pressed, George denies a need, but his behavior affects his safety and he seems unable to consider the consequences of his actions.

### **Consequences and Personal Choices: The Role of Consumer Judgment**

George is faced with eviction if he does not clean up his apartment. The question from the IHSS perspective is not only whether George has the physical capacity to perform necessary tasks, but also whether George's judgment affects his ability to care for himself. It is clear that George's behavior based on his mental health status creates a need for IHSS.

### **Discriminating between Value Judgment and Professional Assessment**

Uniformity means IHSS workers all ask similar questions in an assessment interview, gather the same information based on observations, and assess the information according to the same assessment standards. Many workers will have different personal opinions about the conditions and responses observed during the interview. Uniformity is a matter of applying professional standards, recognizing that these standards may be different from our personal opinions. In George's case, his safety is at risk because of his way of living. His clutter and stale food are a health hazard to himself and others in his apartment complex. He is not able to consider the consequences of his actions or alternatives to pursue.

## **DISCUSSION GUIDE GEORGE DAVIS**

1. How did you rank George in housework? Why?
2. How did you rank George in shopping and errands? Why?
3. How did you rank George in meal preparation and cleanup? Why?
4. How did you rank George in memory? Why?
5. How did you rank George in orientation? Why?
6. How did you rank George in judgment? Why?
7. Where did you agree with your peers? Where did you disagree?



## Joe

Joe is a 19-year-old male, living in a house with his parents, Nola and Jim, and his siblings, Kathy (age 11), and Billy (age 10). Joe was diagnosed with Schizophrenia at age 16. Joe has never gotten a drivers license. He states that he is afraid of strangers, believes people are following him, and afraid to go anywhere without at least one of his parents. According to his mother, Joe will not take his medications without direct and persistent encouragement because he believes that someone is trying to kill him through the medications. She expressed frustration that it seems to take her longer and longer to get him to take his medication.

Nola states that Joe would not eat if she did not make him eat three meals a day. She also states that Joe does not go near the stove because he believes there are transmitters hidden in the stove which are trying to take over his mind. Joe requires other family members to eat a few bites of their food before he eats his. When asked during the home visit about his ability to assist his family when they are cleaning up after meals, Joe stated “that is woman’s work.” His mother states that Joe refuses to help clean up after meals for this reason. Joe does, however, enjoy doing laundry, and is always willing to assist his mother with the family’s laundry. His mother complained that she has a difficult time getting Joe to clean his room and sometimes it takes her several days to get him to make his bed.

Joe’s mother states great frustration with Joe’s ongoing refusal to bathe or to change his clothing. She further states that she must be in the room with him when he bathes and dresses, because without constant reminding and supervision, he would just get in the shower, barely wet his hair, put back on the same clothing, and be done. She also says Joe has obsessive thoughts about his teeth (brushing them 4-6 times during the day) and that she does not trust him to shave without close supervision.

According to Joe’s father, Jim, on at least two separate occasions, Joe tried to harm his brother when the two were home without parental supervision because his brother took one of Joe’s Pokémon cards. The father further stated that Joe recently killed the family cat. His mother finally had to leave her job to provide 24-hour care to Joe because of his behavior.

Joe’s parents request Domestic and Related Services and Personal Care as well as Protective Supervision because they are afraid that leaving him alone with his siblings will result in physical harm to them.



## **Mother (Nola)**

Nola is a 45-year-old woman who has left her job of 5 years to care for her son. Her husband Jim is a truck driver and gone from the home more than he is there. Nola had an older brother who had been diagnosed with Schizophrenia and killed himself at age 21. She has always blamed her mother for not staying home with him. Until Joe was 16 years old, Nola had been very active in her other children's lives. Recently, Joe's siblings have begun to resent him because their mother has less time to spend with them. Nola feels guilty that she is not making it to their school activities. In addition, their friends have stopped coming over to the house because Joe is sometimes aggressive towards them. Nola does not know what to do, and believes one of the reasons Jim is on the road so much is so that he does not have to deal with Joe's behavior.

## **Father (Jim)**

Jim is a 47-year-old man. He is a truck driver and gone from the home more than he is there. He is frustrated by his son's behavior because he is unable to control it. He is also worried about his family's safety while he is on the road. Jim states that on at least two separate occasions when his sons were home without parental supervision, Joe tried to harm Billy for taking one of his Pokémon cards. The father further stated that Joe recently killed the family cat.

## **Doctors**

Joe has two doctors: his medical doctor and his psychiatrist. Joe's medical doctor has completed a medical evaluation form for Joe, stating he is not at risk of placement, that he is physically able to provide all personal care, and assist with domestic and related services. His diagnosis is Schizophrenia.

Joe's psychiatrist completed the medical evaluation form stating that Joe is able to do light housekeeping, but is at risk of placement and needs personal care services. He also stated, "Patient's schizophrenia compromises his ability to perform complex tasks, or to plan. He can, however, perform simple tasks and follow sequential instructions, especially when properly supervised. Patient requires 24-hour protective supervision because he frequently refuses to take medications and could become violent towards others."



## Schizophrenia – an overview

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### What is schizophrenia?

Schizophrenia is a chronic, severe, and disabling brain disorder. It affects about 1 percent of Americans.

People with schizophrenia may hear voices other people don't hear or they may believe that others are reading their minds, controlling their thoughts, or plotting to harm them. These experiences are terrifying and can cause fearfulness, withdrawal, or extreme agitation. People with schizophrenia may not make sense when they talk, may sit for hours without moving or talking much, or may seem perfectly fine until they talk about what they are really thinking. Because many people with schizophrenia have difficulty holding a job or caring for themselves, the burden on their families and society is significant as well.

### What are the symptoms of schizophrenia?

The symptoms of schizophrenia fall into three broad categories:

- **Positive symptoms** are unusual thoughts or perceptions, including hallucinations, delusions, thought disorder, and disorders of movement.
- **Negative symptoms** represent a loss or a decrease in the ability to initiate plans, speak, express emotion, or find pleasure in everyday life. These symptoms are harder to recognize as part of the disorder and can be mistaken for laziness or depression.
- **Cognitive symptoms** (or cognitive deficits) are problems with attention, certain types of memory, and the executive functions that allow us to plan and organize. Cognitive deficits can also be difficult to recognize as part of the disorder but are the most disabling in terms of leading a normal life.

### When does it start and who gets it?

Psychotic symptoms (such as hallucinations and delusions) usually emerge in men in their late teens and early 20s and in women in their mid-20s to early 30s. They seldom occur after age 45 and only rarely before puberty, although cases of schizophrenia in children as young as 5 have been reported. In adolescents, the first signs can include a change of friends, a drop in grades, sleep problems, and irritability. Because many normal adolescents exhibit these behaviors as well, a diagnosis can be difficult to make at this stage. In young people who go on to develop the disease, this is called the "prodromal" period.



Research has shown that schizophrenia affects men and women equally and occurs at similar rates in all ethnic groups around the world.

## **Are people with schizophrenia violent?**

People with schizophrenia are not especially prone to violence and often prefer to be left alone. Studies show that if people have no record of criminal violence before they develop schizophrenia and are not substance abusers, they are unlikely to commit crimes after they become ill. Most violent crimes are not committed by people with schizophrenia, and most people with schizophrenia do not commit violent crimes. Substance abuse always increases violent behavior, regardless of the presence of schizophrenia (see sidebar). If someone with paranoid schizophrenia becomes violent, the violence is most often directed at family members and takes place at home.

## **What about suicide?**

People with schizophrenia attempt suicide much more often than people in the general population. About 10 percent (especially young adult males) succeed. It is hard to predict which people with schizophrenia are prone to suicide, so if someone talks about or tries to commit suicide, professional help should be sought right away.

## **How is schizophrenia treated?**

Because the causes of schizophrenia are still unknown, current treatments focus on eliminating the symptoms of the disease.

### Antipsychotic medications

Antipsychotic medications have been available since the mid-1950s. They effectively alleviate the positive symptoms of schizophrenia. While these drugs have greatly improved the lives of many patients, they do not cure schizophrenia.

Everyone responds differently to antipsychotic medication. Sometimes several different drugs must be tried before the right one is found. People with schizophrenia should work in partnership with their doctors to find the medications that control their symptoms best with the fewest side effects.



# IN-HOME SUPPORTIVE SERVICES PROGRAM

## Background

The In-Home Supportive Services (IHSS) Program provides services to approximately 445,000 low-income aged, blind and disabled consumers with over 414,000 providers that allow them to remain safely in their homes as an alternative to out-of-home institutional care. Services include domestic services, non-medical personal care services, paramedical services, assistance with traveling to medical appointments, teaching and demonstration directed at reducing the need for support, and other assistance.

## History

In the 1950s, California established the Attendant Care Program to enable elderly and disabled consumers who needed assistance to remain safely in their own homes. This program provided grants to consumers so they could contract with providers to provide various domestic services and was funded jointly by the counties, state, and federal government. This program has evolved over the years to assist the most vulnerable population in California. For example, in the 1970s, the Homemaker Chore Program (also known as the Chore Program) was added to the Attendant Care Program to provide personal care services. This addition also enabled those consumers who could not hire or supervise their own providers the opportunity to receive services through county employees or contract with an outside agency. California established the Homemaker Chore Program (now the IHSS Program) which was funded by State General Funds, limited federal funds, and county share-of-cost.

In the 1980s, the IHSS Program went through a tremendous amount of caseload growth which led to statutory monthly caps placed on service hours (283 severely impaired and 195 non-severely impaired). In addition, the California Department of Social Services (CDSS) enhanced a payroll system for individual providers to incorporate a management information feature which became known as the Case Management, Information, and Payrolling System (CMIPS). Counties were then able to access real-time consumer information, produce turn-around eligibility documents, and utilize the system to calculate a consumer's share-of-cost for services. Subsequently, legislation (Welfare and Institutions Code 12309) was enacted which required CDSS to develop and implement a standardized process to make authorization of supportive services equitable while at the same time continue to provide assessments that are individualized based on the needs of the consumer. Henceforth, the Uniformity System was implemented.

The 1990s also brought about changes to the IHSS Program. These changes included a state/local realignment which increased the county-share of funding; authorized CDSS to define the role of Public Authorities as the employer of record for collective bargaining; and established the Personal Care Services Program with 50 percent Medi-Cal funding while California maintained the IHSS Residual Program to fund services received by consumers ineligible for federal funding.

Many other changes came in the early 2000s. One significant change came about in 2004 when the CDSS enacted the IHSS/Quality Assurance (QA) Initiative as part of the Budget Trailer Bill Senate Bill 1104. The key features are ongoing social worker training, state/county QA monitoring, development of Hourly Task Guidelines with exceptions criteria, interagency collaboration to prevent/detect fraud and maximize overpayments recovery, and annual error-rate studies. In addition, the IHSS Plus Waiver Program became effective in August 2004 utilizing Medi-Cal funding primarily for services provided by parents and spouses. In August 2009, the IPW Program was replaced by the IHSS Plus Option (IPO) Program with no change in program eligibility requirements.



**CALIFORNIA DEPARTMENT OF SOCIAL SERVICES  
ADULT PROGRAMS POLICY & OPERATIONS BUREAU  
POLICY INTERPRETATION REQUEST**

**PHONE: (916) 651-5350**

**FAX: (916) 653-2220**

<b>COUNTY:</b>	<b>DATE:</b>
<b>NAME:</b>	<b>TITLE:</b>
<b>TELEPHONE:</b>	<b>EMAIL:</b>
<b>SUBJECT:</b>	
<b>QUESTION(S)</b>	
<b>RESPONSE</b>	
<i>This response is based on the particular facts and circumstances presented here, applicable to this case only, and is not intended to serve as a precedent for any other case. This response is not intended to apply generally or to constitute a declaration of the manner in which any class of cases shall be decided.</i>	
<b>ANALYST:</b>	<b>DATE:</b>
<b>MANAGEMENT APPROVAL:</b>	<b>DATE:</b>

**ATTACHMENTS:**





**Senate Bill No. 1104**

**CHAPTER 229**

An act to amend Section 8263 of, to add Section 8263.4 to, and to add Article 16.5 (commencing with Section 8385) to Chapter 2 of Part 6 of, the Education Code, to amend Section 11796 of the Government Code, to amend Sections 1522, 1523.1, 1523.2, 1568.05, 1569.185, 1596.803, 1596.816, 1596.871, 1596.872a, 1596.872b, and 11970.2 of, and to add Section 128241 to, the Health and Safety Code, to amend Section 273d of the Penal Code, to amend Section 1611.5 of the Unemployment Insurance Code, and to amend Sections 10531, 10532, 11320.1, 11322.8, 11322.9, 11325.21, 11325.22, 11325.23, 11325.7, 11326, 11403.1, 11403.3, 11453, 11454, 11454.5, 11454.6, 11462, 11462.06, 11466.21, 12201, 12300, 12301.1, 14132.95, 15204.2, 17021, 18939, and 19806 of, to amend and renumber Section 10553.2 of, to add Sections 9404, 11401.5, 11486.3, 12301.21, 12305.7, 12305.71, 12305.72, 12305.8, 12305.81, 12305.82, 12305.83, 12317, 12317.1, 12317.2, 14132.951, and 16521.3 to, to repeal and add Section 12301.2 of, and to repeal Chapter 2.4 (commencing with Section 16145) of Part 4 of Division 9 of, the Welfare and Institutions Code, relating to human services, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor August 16, 2004. Filed with  
Secretary of State August 16, 2004.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1104, Committee on Budget and Fiscal Review. Budget Act of 2004: human services.

(1) Existing law provides for a system of priority for state and federally subsidized child development services and provides that first priority is given to neglected or abused children, or children who are at risk of being neglected or abused.

This bill would provide that a family receiving child care services on the basis of a child being at risk of abuse is eligible to receive services for up to 3 months, unless the county child welfare agency certifies that child care services continue to be necessary, or the child is receiving child protection services, requires child care, and remains otherwise eligible for services, in which case the family may receive child care services for up to 12 months.

(2) The department, in consultation with the county welfare departments and the State Department of Health Services, shall determine, define, and issue instructions to the counties describing the roles and responsibilities of the department, the State Department of Health Services, and counties for resolving data match discrepancies requiring followup, defining the necessary actions that will be taken to resolve them, and the process for exchange of information pertaining to the findings and disposition of data match discrepancies.

(c) The department shall develop methods for verifying the receipt of supportive services by program recipients. In developing the specified methods the department shall obtain input from program stakeholders as provided in Section 12305.72. The department shall, in consultation with the county welfare departments, also determine, define, and issue instructions describing the roles and responsibilities of the department and the county welfare departments for evaluating and responding to identified problems and discrepancies.

(d) The department shall make available on its Internet Web site the regulations, all-county letters, approved forms, and training curricula developed and officially issued by the department to implement the items described in Section 12305.72. The department shall inform supportive services providers, recipients, and the general public about the availability of these items and of the Medi-Cal toll free fraud hotline and Web site for reporting suspected fraud or abuse in the provision or receipt of supportive services.

(e) The department shall, in consultation with counties and in accordance with Section 12305.72, develop a standardized curriculum, training materials, and work aids, and operate an ongoing, statewide training program on the supportive services uniformity system for county workers, managers, quality assurance staff, state hearing officers, and public authority or nonprofit consortium staff, to the extent a county operates a public authority or nonprofit consortium. The training shall be expanded to include variable assessment intervals, statewide hourly task guidelines, and use of the protective supervision medical certification form as the development of each of these components is completed. Training shall be scheduled and provided at sites throughout the state. The department may obtain a qualified vendor to assist in the development of the training and to conduct the training program. The design of the training program shall provide reasonable flexibility to allow counties to use their preferred training modalities to educate their supportive services staff in this subject matter.

(f) The department shall, in conjunction with the counties, develop protocols and procedures for monitoring county quality assurance programs. The monitoring may include onsite reviews of county quality

**DEPARTMENT OF SOCIAL SERVICES**

744 P Street, MS 19-96, Sacramento, CA 95814



September 30, 2004

ALL-COUNTY INFORMATION NOTICE NO. I-69-04

TO: ALL COUNTY WELFARE DIRECTORS  
ALL IHSS PROGRAM MANAGERS

Reason For This Transmittal

- State Law Change  
 Federal Law or Regulation Change  
 Court Order or Settlement Agreement  
 Clarification Requested by one or More Counties  
 Initiated by CDSS

**SUBJECT: IN-HOME SUPPORTIVE SERVICES/PERSONAL CARE SERVICES PROGRAM (IHSS/PCSP) QUALITY ASSURANCE (QA) AND PROGRAM INTEGRITY PROVISIONS OF THE FISCAL YEAR (FY) 2004/05 HEALTH AND HUMAN SERVICES' BUDGET TRAILER BILL SENATE BILL (SB) 1104**

This All-County Information Notice (ACIN) provides information regarding the In-Home Supportive Services/Personal Care Services Program (IHSS/PCSP) Quality Assurance (QA) and program integrity provisions of the Fiscal Year (FY) 2004/05 health and human services' budget trailer bill Senate Bill (SB) 1104.

**BACKGROUND**

The California Department of Social Services (CDSS) proposed an IHSS/PCSP QA Initiative as an element of the Governor's 2004/05 State Budget. The proposal outlined a number of enhanced activities to be performed by CDSS, the counties, and the California Department of Health Services (DHS) to improve the quality of IHSS/PCSP service need assessments, enhance program integrity, and detect and prevent program fraud and abuse. The proposal requested: (1) State and county staffing augmentations specifically for QA activities, (2) funding to establish an ongoing State training component for IHSS/PCSP workers, and (3) funding for specified systems changes tied to QA and program integrity improvements.

The CDSS QA proposal was adopted by the Administration. Funding for new State and county QA staff, the IHSS/PCSP training program, and systems changes was included in the FY 2004/05 Budget Act along with projected program savings expected as a result of the program improvements.

**Example of a Statute that has become Regulation**  
**From ACIN I -69-04 pages 5-7**

**3. WIC Section 12305.7**

**Summary:** Establishes requirements for State-level IHSS/PCSP QA and program integrity functions.

- Requires CDSS, in consultation with DHS and the counties, to design and conduct an annual IHSS/PCSP payment error rate study beginning in the 04/05 FY to provide baseline data for prioritizing and directing QA and program integrity efforts at the State and county levels.
- Requires CDSS and DHS to conduct automated data matches between IHSS/PCSP paid hours data and Medi-Cal claims payment data to identify potential service overlap, duplication, and third-party liability among other things.
  - Requires CDSS to work with the counties to determine, define, and issue instructions to the counties describing the roles and responsibilities of the CDSS, the DHS, and the counties for resolving data match discrepancies requiring follow-up, defining the necessary actions that will be taken to resolve them, and the process for exchange of information pertaining to the findings and disposition of data match discrepancies.
- Requires CDSS to develop methods for verifying recipient receipt of services and work with the counties to determine, define, and issue instructions describing the roles and responsibilities of the Department and the county welfare departments for evaluating and responding to identified problems and discrepancies.
  - Requires CDSS to get input from counties and other stakeholders when developing the methods for verifying recipient receipt of services.
- Requires CDSS to make available on its website specified information regarding IHSS/PCSP including IHSS/PCSP QA and program integrity regulations, ACLs, program forms, IHSS/PCSP training and materials developed to implement the Trailer Bill's IHSS/PCSP program QA and program integrity provisions. Requires CDSS to notify program stakeholders of the availability of the information on the CDSS website.
- Requires CDSS to notify IHSS/PCSP providers, recipients, and the general public about the toll-free Medi-Cal hotline and website for reporting suspected fraud and abuse.
- Requires CDSS to work in consultation with the counties to develop a statewide training program for county IHSS/PCSP workers, managers, QA staff, State hearing officers, and Public Authority or Non-Profit Consortium

**Example of a Statute that has become Regulation**  
**From ACIN I -69-04 pages 5-7**

staff on the IHSS/PCSP Uniformity System and other elements of IHSS/PCSP QA and program integrity as they are developed. Requires CDSS to obtain input from program stakeholders while developing the training. Specifically:

- Authorizes CDSS to obtain a contractor to assist in developing and to conduct the training.
- Requires that the design of the training afford reasonable flexibility to counties to use their preferred modalities arranging the training.
- Requires CDSS to monitor county IHSS/PCSP QA programs. This may include on-site visits.
  - Requires CDSS to work with the counties to develop protocols and procedures for monitoring county QA programs and protocols and procedures under which the Department will report its monitoring findings to a county, disagreements over the findings will be resolved, to the extent possible, and the county, DHS and CDSS will follow-up on the findings.
- Requires CDSS to conduct a review of IHSS/PCSP regulations in effect on the date of enactment of this section and revise the regulations as necessary to conform to the changes in statute that have occurred since the regulations were initially promulgated and to conform to federally authorized program changes, such as the federal waiver.

**4. WIC Section 12305.71**

**Summary:** Requires each county to establish a dedicated, specialized IHSS/PCSP QA function or unit and specifies activities the function is to perform.

- Requires the counties to perform routine, scheduled reviews of supportive services cases to ensure that caseworkers appropriately apply the IHSS/PCSP uniformity system and other IHSS/PCSP rules and policies for assessing recipients' need for services to the end that there are accurate assessments of needs and hours. Authorizes counties to consult with State QA staff for technical assistance.
- Requires CDSS and the counties to develop policies, procedures, implementation timelines, and instructions under which the county QA function will perform the following specified QA activities:
  - Receive, resolve, and respond appropriately to claims data matches discrepancies or other State-level QA and program integrity information that indicates potential overpayments to providers or recipients or third party liability for supportive services.

**Example of a Statute that has become Regulation**  
**From ACIN I -69-04 pages 5-7**

- Implement procedures to identify potential sources of third party liability for IHSS/PCSP services.
- Monitor the delivery of supportive services in the county to detect and prevent potential fraud by providers, recipients, and others and maximize the recovery of overpayments from providers or recipients.
- Inform IHSS/PCSP providers and recipients and the general public that suspected fraud in the provision or receipt of supportive services can be reported using of the toll-free Medi-Cal fraud hotline and website.
- Requires each county to develop a schedule beginning with July 1, 2005, under which county QA staff will periodically perform targeted IHSS/PCSP QA studies.
- Provides that, in accordance with protocols developed by the CDSS and county welfare departments, county QA staff will conduct joint case review activities with State QA staff, including random post-payment paid claims reviews to ensure that payments to providers were valid and were associated with existing program recipients; identify, refer to, and work with appropriate agencies in investigation, administrative action, or prosecution of instances of fraud in the provision of supportive services.
  - Requires that protocols take into account the relative priority of the activities required of county IHSS/PCSP QA functions and available resources.



## IHSS ELIGIBILITY

### Financial

- Receives SSI/SSP (called Status Eligible)
  - Potentially eligible for all IHSS programs without a share of cost.
  - Social Security Administration (SSA) determines eligibility and issues monthly checks (sometimes called gold checks to differentiate from the green checks Social Security Administration issues without a means test to people who paid into the Social Security system while they worked).
  - Aged (over 65 years old), or Blind, or Disabled (unable to work because of an impairment that is expected to last at least a year or end in death earlier). This determination is done by CDSS Disability and Evaluation Division staff who evaluates medical information and the person's work history. [A person could, for example, have a spinal cord injury but considered not to be disabled if his/her employment prior to the accident was a desk job. On the other hand, that same person would be considered disabled if his/her only work history was as a truck driver and that person had no other marketable skills.]
  - Low income – The SSA evaluates net nonexempt monthly income within the following:

Category	2012 Total Monthly Payment		
	Aged	Disabled	Blind
<i>Single people</i> Independent living status	\$854.40	\$854.40	\$909.40
<i>Aged person and disabled spouse</i> Independent living status	\$1,444.20		
<i>Blind couples</i> Independent living status			\$1,591.20
<i>Blind person with an aged or disabled spouse</i> Independent living status			\$1,535.20

- Countable Resources under \$2,000 for an individual or \$3,000 for a couple. Resources are things like savings, checking, stocks, and bonds. A home where the client lives is not counted as a resource.
- Is a U.S. citizen or a legal immigrant with certain other requirements.
- A resident of California.
- Does not receive SSI/SSP but received unrestricted Medi-Cal (called Income Eligible)
  - County Medi-Cal Eligibility Workers evaluate income, resources and other criteria to determine eligibility.
  - An Aid Code chart is provided to determine which Medi-Cal beneficiaries have unrestricted Medi-Cal and other conditions must be met to qualify for the various IHSS programs.
  - Recipients may or may not have a Share of Cost. If there is a Share of Cost, that must be obligated before the IHSS service provider can be paid. The Share of Cost is obligated either to a health care provider such as a doctor or a pharmacy or to the IHSS provider whose net pay check will be reduced by the amount of the unpaid Share of Cost.



## **Threshold of Need**

- MPP §30-700.1 states, “The In-Home Supportive Services (IHSS) Program provides assistance to those eligible aged, blind and disabled individuals who are unable to remain safely in their own homes without this assistance. IHSS is an alternative to out-of-home care.”
- People who are not at risk without the provision of paid or unpaid assistance from another are not eligible for IHSS.

## **Own Home**

- To qualify for IHSS, the person must be living in his/her “own home.”
  - MPP §30-701(o)(2) defines own home as, “...the place in which the individual chooses to reside. An individual’s “own home” does not include an acute care hospital, skilled nursing facility, intermediate care facility, or a board and care facility. A person receiving an SSI/SSP payment for a nonmedical out-of-home living arrangement is not considered to be living in his/her home.
  - A person can be living with family members and still be living in his/her “own home.”
  - A person living in a homeless shelter is living in his/her “own home,” but that specific IHSS which are provided by the shelter (such as meal preparation) cannot also be authorized.

## **IHSS Programs**

- *PCSP* – For Status Eligible or Income Eligible people who are not disqualified from the Program because of one of the conditions listed in IPO or Residual.
- *IHSS Plus Option (IPO)* – For individuals who are Full Scope FFP Medi-Cal, and have their services provided by a Spouse or Parent of a minor child, or are receiving Restaurant Meal Allowance or Advance Pay.
- *Residual* – Not Full Scope Medi-Cal but meets the eligibility requirements found in MPP §30-755.
  - This is unusual.
  - The consumer’s Share of Cost is the difference between the SSI/SSP payment level and the consumer’s net nonexempt income.
  - The cost of care is more expensive to the state and county because there is no federal funding for the care.

## IHSS PROGRAM CATEGORIES

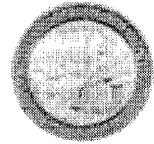
Program Title	Characteristics	Payment Source
<b>IHSS Plus Option (IPO)</b>	<p>Covers consumers who are eligible for Full Scope Federal Financial Participation (FFP) Medi-Cal, but not eligible for Personal Care Services (PCSP) due to one or more of the following:</p> <ul style="list-style-type: none"> <li>• Consumer has a spouse for a provider; <b>or</b></li> <li>• Consumer is a minor child with a parent for a provider; <b>or</b></li> <li>• Consumer receives Advance Pay; <b>or</b></li> <li>• Consumer receives Restaurant Meal Allowance.</li> </ul>	<p>Federal, State and County</p> <p><b>Note:</b> IPO services are eligible for FFP as a Section 1915(j) State Plan Option.</p>
<b>Personal Care Services Program (PCSP)</b>	<p>Covers consumers who are eligible for Full Scope FFP Medi-Cal. Services include: Domestic and Related Services, Personal Care Services, and Protective Supervision.</p> <p><b>Note:</b> If one of the four IPO conditions listed above exists, the case would be an IPO case rather than PCSP. If the consumer is not eligible for FFP Medi-Cal, the consumer would be in the Residual Program.</p>	<p>Federal, State, and County</p> <p><b>Note:</b> Cases with Protective Supervision and cases with only Domestic and Related Services were added to the PCSP Program in 2004.</p>
<b>Residual Program</b>	<p>Covers consumers who are not eligible for Full Scope FFP Medi-Cal and who meet the IHSS eligibility criteria (MPP 30-755).</p>	<p>State and County</p>





JOHN A. WAGNER  
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY  
**DEPARTMENT OF SOCIAL SERVICES**  
744 P Street • Sacramento, CA 95814 • www.cdss.ca.gov



ARNOLD SCHWARZENEGGER  
GOVERNOR

April 21, 2010

ALL-COUNTY INFORMATION NOTICE: I-33-10

TO: ALL COUNTY WELFARE DIRECTORS  
ALL COUNTY IHSS PROGRAM MANAGERS

SUBJECT: EXPIRATION OF THE IN-HOME SUPPORTIVE SERVICES (IHSS)  
PLUS WAIVER AND APPROVAL OF AN STATE PLAN OPTION

REFERENCE: Welfare and Institutions Code (WIC) 14132.952

This is to inform counties that the US Department of Health Care Services, Centers for Medicare and Medicaid Services (CMS) approved a Social Security Act § 1915(j) Self-Directed Personal Assistance Services State Plan Option program for California. This program is known as the IHSS Plus Option (IPO) and became effective October 1, 2009. This All-County Information Notice conveys information regarding the transition of the IHSS Plus Waiver (IPW) population to the IPO.

**Background**

In 2004, California implemented a Social Security Act § 1115 Demonstration Waiver, the IPW program. This Waiver allowed California to move almost all of the IHSS-Residual recipients into either the IPW or Personal Care Services Program, and receive Federal Financial Participation (FFP) for services to these recipients. The IPW was limited to five years with a possibility of renewal; however, during that time, CMS initiated new options to allow recipients in the IPW to be served in a State Plan Option program. The new IPO program continues federal funding for the IPW population.

The following provides counties with information on the transition of the IPW population to the IPO:

- The IPW population was moved into the new IPO program on October 1, 2009.
- The Medi-Cal secondary aid code for this population will continue to be 2L.
- IPW and IPO program expenditures will be differentiated in the CMIPS Legacy system based upon service date (i.e. service dates through September 30, 2009 are IPW expenditures, and Oct. 1, 2009 forward is IPO).
- The program criteria will continue to be the same as for the IPW:

<u>REASON FOR THIS TRANSMITTAL</u>
<input checked="" type="checkbox"/> State Law Change
<input type="checkbox"/> Federal Law or Regulation Change
<input type="checkbox"/> Court Order
<input type="checkbox"/> Clarification Requested by One or More Counties
<input type="checkbox"/> Initiated by CDSS

ACIN No: I-33-10  
Page Two

- Individuals who are full scope FFP Medi-Cal, and have their services provided by a spouse, or parent of a minor child; or are receiving Restaurant Meal Allowance or Advance Pay.

Additional information on the IPO program will follow. If you have questions regarding any of this information, please call the Waiver and Policy Development Unit at (916) 229-4000 or send an email to [APBpolicy@dss.ca.gov](mailto:APBpolicy@dss.ca.gov).

Sincerely,

***Original Document Signed By:***

EVA L. LOPEZ  
Deputy Director  
Adult Programs Division

## MEDI-CAL AID CODES

This Medi-Cal Aid Codes Master Chart describes the meaning of each Aid Code, the type of coverage (full or restricted), whether the beneficiary qualifies financially for PCSP or IPO, and whether the person has a Share of Cost (SOC). Beneficiaries have one primary Aid Code but also may have a secondary Aid Code. A single Aid Code qualifies a person for PCSP or IPO; all Aid Codes need not be qualifying. **To determine which cases have more than one aid code, check all eligibility screens. (QM, Q1, Q2 etc.)**

The first 2 digits of the Medi-Cal case number designate the beneficiary's county of residence. The next 2 are the Aid Code. The Aid Code is followed by a serial number assigned to the case (most often, the serial number will be shared by husband and wife and other family members). Following the serial number is the Medi-Cal Family Budget Unit number (MFBU); each person sharing the serial number is assigned an FBU number. The most reliable source to verify the Medi-Cal case number is MEDS, an online computer system.

Financial eligibility for PCSP/IPO is determined by either the Social Security Administration (SSA) for people who qualify for SSI/SSP or the county Medi-Cal worker. If a person receives SSI/SSP and meets all other eligibility criteria, s/he is *Status Eligible*. People who do not receive SSI/SSP but get full Federal Financial Participation (FFP) Medi-Cal with a qualifying Aid Code and meet all other eligibility criteria are *Income Eligible*. All of the Full Scope Medi-Cal Aid Codes, except 10, 20, or 60, may be FFP or non-FFP. Counties should rely on the CMIPS-MEDS interface to make that determination. Those who are eligible to state only Medi-cal programs are part of the IHSS-R program.

To qualify for PCSP or IPO, the person must have federally funded Full Scope Medi-Cal, must not have Long Term Care (LTC) coverage, and must have a functional impairment or disabling condition that is expected to last at least 12 months or end in death before that time. Some Aid Codes designate that the disabling condition has already been determined. In those circumstances, the PCSP/IPO column indicates "Yes." If the person's Medi-Cal is restricted, "No" has been entered in that column. If they have full Medi-Cal but disability may not yet be established, this column indicates ND Disability. If the person's Aid Code indicates that coverage is for LTC, "OHC" (Out of Home Care) is listed in the PCSP/IPO column; the person would not qualify for services because s/he is not living in his/her "own home." **Aid codes which designate (LTC) Long Term Care status or indicate out of home (OHC) placement often change mid-month. Check with your consumer, their family or the eligibility worker to determine if their status/residence has changed before terminating or denying IHSS. These aid codes have be marked with a double asterisk (\*\*) following the aide code.**

If a person has a Share of Cost (SOC), that means that his/her income is higher than the allowable to qualify for free Medi-Cal. The SOC must be obligated before payment of Medi-Cal services, including PCSP/IPO. If the consumer does not incur costs against the SOC before the PCSP/IPO timesheet is processed, the SOC is applied to the provider's timesheet, deducting the unmet SOC against the provider's gross pay. If the SOC has been obligated to other medical costs, the provider's pay will not be reduced. Medi-Cal payments (including PCSP/IPO) cannot be issued until the Share of Cost is met. For more information on SOC, refer to CMIPS Manual Page V-B-19 through V-B-25.

**Some codes are time limited and may either terminate eligibility or change eligibility status within the IHSS authorization year. Be sure to communicate with the eligibility worker.**

## MEDI-CAL AID CODES

Code	Benefits	PCSP/ IPO	SOC	Program/Description
0A	Full	Nd Disab	No	Refugee Cash Assistance (RCA). Covers all eligible refugees during their first eight months in the United States, including unaccompanied children who are not subject to the eight-month limitation. This population is the same as aid code 01, except that they are exempt from grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.
0C	HF services only (no Medi-Cal)	No	No	Access for Infants and Mothers (AIM) – Infants enrolled in Healthy Families (HF). Infants from a family with an income of 200 to 300 percent of the federal poverty level, born to a mother enrolled in AIM. The infant's enrollment in the HF program is based on their mother's participation in AIM.
0L	Restricted	No	No	<p>Breast and Cervical Cancer Treatment Program (BCCTP) Transitional Coverage Until the County Makes a Determination of Medi-Cal Eligibility. Covers:</p> <ul style="list-style-type: none"> <li>• BCCTP recipients formerly in aid code 0U, without satisfactory immigration status, who are no longer in need of treatment, and/or have creditable health coverage and are not eligible for state-funded BCCTP.</li> <li>• BCCTP recipients formerly in aid code 0V, without satisfactory immigration status, who have turned 65 years of age, have other health coverage, and/or are no longer in need of treatment and have exhausted their 18-month (breast cancer) or 24-month (cervical cancer) time limit.</li> <li>• BCCTP recipients formerly in aid code 0X with creditable health coverage who have exhausted their 18 months (breast cancer) or 24 months (cervical cancer) of state eligibility.</li> <li>• BCCTP recipients formerly in aid code 0Y, age 65 or older who have exhausted their 18 months (breast cancer) or 24 months (cervical cancer) of state eligibility.</li> </ul> <p>Recipients eligible only for transitional federal emergency, pregnancy-related and state-only Long Term Care (LTC) services.</p>
0M	Full	Nd Disab	No	BCCTP – Accelerated Enrollment (AE). Provides temporary AE for full-scope, no Share of Cost (SOC) Medi-Cal for eligible females younger than 65 years of age who have been diagnosed with breast and/or cervical cancer. Limited to two months.

## MEDI-CAL AID CODES

Code	Benefits	PCSP/ IPO	SOC	Program/Description
0N	Full	Nd Disab	No	BCCTP – AE. Provides temporary AE for full-scope, no SOC Medi-Cal while an eligibility determination is made for eligible females younger than 65 years of age without creditable health coverage who have been diagnosed with breast and/or cervical cancer.
0P	Full	Nd Disab	No	BCCTP. Provides full-scope, no SOC Medi-Cal for eligible females younger than 65 years of age who are diagnosed with breast and/or cervical cancer and are without creditable insurance coverage. They remain eligible while still in need of treatment and meet all other eligibility requirements.
0R	Restricted Services	No	No	BCCTP – High Cost Other Health Coverage (OHC). State-funded. Provides payment of premiums, co-payments, deductibles and coverage for non-covered cancer-related services for eligible all-age males and females, including undocumented aliens, who have been diagnosed with breast and/or cervical cancer, if premiums, co-payments and deductibles are greater than \$750. Breast cancer-related services covered for 18 months. Cervical cancer-related services covered for 24 months.
0T	Restricted Services	No	No	BCCTP – State-funded. Provides 18 months of breast cancer treatments and 24 months of cervical cancer treatments for eligible all-age males and females 65 years of age or older, regardless of citizenship, who have been diagnosed with breast and/or cervical cancer. Does not cover individuals with expensive, creditable insurance. Breast cancer-related services covered for 18 months. Cervical cancer-related services covered for 24 months.
0U	Restricted Services	No	No	BCCTP – Undocumented Aliens. Provides emergency, pregnancy-related and Long Term Care (LTC) services to females younger than 65 years of age with unsatisfactory immigration status who have been diagnosed with breast and/or cervical cancer. Does not cover individuals with creditable insurance. State-funded cancer treatment services are <b>covered for</b> 18 months (breast) and 24 months (cervical).  <i>Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).</i>



## MEDI-CAL AID CODES

Code	Benefits	PCSP/ IPO	SOC	Program/Description
0V	Restricted Services	No	No	<p>Post-BCCTP. Provides limited-scope no SOC Medi-Cal emergency, pregnancy-related and Long Term Care (LTC) services for females younger than 65 years of age with unsatisfactory immigration status and without creditable health insurance coverage who have exhausted their 18-month (breast) or 24-month (cervical) period of cancer treatment coverage under aid code 0U. No cancer treatment. Continues as long as the woman is in need of treatment and, other than immigration, meets all other eligibility requirements.</p> <p><i>Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).</i></p>
0W	Full	Nd Disab	No	<p>BCCTP Transitional Coverage. Covers recipients formerly in aid code 0P who no longer meet federal BCCTP requirements due to reaching age 65, are no longer in need of treatment for breast and/or cervical cancer, or have obtained creditable health coverage. Recipients in aid code 0W will continue to receive transitional full-scope Medi-Cal services until the county completes an eligibility determination for other Medi-Cal programs.</p>
0X	Restricted	No	No	<p>BCCTP Transitional Coverage. Covers recipients formerly in aid code 0U who do not have satisfactory immigration status, have obtained creditable health coverage, still require treatment for breast and/or cervical cancer and have not exhausted their 18 months (breast cancer) or 24 months (cervical cancer) of coverage under state-funded BCCTP. Recipients eligible only for transitional emergency, pregnancy-related and state-only LTC services, and co-pays, deductibles and/or non-covered breast and/or cervical cancer treatment and related services.</p>
0Y	Restricted	No	No	<p>BCCTP Transitional Coverage. Covers recipients formerly in aid code 0U who do not have satisfactory immigration status, have reached 65 years of age, still require treatment for breast and/or cervical cancer and have not exhausted their 18 months (breast cancer) or 24 months (cervical cancer) state-funded BCCTP. Recipients eligible only for transitional emergency, pregnancy-related and state-only LTC services, and state-funded cancer treatment and related services.</p>

## MEDI-CAL AID CODES

Code	Benefits	PCSP/ IPO	SOC	Program/Description
01	Full	Nd Disab	No	Refugee Cash Assistance (RAC). Covers all eligible refugees during their first eight months in the United States, including unaccompanied children who are not subject to the eight-month limitation.
02	Full	Nd Disab	Y/N	Refugee Medical Assistance/Entrant Medical Assistance. Covers eligible refugees and entrants who are not eligible for Medi-Cal or Healthy Families and do not qualify for or want cash assistance.
03	Full	Nd Disab	No	Adoption Assistance Program (AAP). Covers children receiving federal cash grants under Title IV-E to facilitate the adoption of hard-to-place children who would require permanent foster care placement without such assistance.
04	Full	Nd Disab	No	Adoption Assistance Program/Aid for Adoption of Children (AAP/AAC). <b>Covers children receiving cash grants under the state-only AAP/AAC program.</b>
06	Full	Nd Disab	No	Adoption Assistance Program (AAP) Child. Covers children receiving federal AAP cash subsidies from out of state. Provides eligibility for Continued Eligibility for Children (CEC) if for some reason the child is no longer eligible under AAP prior to his/her 18th birthday.
08	Full	Nd Disab	No	Entrant Cash Assistance (ECA). Covers Cuban/Haitian entrants during their first eight months in the United States who are receiving ECA benefits, including unaccompanied children who are not subject to the eight-month provision.
1E	Full	Yes	No	<u>Craig v. Bonta</u> Aged Pending SB 87 Redetermination. Covers former Supplemental Security Income/State Supplementary Payment recipients who are aged, until the county redetermines their Medi-Cal eligibility.
1H	Full	Yes	No	Federal Poverty Level – Aged (FPL-Aged). Covers the aged in the Aged and Disabled FPL program.
1U	Restricted to pregnancy and emergency services	No	No	Restricted Federal Poverty Level – Aged. Covers the aged in the Aged and Disabled FPL program that do not have satisfactory immigration status.
1X	Full	Yes	No	Aid to the Aged – Multipurpose Senior Services Program (MSSP). Allows special institutional deeming rules (spousal impoverishment) for MSSP transitional and non-transitional services for individuals 65 years of age or older.
1Y	Full	Yes	Yes	Aid to the Aged – MSSP. Allows special institutional deeming rules (spousal impoverishment) for MSSP transitional and non-transitional services for individuals 65 years of age or older.
10	Full	Yes	No	Aid to the Aged – SSI/SSP.

## MEDI-CAL AID CODES

Code	Benefits	PCSP/ IPO	SOC	Program/Description
13**	Full	OHC	Y/N	Aid to the Aged – Long Term Care (LTC). Covers persons 65 years of age or older who are medically needy and in LTC status.
14	Full	Yes	No	Aid to the Aged – Medically Needy.
16	Full	Yes	No	Aid to the Aged – Pickle Eligibles.
17	Full	Yes	Yes	Aid to the Aged – Medically Needy, SOC.
18	Full	Yes	No	Aid to the Aged – In-Home Support Services (IHSS).
2A	Full	Nd Disab	No	Abandoned Baby Program. Provides full-scope benefits to children up to 3 months of age who were voluntarily surrendered within 72 hours of birth pursuant to the Safe Arms for Newborns Act.
2E	Full	Yes	No	<u>Craig v. Bonta</u> Blind – Pending SB 87 Redetermination. Covers former Supplemental Security Income/State Supplementary Payment recipients who are blind, until the county redetermines their Medi-Cal eligibility.
20	Full	Yes	No	Blind – SSI/SSP – Cash.
23**	Full	OHC	Y/N	Blind – Long Term Care (LTC).
24	Full	Yes	No	Blind – Medically Needy.
26	Full	Yes	No	Blind – Pickle Eligibles.
27	Full	Yes	Yes	Blind – Medically Needy, SOC.
28	Full	Yes	No	Blind – IHSS.
3A	Full	Nd Disab	No	California Work Opportunity and Responsibility to Kids (CalWORKs), Timed-Out, Safety Net – All Other Families.
3C	Full	Nd Disab	No	CalWORKs Timed-Out, Safety Net – Two-Parent Families.
3D	Full	Nd Disab	No	CalWORKs – Pending, Medi-Cal Eligible.
3E	Full	Nd Disab	No	CalWORKs – Legal Immigrant – Family Group.
3G	Full	Nd Disab	No	CalWORKs – Zero Parent Exempt.
3H	Full	Nd Disab	No	CalWORKs – Zero Parent Mixed.
3L	Full	Nd Disab	No	CalWORKs – Legal Immigrant – Aid to families.
3M	Full	Nd Disab	No	CalWORKs – Legal Immigrant – Two Parent.
3N	Full	Nd Disab	No	Aid to Families with Dependent Children (AFDC) – 1931(b) Non-CalWORKs.

## MEDI-CAL AID CODES

Code	Benefits	PCSP/ IPO	SOC	Program/Description
3P	Full	Nd Disab	No	CalWORKS – All Families – Exempt.
3R	Full	Nd Disab	No	CalWORKS – Zero Parent – Exempt.
3T	Restricted to pregnancy and emergency services	No	No	Initial Transitional Medi-Cal (TMC). Provides six months of coverage for eligible aliens without satisfactory immigration status who have been discontinued from Section 1931(b) due to increased earnings from employment.
3U	Full	Nd Disab	No	CalWORKS – Legal Immigrant – Two Parent Mixed.
3V	Restricted to pregnancy and emergency services	No	No	AFDC – 1931(b) Non CalWORKS. Covers those eligible for the Section 1931(b) program who do not have satisfactory immigration status.
3W	Full	Nd Disab	No	Temporary Assistance to Needy Families (TANF) Timed-Out, Mixed Case.
30	Full	Nd Disab	No	CalWORKS – All Families.
32	Full	Nd Disab	No	TANF Timed out.
33	Full	Nd Disab	No	CalWORKS – Zero Parent.
34	Full	Nd Disab	No	AFDC – Medically Needy.
35	Full	Nd Disab	No	CalWORKS – Two Parent.
36	Full	Nd Disab	No	Aid to Disabled Widow(er)s
37	Full	Nd Disab	Yes	AFDC – Medically Needy SOC.
38	Full	Nd Disab	No	<u>Edwards v. Kizer</u> .
39	Full	Nd Disab	No	Initial Transitional Medi-Cal (TMC) (6 months). Provides six months of coverage for those discontinued from CalWORKS or the Section 1931(b) program due to increased earnings or increased hours of employment.
4A	Full	No Resi- dence	No	Out-of-State Adoption Assistance Program (AAP). Covers children for whom there is a state-only AAP agreement between any state other than California and adoptive parents.
4F	Full	Nd Disab	No	Kinship Guardianship Assistance Payment (Kin-GAP) Cash Assistance. Covers children in the federal program for children in relative placement receiving cash assistance.

## MEDI-CAL AID CODES

Code	Benefits	PCSP/ IPO	SOC	Program/Description
4G	Full	Nd Disab	No	Kin-GAP Cash Assistance. Covers children in the state program for children in relative placement receiving cash assistance.
<b>4K**</b>	Full	OHC	No	Emergency Assistance Foster Care. Covers juvenile probation cases placed in foster care.
4M	Full	Nd disab	No	Former Foster Care Children (FFCC).
<b>40**</b>	Full	OHC	No	AFDC-Foster Care. Covers children on whose behalf financial assistance is provided for state only foster care placement.
<b>42**</b>	Full	OHC	No	AFDC-Foster Care. Covers children on whose behalf financial assistance is provided for federal foster care placement.
44	Restricted to pregnancy-related services	No	No	200 Percent FPL Pregnant (Income Disregard Program – Pregnant). Provides eligible pregnant women of any age with family planning, pregnancy-related and postpartum services if family income is at or below 200 percent of the federal poverty level.
<b>45**</b>	Full	OHC	No	Foster Care. Covers children supported by public funds other than AFDC-FC.
<b>46**</b>	Full	OHC	No	Interstate Compact on the Placement of Children (ICPC) Child. Covers foster children placed in California from another state. Provides eligibility for CEC if for some reason the child is no longer eligible under foster care prior to his/her eighteenth birthday. Also provides eligibility for the Former Foster Care Children (FFCC) program (aid code 4M) at age 18.
<b>47**</b>	Full	Nd Disab  OHC possib	No	200 Percent FPL Infant (Income Disregard Program – Infant). Provides full Medi-Cal benefits to eligible infants up to 1 year old or continues beyond 1 year when inpatient status, which began before first birthday, continues and family income is at or below 200 percent of the federal poverty level.
48	Restricted to pregnancy-related services	No	No	200 Percent FPL Pregnant Omnibus Budget Reconciliation Act (OBRA) (Income Disregard Program – Pregnant OBRA). Provides eligible pregnant aliens of any age without satisfactory immigration status with family planning, pregnancy-related and postpartum, if family income is at or below 200 percent of the federal poverty level.
5F	Restricted to pregnancy and emergency services	No	Y/N	OBRA Alien – Pregnant Woman. Covers eligible pregnant alien women who do not have satisfactory immigration status.

## MEDI-CAL AID CODES

Code	Benefits	PCSP/ IPO	SOC	Program/Description
5J	Restricted to pregnancy-related and emergency services	No	No	SB 87 Pending Disability Program.
5K**	Full	OHC	No	Emergency Assistance (EA) Foster Care. Covers child welfare cases placed in EA foster care.
5R	Restricted to pregnancy-related and emergency services	No	Yes	SB 87 Pending Disability Program.
5T	Restricted to pregnancy and emergency services	No	No	Continuing TMC. Provides an additional six months of emergency services coverage for those beneficiaries who received six months of initial TMC coverage under aid code 3T.
5W	Restricted to pregnancy and emergency services	No	No	Four-Month Continuing Pregnancy and Emergency Services Only. Provides four months of emergency services for aliens without satisfactory immigration status who are no longer eligible for Section 1931(b) due to the collection or increased collection of child/spousal support.
50	Restricted to CMSP emergency services only	No	Y/N	County Medical Services Program (CMSP). OBRA/Out of County Care.
53**	Restricted to LTC and related services	No	Y/N	<p>Medically Indigent – <u>Long Term Care (LTC)</u> services. Covers eligible persons age 21 or older and under 65 years of age who are residing in a Nursing Facility Level A or B with or without SOC. For more information about LTC services, refer to the <i>County Medical Services Program (CMSP)</i> section in this manual.</p> <p><i>Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).</i></p>
54	Full	Nd Disab	No	Four-Month Continuing Eligibility. Covers persons discontinued from CalWORKs or Section 1931(b) due to the increased collection of child/spousal support.

## MEDI-CAL AID CODES

Code	Benefits	PCSP/ IPO	SOC	Program/Description
55	Restricted to pregnancy and emergency services	No	No	OBRA Not PRUCOL – <u>Long Term Care (LTC)</u> services. Covers eligible undocumented aliens in LTC who are not PRUCOL Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the <i>OBRA and IRCA</i> section in this manual.  <i>Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).</i>
58	Restricted to pregnancy and emergency services	No	Y/N	OBRA Aliens. Covers eligible aliens who do not have satisfactory immigration status.
59	Full	Nd Disab	No	Continuing TMC (6 months). Provides an additional six months of TMC for beneficiaries who had six months of initial TMC coverage under aid code 39.
6A	Full	Yes	No	Disabled Adult Child(ren) (DAC) Blind.
6C	Full	Yes	No	Disabled Adult Child(ren) (DAC) Disabled.
6E	Full	Yes	No	<u>Craig v. Bonta</u> Disabled – Pending SB 87 redetermination. Covers former Supplemental Security Income/State Supplementary Payment recipients who are disabled, until the county redetermines their Medi-Cal eligibility.
6G	Full	Yes	No	250 Percent Working Disabled Program.
6H	Full	Yes	No	Disabled – FPL. Covers the disabled in the Aged and Disabled Federal Poverty Level program.
6J	Full	Nd Disab	No	SB 87 Pending Disability. Covers with no SOC beneficiaries ages 21 to 65 who have lost their non-disability linkage to Medi-Cal and are claiming disability.
6N	Full	Nd Disab	No	Former SSI No Longer Disabled in SSI Appeals Status.
6P	Full	No	No	PRWORA/No Longer Disabled Children.
6R	Full	Nd Disab	Yes	SB 87 Pending Disability (SOC). Covers with an SOC those ages 21 to 65 who have lost their non-disability linkage to Medi-Cal and are claiming disability.
6U	Restricted to pregnancy and emergency services	No	No	Restricted Federal Poverty Level – Disabled. Covers the disabled in the Aged and Disabled FPL program who do not have satisfactory immigration status.
6V	Full	Yes	No	Department of Developmental Services (DDS) Waivers (No SOC).

## MEDI-CAL AID CODES

Code	Benefits	PCSP/ IPO	SOC	Program/Description
6W	Full	Yes	Yes	DDS Waivers (SOC).
6X	Full	Yes	No	Medi-Cal In-Home Operations (IHO) Waiver (No SOC).
6Y	Full	Yes	Yes	Medi-Cal In-Home Operations (IHO) Waiver (SOC).
60	Full	Yes	No	Disabled – SSI/SSP – Cash.
63	Full	OHC	Y/N	Disabled – <u>Long Term Care (LTC)</u> .
64	Full	Yes	No	Disabled – Medically Needy.
65	Full	Yes	Y/N	Katrina-Covers eligible evacuees of Hurricane Katrina.
66	Full	Yes	No	Disabled – Pickle Eligibles.
67	Full	Yes	Yes	Disabled – Medically Needy SOC.
68	Full	Yes	No	Disabled – IHSS.
69	Restricted to emergency services	No	No	200 Percent Infant OBRA. Provides emergency services only for eligible infants without satisfactory immigration status who are under 1 year of age or beyond 1 year when inpatient status, which began before 1st birthday, continues and family income is at or below 200 percent of the federal poverty level.
7A	Full	Nd Disab	No	100 Percent Child. Provides full benefits to otherwise eligible children, ages 6 to 19 or beyond 19 when inpatient status began before the 19th birthday and family income is at or below 100 percent of the federal poverty level.
7C	Restricted to pregnancy and emergency services	No	No	100 Percent OBRA Child. Covers emergency and pregnancy-related services to otherwise eligible children, without satisfactory immigration status who are ages 6 to 19 or beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the federal poverty level.
7F	Valid for pregnancy verification office visit	No	No	Presumptive Eligibility (PE) – Pregnancy Verification. This option allows the Qualified Provider to make a determination of PE for outpatient prenatal care services based on preliminary income information. 7F is valid for pregnancy test, initial visit, and services associated with the initial visit. Persons placed in 7F have pregnancy test results that are negative.
7G	Valid only for ambulatory prenatal care services	No	No	Presumptive Eligibility (PE) – Ambulatory Prenatal Care. This option allows the Qualified Provider (QP) to make a determination of PE for outpatient prenatal care services based on preliminary income information. 7G is valid for Ambulatory Prenatal Care Services. Persons placed in 7G have pregnancy test results that are positive. QP issues paper PE ID Card.



## MEDI-CAL AID CODES

<b>Code</b>	<b>Benefits</b>	<b>PCSP/ IPO</b>	<b>SOC</b>	<b>Program/Description</b>
7H	Valid only for TB-related outpatient services	No	No	Tuberculosis (TB) Program. Covers eligible individuals who are TB-infected for TB-related outpatient services only.
7J	Full	Nd Disab	No	Continuous Eligibility for Children (CEC). Provides full-scope benefits to children up to 19 years of age who would otherwise lose their no Share of Cost Medi-Cal.
7K	Restricted to pregnancy and emergency services	No	No	Continuous Eligibility for Children (CEC). Provides emergency and pregnancy-related benefits (no Share of Cost) to children without satisfactory immigration status who are up to 19 years of age who would otherwise lose their no Share of Cost Medi-Cal.
7M	Valid for Minor Consent services	No	Y/N	Minor Consent Program. Covers eligible minors at least 12 years of age and under the age of 21. Limited to services related to Sexually Transmitted Diseases, sexual assault, drug and alcohol abuse, and family planning. Paper Medi-Cal ID Card issued.
7N	Valid for Minor Consent services	No	No	Minor Consent Program. Covers eligible pregnant minors under the age of 21. Limited to services related to pregnancy and family planning. Paper Medi-Cal ID card issued.
7P	Valid for Minor Consent services	No	Y/N	Minor Consent Program. Covers eligible minors at least 12 years of age and under the age of 21. Limited to services related to Sexually Transmitted Diseases, sexual assault, drug and alcohol abuse, family planning, and outpatient mental health treatment. Paper Medi-Cal ID card issued.
7R	Valid for Minor Consent services	No	Y/N	Minor Consent Program. Covers eligible minors under age 12. Limited to services related to family planning and sexual assault. Paper Medi-Cal ID card issued.
7T	Full	Nd Disab	No	Express Enrollment – National School Lunch Program (NSLP).
7X	Full	Nd Disab	No	One-Month Medi-Cal to Healthy Families Bridge.
7I	Restricted to dialysis and supplemental dialysis-related services	No	Y/N	Medi-Cal Dialysis Only Program/Medi-Cal Dialysis Supplement Program (DP/DSP). Covers eligible persons of any age who are eligible only for dialysis and related services.

## MEDI-CAL AID CODES

Code	Benefits	PCSP/ IPO	SOC	Program/Description
72**	Full	Nd Disab	No	133 Percent Program. Provides full Medi-Cal benefits to eligible children ages 1 up to 6 or beyond 6 years when inpatient status, which began before 6th birthday, continues and family income is at or below 133 percent of the federal poverty level.
73	Restricted to parenteral hyperalimentation-related expenses	No	Y/N	Total Parenteral Nutrition (TPN). Covers eligible persons of any age who are eligible for parenteral hyperalimentation and related services and persons of any age who are eligible under the Medically Needy or Medically Indigent Programs.
74**	Restricted to emergency services	No	No	133 Percent Program (OBRA). Provides emergency services only for eligible children without satisfactory immigration status who are ages 1 up to 6 or beyond 6 years when inpatient status, which began before 6th birthday, continues and family income is at or below 133 percent of the federal poverty level.
76	Restricted to 60-day postpartum services	No	No	60-Day Postpartum Program. Provides Medi-Cal at no SOC to women who, while pregnant, were eligible for, applied for, and received Medi-Cal benefits. They may continue to be eligible for all postpartum services and family planning. This coverage begins on the last day of pregnancy and ends the last day of the month in which the 60th day occurs.
8E	Full	Nd Disab	No	Accelerated Enrollment. Provides immediate, temporary, fee-for-service, full-scope Medi-Cal benefits to certain children under the age of 19.
8F	CMSP acute inpatient services only	OHC	Y/N	CMSP Companion Aid Code. Used in conjunction with Medi-Cal aid code 53. Aid Code 8F will appear as a special aid code and will entitle the eligible client to acute inpatient services only while residing in a Nursing Facility Level A or B. For more information about Long Term Care (LTC) services, refer to the <i>County Medical Services Program (CMSP)</i> section in this manual.
8G	Full	Yes	No	Severely Impaired Working Individual (SIWI).
8H	Family Planning	No	N/A	Family PACT (FPACT). Comprehensive family planning services for low income residents of California with no other source of health care coverage. HAP Card Issued.
8N**	Restricted to emergency services	No	No	133 Percent Excess Property Child – Emergency Services Only. Provides emergency services only for eligible children without satisfactory immigration status who are ages 1 up to 6 or beyond 6 years when inpatient status, which began before 6th birthday, continues, and family income is at or below 133 percent of the federal poverty level.

## MEDI-CAL AID CODES

Code	Benefits	PCSP/ IPO	SOC	Program/Description
<b>8P**</b>	Full	OHC	No	133 Percent Excess Property Child. Provides full-scope Medi-Cal benefits to eligible children ages 1 up to 6 or beyond 6 years when inpatient status, which began before 6th birthday, continues, and family income is at or below 133 percent of the federal poverty level.
<b>8R**</b>	Full	OHC	No	100 Excess Property Child. Provides full-scope benefits to otherwise eligible children, ages 6 to 19 or beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the Federal poverty level.
<b>8T</b>	Restricted to pregnancy and emergency services	No	No	100 Percent Excess Property Child – Pregnancy and Emergency Services Only. Covers emergency and pregnancy-related services only to otherwise eligible children without satisfactory immigration status who are ages 6 to 19 or beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the Federal poverty level.
<b>8U</b>	Full	Nd Disab	No	CHDP Gateway Deemed Infant. Provides full-scope, no Share of Cost (SOC) Medi-Cal benefits for infants born to mothers who were enrolled in Medi-Cal with no SOC in the month of the infant’s birth.
<b>8V</b>	Full	Nd Disab	Yes	CHDP Gateway Deemed Infant SOC. Provides full-scope Medi-Cal benefits with a Share of Cost (SOC) for infants born to mothers who were enrolled in Medi-Cal with a SOC in the month of the infant’s birth and SOC was met.
<b>8W</b>	Full	Nd Disab	No	CHDP Gateway Medi-Cal. Provides for the pre-enrollment of children into the Medi-Cal program who are screened as probable for Medi-Cal eligibility. Provides temporary full-scope Medi-Cal benefits with no SOC.
<b>8X</b>	Full	Nd Disab	No	CHDP Gateway Healthy Families. Provides for the pre-enrollment of children into the Medi-Cal program who are screened as probable for Healthy Families eligibility. Provides temporary full-scope Medi-Cal benefits with no SOC.
<b>8Y**</b>	CHDP services only	No	No	CHDP. Covers CHDP eligible children who are also eligible for Medi-Cal emergency, pregnancy-related and Long Term Care (LTC) services.
<b>80</b>	Restricted to Medicare expenses	No	No	Qualified Medicare Beneficiary (QMB). Provides payment of Medicare Part A premium and Part A and B coinsurance and deductibles for eligible low income aged, blind or disabled individuals.
<b>81</b>	Full	Nd Disab	Y/N	MI – Adults Aid Paid Pending.

## MEDI-CAL AID CODES

Code	Benefits	PCSP/ IPO	SOC	Program/Description
82	Full	Nd Disab	No	MI – Child. Covers medically indigent persons under 21 who meet the eligibility requirements of medical indigence. Covers persons until the age of 22 who were in an institution for mental disease before age 21. Persons may continue to be eligible under aid code 82 until age 22 if they have filed for a State hearing.
83	Full	Nd Disab	Yes	MI – Child SOC. Covers medically indigent persons under 21 who meet the eligibility requirements of medically indigent.
84	CMSP services only (no Medi-Cal)	No	No	MI – Adult. Covers medically indigent adults aged 21 and over but under 65 years that meet the eligibility requirements of medically indigent.
85	CMSP services only (no Medi-Cal)	No	Yes	MI – Adult. Covers medically indigent adults aged 21 and over but under 65 years, which meet the eligibility requirements of medically indigent.
86	Full	Nd Disab	No	MI – Confirmed Pregnancy. Covers persons aged 21 years or older, with confirmed pregnancy, which meet the eligibility requirements of medically indigent.
87	Full	Nd Disab	Yes	MI – Confirmed Pregnancy SOC. Covers persons aged 21 or older, with confirmed pregnancy, which meet the eligibility requirements of medically indigent but are not eligible for 185 percent/200 percent or the MN programs.
88	CMSP services only (no Medi-Cal)	No	No	MI – Adult – Disability Pending. Covers medically indigent adults aged 21 and over but under 65 years that meet the eligibility requirements of medically indigent and have a pending Medi-Cal disability application.
89	CMSP services only (no Medi-Cal)	No	Yes	MI – Adult – Disability Pending SOC. Covers medically indigent adults aged 21 and over but under 65 years that meet the eligibility requirements of medically indigent and have a pending Medi-Cal disability application.
9A	Cancer Detection Programs: Every Woman Counts only	No	No	The Cancer Detection Programs: Every Woman Counts recipient identifier. Cancer Detection Programs: Every Woman Counts offers benefits to uninsured and underinsured women, 25 years and older, whose household income is at or below 200 percent of the Federal poverty level. Cancer Detection Programs: Every Woman Counts offers reimbursement for screening, diagnostic and case management services.  <i>Please note: Cancer Detection Programs: Every Woman Counts and Medi-Cal are separate programs; however, Cancer Detection Programs: Every Woman Counts relies on the Medi-Cal billing process (with few exceptions).</i>

## MEDI-CAL AID CODES

Code	Benefits	PCSP/ IPO	SOC	Program/Description
9H	HF services only (no Medi-Cal)	No	No	Healthy Families Child. Provides a comprehensive health insurance plan for uninsured children from 1 to 19 years of age whose family's income is at or below 200 percent of the Federal poverty level. HF covers medical, dental and vision services to enrolled children.
9J	GHPP	No	No	GHPP-eligible. Eligible for GHPP benefits and case management.
9K	CCS	No	No	CCS-eligible. Eligible for all CCS benefits (i.e., diagnosis, treatment, therapy and case management).
9M	CCS Medical Therapy Program only	No	No	Eligible for CCS Medical Therapy Program services only.
9N	CCS Case Management	No	No	Eligible for CCS only if concurrently eligible for full-scope, no SOC Medi-Cal. CCS authorization required.
9R	CCS	No	No	CCS-eligible Healthy Families child. A child in this program is enrolled in a Healthy Families plan and is eligible for all CCS benefits (i.e., diagnosis, treatment, therapy and case management). <u>The child's county of residence has no cost sharing for the child's CCS services.</u>
9U	CCS	No	No	CCS-eligible Healthy Families child. A child in this program is enrolled in a Healthy Families plan and is eligible for all CCS benefits (i.e. diagnosis, treatment, therapy and case management). The child's county of residence has county cost sharing for the child's CCS services.

**Special Share of Cost (SOC) Case Indicators:** These indicators, which appear on a recipient's SOC Case Summary Form, are used to identify the following:

**RR – Responsible Relative:** An RR is allowed to use medical expenses to meet the SOC for other family members for whom he/she is responsible. Upon certification of the SOC, an RR individual is not eligible for Medi-Cal benefits in this Medi-Cal Budget Unit (MBU). The individual may be eligible for Medi-Cal benefits in another MBU where the person is not identified as RR.

## County Number Table

01	Alameda	30	Orange
02	Alpine	31	Placer
03	Amador	32	Plumas
04	Butte	33	Riverside
05	Calaveras	34	Sacramento
06	Colusa	35	San Benito
07	Contra Costa	36	San Bernardino
08	Del Norte	37	San Diego
09	El Dorado	38	San Francisco
10	Fresno	39	San Joaquin
11	Glenn	40	San Luis Obispo
12	Humboldt	41	San Mateo
13	Imperial	42	Santa Barbara
14	Inyo	43	Santa Clara
15	Kern	44	Santa Cruz
16	Kings	45	Shasta
17	Lake	46	Sierra
18	Lassen	47	Siskiyou
19	Los Angeles	48	Solano
20	Madera	49	Sonoma
21	Marin	50	Stanislaus
22	Mariposa	51	Sutter
23	Mendocino	52	Tehama
24	Merced	53	Trinity
25	Modoc	54	Tulare
26	Mono	55	Tuolumne
27	Monterey	56	Ventura
28	Napa	57	Yolo
29	Nevada	58	Yuba





WILL LIGHTBOURNE  
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY  
**DEPARTMENT OF SOCIAL SERVICES**  
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EDMUND G. BROWN JR.  
GOVERNOR

July 24, 2012

ALL-COUNTY LETTER NO.: 12-36

TO: ALL COUNTY WELFARE DIRECTORS  
ALL IHSS PROGRAM MANAGERS

SUBJECT: PROGRAM POLICY FOR THE CASE MANAGEMENT  
INFORMATION AND PAYROLLING SYSTEM II (CMIPS II)

- INQUIRY, REFERRAL AND APPLICATION
- PERSON NOTES/CASE NOTES/CASE (ASSESSMENT) NARRATIVE
- PERSONAL CARE SERVICES PROGRAM/IHSS PLUS OPTION/IHSS RESIDUAL
- SOCIAL SECURITY NUMBER REQUIREMENTS
- IHSS RECIPIENT RESIDENCE
- USE OF RANK 6
- INTER-COUNTY TRANSFER

REFERENCE: All County Letter No. 88-118  
All County Letters Nos. 06-34 and 06-34E2  
All County Letter No. 09-30

This All-County Letter (ACL) explains the difference between an inquiry, a referral and an application for In-Home Supportive Services (IHSS) and provides policy direction related to Medi-Cal eligibility, pending Disability Evaluation Determinations (DEDs), loss of Medi-Cal eligibility and eligibility for IHSS Residual (IHSS-R). In addition, it will define the use for the following in CMIPS II: Use of new Person Note/Case Note/Narrative functionality; Social Security Number (SSN) requirements; Recipient Primary Residence; Rank 6 and Inter-County Transfer (ICT) process. In this letter, all references to IHSS shall be recognized to include the Personal Care Services Program (PCSP), IHSS Plus Option (IPO), and IHSS-R unless specified otherwise.

**INQUIRY, REFERRAL AND APPLICATION**

With the impending transition to CMIPS II, this ACL will explain the enhanced referral and application functionality that counties will be required to complete in CMIPS II as

<u>REASON FOR THIS TRANSMITTAL</u>
<input type="checkbox"/> State Law Change
<input type="checkbox"/> Federal Law or Regulation Change
<input type="checkbox"/> Court Order
<input checked="" type="checkbox"/> Clarification Requested by One or More Counties
<input checked="" type="checkbox"/> Initiated by CDSS



the system is implemented in each county. It will also clarify the differences between an inquiry, a referral and an application that exist today, as well as describe the required county actions related to these activities in both Legacy CMIPS and CMIPS II. In the case of CMIPS II activities, this letter will direct counties to the appropriate CMIPS II screens, but will not provide directions for screen entry; those step-by-step directions will be covered in CMIPS II training. When a county receives an initial contact regarding the IHSS program, the county may determine the nature of the contact based on the direction provided in this ACL.

Inquiry:

If a county receives a call from an individual making an informational inquiry regarding the IHSS program only, e.g., what kinds of services does IHSS provide, it is considered an inquiry and does not merit a referral or qualify as an application. During an inquiry, the county will generally not receive or respond to any person-specific information. The county is not required to take any further action.

Referral:

A referral is a contact about the IHSS program received by the county from a third party who does not have legal authority to make decisions on behalf of the potential applicant, e.g., a health care professional, neighbor, friend or religious affiliate, or a person who is not the authorized representative of the individual they are referring. The county must record the contact as a Referral until the county has contacted the individual or their authorized representative to determine whether the referred individual or their authorized representative is interested in applying for IHSS.

Legacy CMIPS: For the time that a county remains on Legacy CMIPS, the county is encouraged to enter the referral information in Record (R) status; however, counties using external tools to record and track referrals may continue to do so.

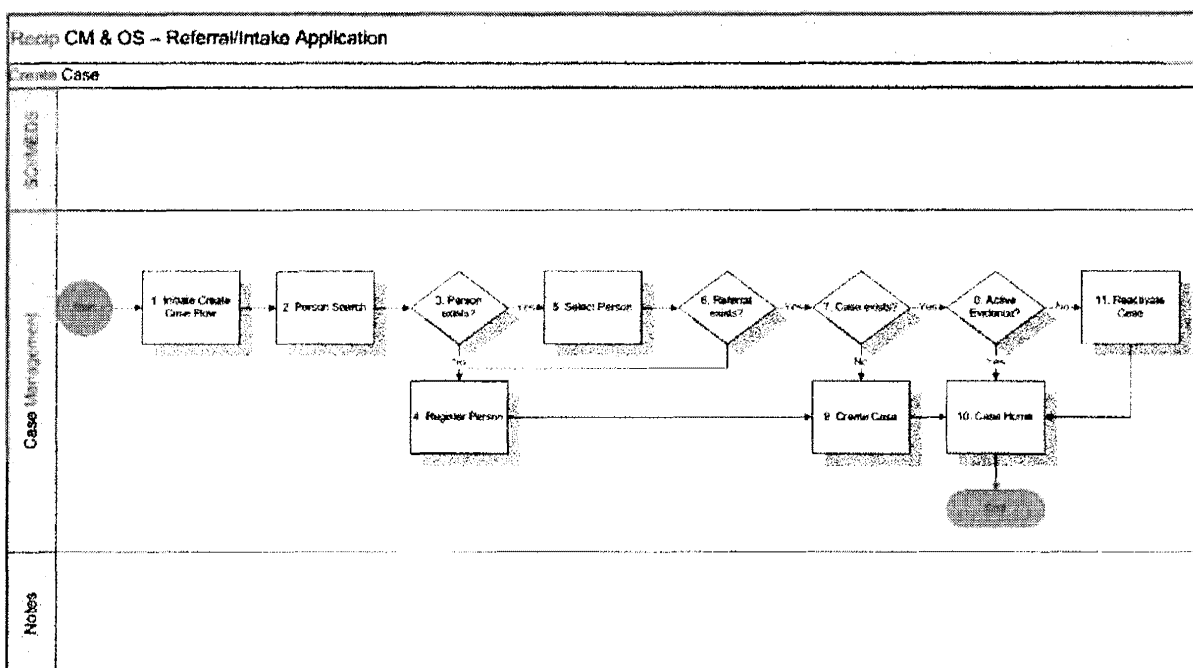
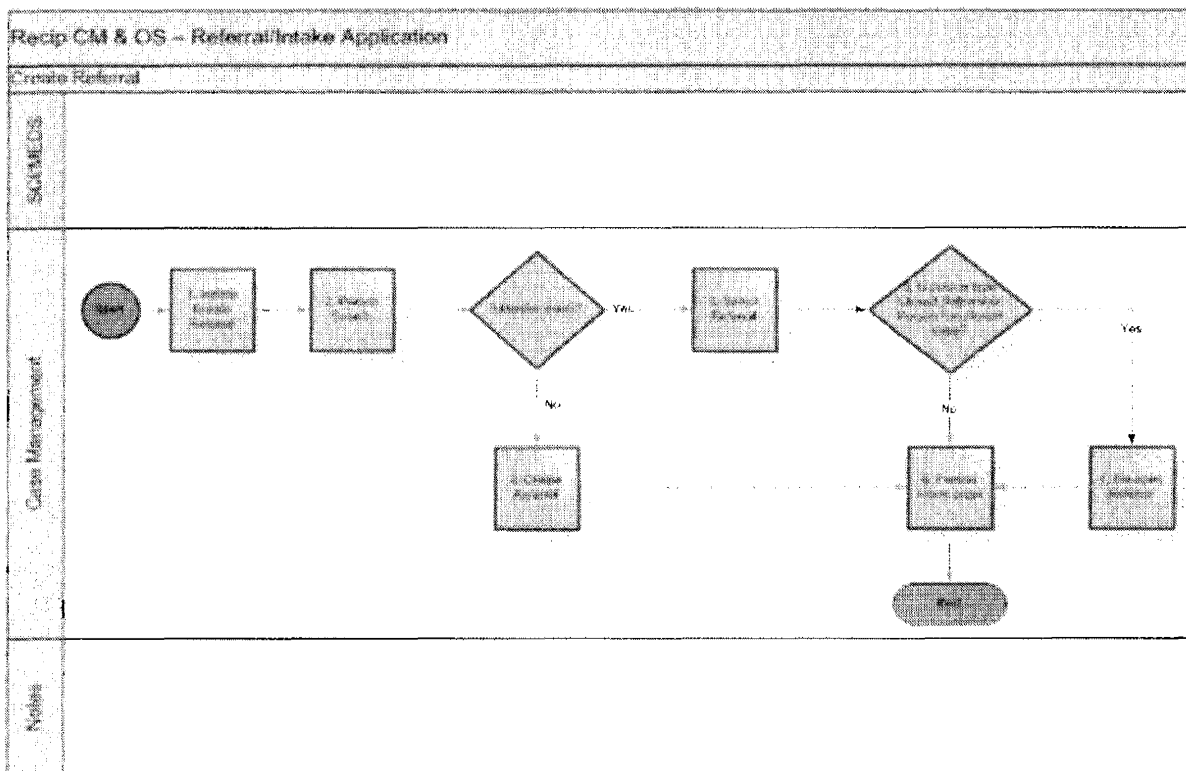
**CMIPS II:**

- The county shall initiate a Person Search to determine if the individual calling or being referred to IHSS is already known to CMIPS II. An individual shall exist only once in CMIPS II.
- If the person calling is the individual seeking services or their authorized representative, the county shall proceed to the Create Application screen and initiate the application process. (See Create Application Flowchart below.)
- If the person calling is a third party not authorized to open an application on the referred individual's behalf, the county must initiate the Referral using the Create Referral screen. (See Create Referral Flowchart below.) The Create Referral screen allows the entry of minimal referral data regarding the individual being referred. These data include the first and last names, the referral source, and either the person's address or telephone number. When the record is saved, the Person Type is indicated as Referral.

The outcome of either the Create Referral or Create Application process in CMIPS II is the creation of a single Person Record in CMIPS II. All persons are registered and are identified with one of the following Person Type Indicators: Referral, Applicant, Recipient, or Provider. An individual may have more than one Person Type, i.e., a person can be both a Recipient and a Provider.

CMIPS II uses a new case number configuration for both Applicants/Recipients and Providers. An Applicant will be assigned a random Case Number consisting of seven (7) digits, e.g., 1234567. This number is part of the Person Record and will remain as the Case Number for an Applicant/Recipient for the life of the case record, even if the Recipient moves to another county. The county numeric identifier is no longer directly associated with the Recipient Case Number. The county that owns the Recipient case can be found on the Case Home page using the same numeric county identifiers as were used in Legacy CMIPS.

Providers will be assigned random Provider numbers consisting of nine (9) digits, e.g., 123456789. These numbers will be random and not associated in any way with the Providers SSN as they were in Legacy. Like Recipient Case Numbers, this assigned Provider identifier will be the same regardless of the number of Recipients for whom the Provider works or the number of counties in which the Provider works. This number will remain associated to the Provider for the duration of their CMIPS II record.



Application:

Manual of Policies and Procedures (MPP) section 30-009.221 states "Any person shall have the right to apply for services or to make application through another person on his behalf." Once an individual or their authorized representative indicates that they wish to apply for IHSS, an application shall be taken immediately (MPP section 30-009.222). The county shall not deny or in any way dissuade the individual or their representative from making an application for IHSS based on information communicated during a phone call or face-to-face visit. The individual must be afforded due process by being allowed to make an application for IHSS if they are so inclined, and have that application assessed for eligibility based on program rules. The applicant shall receive a Notice of Action detailing the outcome of the county's determination.

An application for IHSS may be made over the phone or in writing by submitting an Application for Social Services (SOC 295). The following data about the applicant is required to complete the Create Applicant process:

- Name;
- SSN or verification that the applicant has applied for an SSN;
- Date of Birth;
- Applicant's preferred spoken and written languages;
- Gender;
- Ethnicity;
- County of Residence;
- Residence and mailing addresses; and
- Applicant's primary phone number.

At the time the application information is entered in either Legacy CMIPS or CMIPS II, a case number will be assigned to the applicant. Legacy counties, to the extent that current business practice allows, and all CMIPS II counties shall provide the case number to the applicant or their authorized representative before the end of the telephone call during which the application is taken, or before they leave the IHSS office so the applicant or their authorized representative will be able to refer to the case number in any communications with the county. For counties still using Legacy CMIPS where current county practice is for key data entry of the application information by a person other than the person taking the application, the county shall enter the application into CMIPS as expeditiously as possible and if the case number is requested, the county will provide it to the applicant as soon as possible.

Applications always require a signature. However, social services staff or the applicant's authorized representative can sign on the applicant's behalf to preserve the application date (MPP section 30-009.224). For those individuals who apply by phone, the SOC 295 may be signed at the IHSS face-to-face assessment.

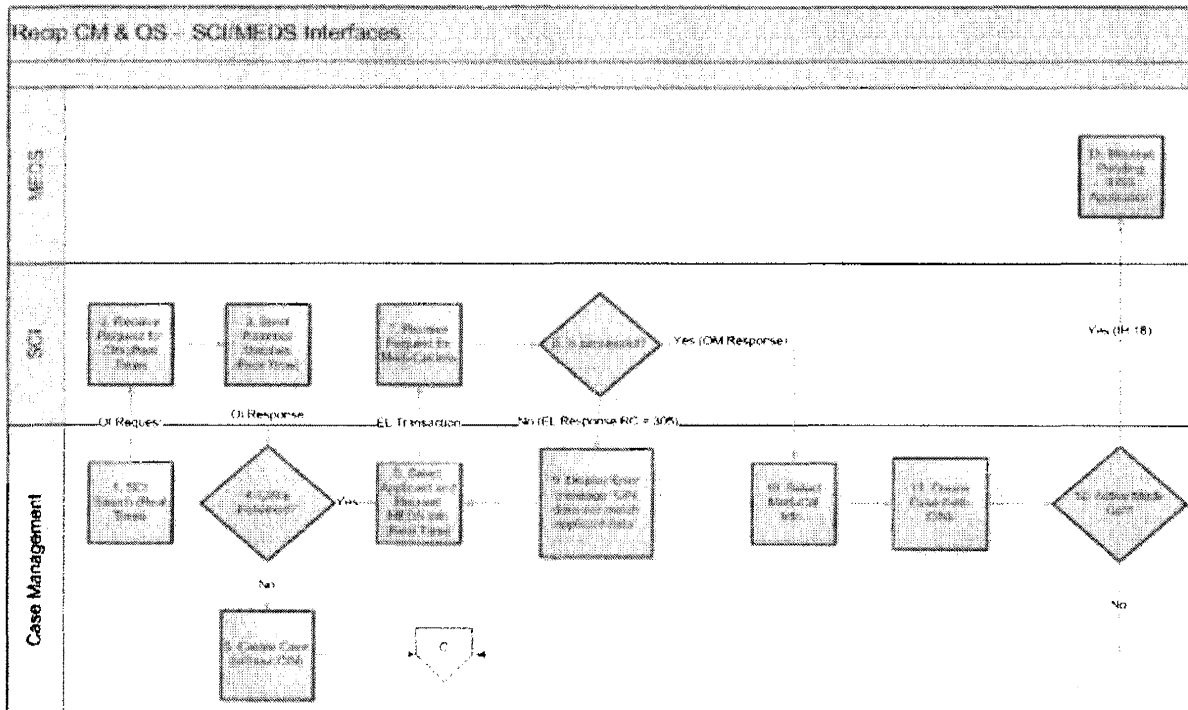
The date the services are requested either by phone or submission of the SOC 295, whichever is earlier, shall be the applicant's "protected date of eligibility". If the applicant is not already a Medi-Cal beneficiary, the county must create the IHSS application to establish the "protected date of eligibility". While counties are still on Legacy CMIPS, non-Medi-Cal applicants should be referred to the local Medi-Cal office to apply for Medi-Cal. At the point a county goes live on CMIPS II, the system will automatically check for Medi-Cal eligibility and generate a referral if no eligibility exists. If the applicant is ultimately determined to be eligible for IHSS, the applicant may be authorized services back to the "protected date of eligibility".

**LEGACY CMIPS:**

- The county shall initiate a name or social security number search to determine if the individual calling or being referred to IHSS is already known to CMIPS.
- The county shall determine if the potential applicant is currently a Medi-Cal beneficiary. If not, the county shall take the application for IHSS and refer the applicant to the local Medi-Cal office to apply for Medi-Cal.
- The county shall enter into CMIPS the information necessary to establish an application and provide the assigned case number to the applicant for use in future communication with the county.

**CMIPS II:**

- The county shall initiate a Person Search to determine if the individual calling or being referred to IHSS is already known to CMIPS II. An individual shall exist only once in CMIPS II.
- From the Person Search, if the person does not exist, the user will access the Create Application screen and proceed with the application to the Create Case screen.
- The county shall provide the assigned case number to the applicant for use in future communications with the county.
- When an application is opened in CMIPS II, the system will check to see if the applicant has active Medi-Cal. If none exists, CMIPS II will generate a referral through an interface with the SAWS system requesting a Medi-Cal eligibility determination be completed. When the Medi-Cal eligibility determination is completed, the information will be sent back to CMIPS II through the interface. (See SCI/MEDS Flowchart below..)



## **PERSON NOTES/CASE NOTES/CASE (AUTHORIZATION) NARRATIVE**

CMIPS II will provide counties with several areas to enter electronic notes and case narratives related to referrals, applicants, recipients and providers that were not available to counties in Legacy CMIPS. The following paragraphs will explain the use of each of these functions as they relate to IHSS case management. The technical aspects of accessing and using each of the functions will be addressed during CMIPS II Training.

CMIPS II has 2 types of notes for an individual – Person and Case. Person Notes should be used when only a referral exists for the individual. Once an application has been taken and a case created all notes regarding the individual shall be entered in Case Notes.

Person Notes and Case Notes entries are displayed in chronological order with the most recent entry displayed first. Counties are advised to instruct their staff to carefully review their entries before saving the entries in either Person Notes or Case Notes. Once an entry is saved, the system will not allow the entry to be edited and a new Person or Case Note must be initiated. CMIPS II will automatically annotate the entry with the worker's name and the current date and time.

### **PERSON NOTES**

Person Notes are entries made in association with a Person Record. Person Notes are specific to an individual before they apply for IHSS services, meaning that Person Notes should only be entered during the "Referral" process. Once an individual moves from being a referral to an applicant or a case, all notes entries should be made in Case Notes.

Person Notes entries are also used when the entry relates specifically to a provider and should be entered on the Notes page attached to that provider's Person Record. Notes related to the provider should only be entered in Person Notes on the provider's Person Record, not in Case Notes.

Examples of Person Notes are:

*Received call from daughter inquiring about possible services for mother. Daughter didn't have sufficient information to open application and wasn't sure her mother will accept services. Daughter requested IHSS application and other appropriate paperwork be mailed to her. Mailed SOC 295 and Health Cert 12/12/12.*

Or

*Daughter wants to be a provider for her father who is an IHSS recipient. Explained provider enrollment requirements and mailed required documents 11/12/13.*

CMIPS II will automatically annotate the entry with the worker's name and the current date and time.

### **CASE NOTES**

The Case Notes function allows users to enter information that is related to a case but not related to a specific assessment. Once the case is created, notes should be entered in Case Notes and no longer entered in Person Notes.

An example of a case note is:

*Received a call from recipient's son stating recipient may be leaving to live with her daughter in Michigan and asking what steps needed to be taken to terminate her case if she decides to move. The move is still uncertain. Advised son to call when plans are firm.*

CMIPS II will automatically annotate the entry with the worker's name and the current date and time.

### **CASE (OR ASSESSMENT) NARRATIVE**

The Case (or Assessment) Narrative is used to record information relating to an initial assessment or reassessment. Each time New Evidence is added to CMIPS II a new Assessment Narrative is created. Assessment Narratives are associated with Evidence and once evidence is authorized that Assessment Narrative is no longer editable

An example of an abridged Assessment Narrative is:

*Reassessment home visit to the 75-year-old female recipient: The recipient lives with her husband in a small 2-BR ground floor apartment. She suffers from severe osteoporosis, but is ambulatory. She is unable to independently perform most domestic and related activities and needs minimal assistance with bathing and dressing; however, her condition has deteriorated since my last visit and I anticipate her need for service will increase over the next year. Her husband is currently able and available, but is also having more difficulty functioning and may need assistance soon himself."*

Generally, the information in the Assessment Narrative will be similar to the narratives created by social workers today. The Assessment Narrative may include observations about the recipient, the recipient's functional abilities, living arrangements, others in the



household and any other information the social worker deems pertinent to the case. The Assessment Narrative is also the area in CMIPS II where information about the recipient's diagnoses may be recorded. The Assessment Narrative is limited to 13,500 characters.

### **PCSP/IPO/IHSS-R**

Welfare and Institutions Code (WIC) section 12300 (g) states that an individual who is eligible to receive services under PCSP or IPO shall not be eligible to receive services under IHSS-R. Therefore, all applicants for IHSS must complete a Medi-Cal eligibility determination prior to being authorized PCSP/IPO/IHSS-R. The only exception to this requirement is if an applicant is complying with all Medi-Cal requirements, but the determination of their eligibility for Medi-Cal is pending a DED, and completion of the DED will require longer than the 45-day statutory maximum for processing a Medi-Cal application. These individuals may be evaluated for potential IHSS-R presumptive eligibility in accordance with MPP section 30-759.3. If eligible, the applicant may be authorized IHSS-R services prior to Medi-Cal completing the eligibility determination. If the Medi-Cal application is denied because the applicant's DED is turned down, IHSS-R services must be discontinued. No other applicants can be served in the IHSS-R program prior to completion of a Medi-Cal eligibility determination. An applicant who does not cooperate or fails to comply with Medi-Cal requirements during the application process is not eligible for IHSS-R.

Individuals who are eligible for Medi-Cal with full Federal Financial Participation (FFP) and who are currently linked to Medi-Cal as aged, blind or disabled; or who meet the MPP section 30-780.2 (b) criteria of a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or result in death within 12 months; and who are determined through an in-home assessment to be unable to remain safely at home without IHSS, may be authorized PCSP or IPO services. Those individuals are not required to have a DED.

IHSS applicants who are not eligible for FFP Medi-Cal or have been denied Medi-Cal eligibility for a reason other than failure to comply with Medi-Cal requirements, or failure to complete the Medi-Cal eligibility process, shall be considered for IHSS-R eligibility. These individuals shall complete a Statement of Facts for In-Home Supportive Services (SOC 310). The IHSS program staff may utilize resource and income information from the State Automated Welfare Systems (SAWS) eligibility system when determining IHSS-R financial eligibility and share of cost calculation so long as the non-FFP Medi-Cal case is active and the most current information in SAWS is used. All IHSS-R rules must be applied and any additional income and resource information required under IHSS-R rules must be collected and entered in CMIPS II. The CMIPS II system

will calculate the IHSS-R financial eligibility and share of cost based on IHSS-R rules. If services are authorized, the recipient is required to pay any IHSS-R share of cost (SOC) to their provider in accordance with MPP section 30-755.233. An IHSS-R recipient who receives non-FFP full scope Medi-Cal and has a Medi-Cal SOC may submit receipts for their IHSS-R SOC payments to Medi-Cal where they will be applied toward meeting their Medi-Cal SOC obligation.

If an IHSS recipient's Medi-Cal eligibility is discontinued, CMIPS II shall generate a task to the social worker/case owner notifying them of the reason for the discontinuance. If the reason for discontinuance is failure to comply with Medi-Cal eligibility, including the annual renewal, the social worker/case owner shall terminate IHSS services. If the Medi-Cal discontinuance is due to change in circumstance the recipient should be considered for IHSS-R eligibility.

### **SOCIAL SECURITY NUMBER (SSN) REQUIREMENTS**

Title 22 of the California Code of Regulations (CCR) section 50187 (22 CCR 50187(a) and (b)), requires that all beneficiaries of Medicaid services, which for purposes of this letter means PCSP or IPO recipients and non-FFP Full-Scope Medi-Cal (State-only Medi-Cal) beneficiaries who meet the eligibility requirements for IHSS-R, must have a valid SSN in order to receive services or show proof of an application for an SSN (form SSA 5028 Evidence of Application for SSN).

In order to be eligible for IHSS-R, applicants/recipients must meet the requirements for Supplemental Security Income (SSI) eligibility except for income. One requirement for SSI eligibility is that the applicant/recipient must have a valid SSN or must have submitted an application for an SSN before or at the same time they submit an application for SSI.

Counties must take an application from an individual requesting to apply who can provide the application criteria described above. However, in the event an applicant does not have a SSN, at the time of application the applicant must provide proof of having applied for an SSN by providing the county with a copy of an SSA 5028 form completed by the Social Security Administration (SSA). Thus, an application cannot be accepted unless it includes an SSN or proof of an application for an SSN (form SSA 5028 Evidence of Application for SSN).

SSA will issue SSN cards clearly marked "NOT VALID FOR EMPLOYMENT" to individuals who are lawfully admitted to the United States without work authorization from the Department of Homeland Security, but who have a valid non-work reason for

needing an SSN, such as a federal law requiring an SSN to get a benefit or service (<http://www.socialsecurity.gov/ssnumber/cards.htm>). Medicaid and SSI each require an SSN for an individual to be eligible.

Qualified aliens are eligible for SSNs that include the designation "NOT VALID FOR EMPLOYMENT" based on the law requiring an SSN to receive a benefit or service. Aliens who are not in a satisfactory immigration status, and who do not have an SSN, can still receive State-Only Medi-Cal, and potentially IHSS-R, if they meet all eligibility requirements. Please see All-County Information Notice Number I-18-08 for more information on IHSS-R Eligibility for Non-Citizens.

Although DHCS has historically assigned pseudo SSNs to Medi-Cal eligible adoptees, this practice is largely out-of-date due to the current strict confidentiality laws. Neither Legacy CMIPS nor CMIPS II will accept pseudo SSNs that include an alpha character as valid entries. Adoptive parents should be directed to use the valid SSN previously assigned to their child or to apply for a new SSN for the child under his/her adopted name.

After taking the IHSS application, counties still using Legacy CMIPS should refer applicants without an SSN or an active Medi-Cal record in the Medi-Cal Eligibility Data System (MEDS) to Medi-Cal to complete a Medi-Cal eligibility determination and to the Social Security Administration (SSA) to apply for an SSN.

In CMIPS II, the county must enter the applicant's information into CMIPS II and conduct a Person Search to see if the applicant is already known to CMIPS II and perform a State Client Index (SCI) look-up to see if the applicant already has a Client Index Number (CIN) and active Medi-Cal. The CMIPS II user will be prompted to either select the correct CIN from any possible matches that are returned or send a Medi-Cal referral via interface to the local SAWS to initiate a Medi-Cal eligibility determination. If there is no CIN match, the user must select the option to send the referral to SAWS. When the Medi-Cal eligibility determination is completed, CMIPS II will receive notification through the interface of the outcome and, if approved, the aid codes assigned to the beneficiary and a notification will be sent to the case owner.

The response from MEDS will include both the MEDS Primary Aid Code and the FFP status indicator. The appropriate secondary Medi-Cal Aid Code (2L IHSS Plus Option – IPO; 2M Personal Care Services Program – PCSP; or 2N IHSS Residual Program – IHSS-R) will be determined by CMIPS II based on programmed eligibility criteria. Applicants cannot be approved for PCSP/IPO services until the individual has been

granted FFP Full-Scope Medi-Cal. Counties should be aware that although the CMIPS II case record may indicate a full-scope FFP primary Medi-Cal Aid Code when compared to the list of current Medi-Cal aid codes, it does not necessarily mean the Recipient has been granted full-scope FFP Medi-Cal. For IHSS program eligibility purposes, the county should rely on the FFP status indicator and the secondary Medi-Cal Aid Code determined by CMIPS II. If CMIPS II displays a secondary aid code of 2N (IHSS-R) it means the recipient/beneficiary has been authorized full-scope, State-only (non-FFP) Medi-Cal and must be evaluated for IHSS-R eligibility using IHSS-R rules before services can be authorized.

If an applicant for IHSS submits as their own an SSN that is already associated with a Person Record in CMIPS II and which has been provided by a different individual, the county must follow the system processes that will be described in detail as part of CMIPS II user training to take the application and potentially authorize services while the issue is researched and resolved. County staff should contact their Medi-Cal program staff to determine if Medi-Cal has completed a Social Security Administration Referral Notice (MC 194) form a copy of which is attached to this letter. This form is a request to SSA to research and resolve the conflict in SSN numbers. If Medi-Cal program staff has not initiated this process, IHSS program staff should request that it be initiated. When SSA has completed its research, it will return the MC 194 with the outcome to Medi-Cal. The IHSS program should take actions consistent with the outcome SSA provides to Medi-Cal, and deny or terminate services as appropriate to the applicant/recipient determined by SSA to have provided an SSN not issued to that person.

### **RECIPIENTS RESIDING IN MORE THAN ONE COUNTY**

An IHSS recipient may reside and receive services in more than one county. As an example, a child recipient may live a portion of the time with their mother in one county and the remainder of the time with their father in a separate county. Similarly, an elderly parent who receives IHSS may divide their time between three adult children who live in separate counties and receive services in all three counties.

In Legacy CMIPS, the recipient would likely have had a case in each county in which they received services. However, in CMIPS II, a recipient will have one Person Record and thereby one case record regardless of the number of counties in which they receive services.

If an IHSS recipient has residence in more than one county a "primary county of residence" must be designated. The primary county of residence will be the county that carries the case. In general, the primary county of residence for the IHSS case should

be the same county where the recipient has active Medi-Cal. There may be exceptions to this, such as when the Medi-Cal case is carried by the county in which eligibility was initially determined regardless of the recipient's county of residence. In these types of circumstances, the recipient may choose the county they want to designate as the IHSS primary county of residence. Please note that it is perfectly acceptable for the Medi-Cal case and the IHSS case to be in different counties; it will not impact Medi-Cal eligibility or FFP for the IHSS case.

The primary county of residence is responsible for all aspects of the case including: conducting the needs assessment; authorizing services; enrolling providers; issuing timesheets; and funding the case. Other counties of residence should be viewed as "alternate service sites" similar to services received in the work place. The services received at the alternate service sites are limited to those currently authorized in the primary county of residence.

The case owner in the primary county of residence should work with the recipient to identify and designate a specific number of the authorized hours available for each alternate service site based on the time the recipient spends at that site. If the recipient chooses, the designated hours may be assigned to the provider at each alternate service site and the recipient should complete and sign an IHSS Recipient Request For Assignment Of Authorized Hours To Providers (SOC 838). The place of residence in each county must also meet the IHSS "own home" criteria. All Individual Providers for the recipient must complete the provider enrollment criteria in order to be enrolled on the case and will receive the wages of the primary county of residence and any benefits offered by that county for which they are eligible.

### **REINSTATEMENT OF RANK 6**

In ACL 88-118 (issued September 6, 1988), the Assessment Standards specified the use of Rank 6 in the following service categories: Meal Preparation & Clean-up, Feeding and Respiration. ACL 88-118 directed counties to assess Rank 6 for these service categories when all services were exclusively paramedical. Legacy CMIPS has been programmed according to this direction since 1988. Design and development of CMIPS II has also incorporated the use of Rank 6 as described in this paragraph.

Manual of Policies and Procedures (MPP) section 30-756.41 currently states that county staff shall assess Rank 1 when all services are exclusively paramedical. It is unclear whether the MPP section has been written this way as far back as 1988, when the ACL was issued. It is uncertain if the need for Rank 6 was realized only after the regulations were promulgated and the regulations were never amended to include Rank 6, or if the MPP section was erroneously amended at some time subsequent to

the 1988 ACL. Regardless, the intent of the direction in ACL 88-118 has always been clear that Rank 6 was to be used when all Meal Preparation and Clean-up, Feeding and/or Respiration services are provided under Paramedical Services.

Please note that the instructions in this ACL supersede the instructions given in ACL 88-118 and ACLs 06-34 and 06-34E2. ACL 06-34 (issued August 31, 2006) included Rank 6 in the Annotated Assessment Criteria. However, ACL Errata 06-34E2 (issued May 4, 2007) eliminated Rank 6 for Meal Preparation & Clean-up, Feeding and Respiration in the Annotated Assessment Criteria. As a result, some counties discontinued using Rank 6 to identify Paramedical needs in these service categories. The elimination of Rank 6 precluded counties from accurately reflecting recipients' needs for Paramedical Services in cases where such services were authorized in addition to human assistance.

Upon receipt of this ACL, counties shall begin using Rank 6 for the following service categories, when applicable, during initial assessments and all reassessments:

- Meal Preparation & Clean-up
- Feeding
- Respiration
- Bowel, Bladder and Menstrual Care

In ACL 09-30, Question #12 asks if there is a Rank 6 for Bowel and Bladder care. The answer stated, "No, Rank 6 is not used for Bowel and Bladder. The recipient should be ranked from one to five based on level of function, irrespective of any related Paramedical Services."

CDSS has reconsidered its position and determined it is appropriate in certain instances for Bowel, Bladder and Menstrual Care to be provided only in the form of Paramedical Services. For instance, you have a recipient who does not need assistance toileting because he is able to get to the bathroom and urinate independently. However, he does need assistance maintaining his colostomy site (a paramedical service). He should be ranked a 6 in Bowel, Bladder and Menstrual Care because all his Bowel, Bladder and Menstrual needs are being met through a Paramedical Service. Therefore, the category of Bowel, Bladder & Menstrual Care has been added to the list of service categories where Rank 6 may be assessed if the need is met only by Paramedical Services. Please note this ACL supersedes the response provided to Question #12 in ACL 09-30.

Rank 6 will be added to the regulation sections for Meal Preparation & Clean-up, Feeding, Respiration and Bowel, Bladder & Menstrual Care in the next amendment to the MPPs. Until that time, ACL 88-118 and this ACL will serve as the authorities for including Rank 6 as part of the assessment criteria when conducting assessments and reassessments. Additionally, the Annotated Assessment Criteria will be modified to reflect these changes.

Functionality for the use of Rank 6 in Legacy CMIPS Rank 6 has not changed since the issuance of ACL 88-118. Counties should resume using Rank 6 based on the instructions in that ACL. Bowel, Bladder and Menstrual has just been added to the categories that are eligible for an assignment of Rank 6 and due to the imminent conversion to CMIPS II, Legacy CMIPS has not been modified to accept a Rank 6 for this service category.

CMIPS II expands the functionality of Rank 6 so social workers may assess and assign Rank 6, as needed, for the authorization of Paramedical Services in Meal Preparation/Clean-up, Feeding, Respiration and Bowel, Bladder and Menstrual Care.

Similar to Legacy CMIPS, CMIPS II will continue to display error messages when there are discrepancies between services authorized and its assigned functional rankings (i.e., Rank 6 has been assigned to a Service Type but there are no Paramedical Services authorized). These validation edits will appear on the screens and documents the error messages that will be displayed for each edit.

- When an attempt is made to save Create or Modify Service Type Feeding and the Functional Rank for Feeding is 6, the following error message will be displayed: Assessed Need not allowed because Functional Area Feeding is indicated as Paramedical.
- When an attempt is made to save a Service Type associated with Meal Prep & Clean-up and the Functional Rank for Meal Prep & Clean-up is 6, the following error message will be displayed: Assessed Need not allowed because Functional Area Meal Prep & Clean-up is indicated as Paramedical.
- When an attempt is made to save a Respiration Service Type and the Functional Rank for Respiration is 6, the following error message will be displayed: Assessed Need not allowed because Functional Area Respiration is indicated as Paramedical.
- When an attempt is made to save a Service Type associated with Bowel & Bladder Care and the Functional Rank for Bowel & Bladder Care is 6, the following error message will be displayed: Assessed Need not allowed because Functional Area Bowel & Bladder is indicated as Paramedical.

To resolve these error messages, the social worker will need to check the functional ranking for the Service Types and confirm a Rank 6 is needed and/or to reassess the functional ranking, if needed. Additionally, the social worker will need to determine why Paramedical Services have not been authorized on the Service Evidence screen if a Service Type has been assigned a Rank 6.

### **INTER-COUNTY TRANSFER (ICT) PROCESS IN CMIPS II**

Conversion to CMIPS II will not create a need for changes to the existing regulatory requirements related to ICTs (MPP sections 30-759.9 to .972). An ICT occurs when an IHSS recipient moves from one county to another and the originating county that has been responsible for the management of the recipient case transfers management of that case to the receiving county.

When an ICT is completed in Legacy CMIPS, the recipient is terminated in the transferring county and a new case is opened and a new case number assigned in the receiving county. The process is primarily a manual exchange between the sending and receiving counties.

In CMIPS II, the ICT process is much more automated providing a more efficient process. For example, a recipient will have a single Person Record and case number for the life of the IHSS case that will follow the recipient during an ICT, rather than terminating the case in the sending county and creating a new case in the receiving county. In CMIPS II, when the receiving county accepts the ICT, the only change to the case number will be the numeric county indicator at the beginning of the case number. For example, in Fresno County the case number might be 10-123456; the 10 at the beginning representing the Fresno County code. After an ICT to Sacramento County, the 10 would change to 34, Sacramento County's code. The second portion of the case number, 123456, remains the same. Thus, the case number would change to 34-123456.

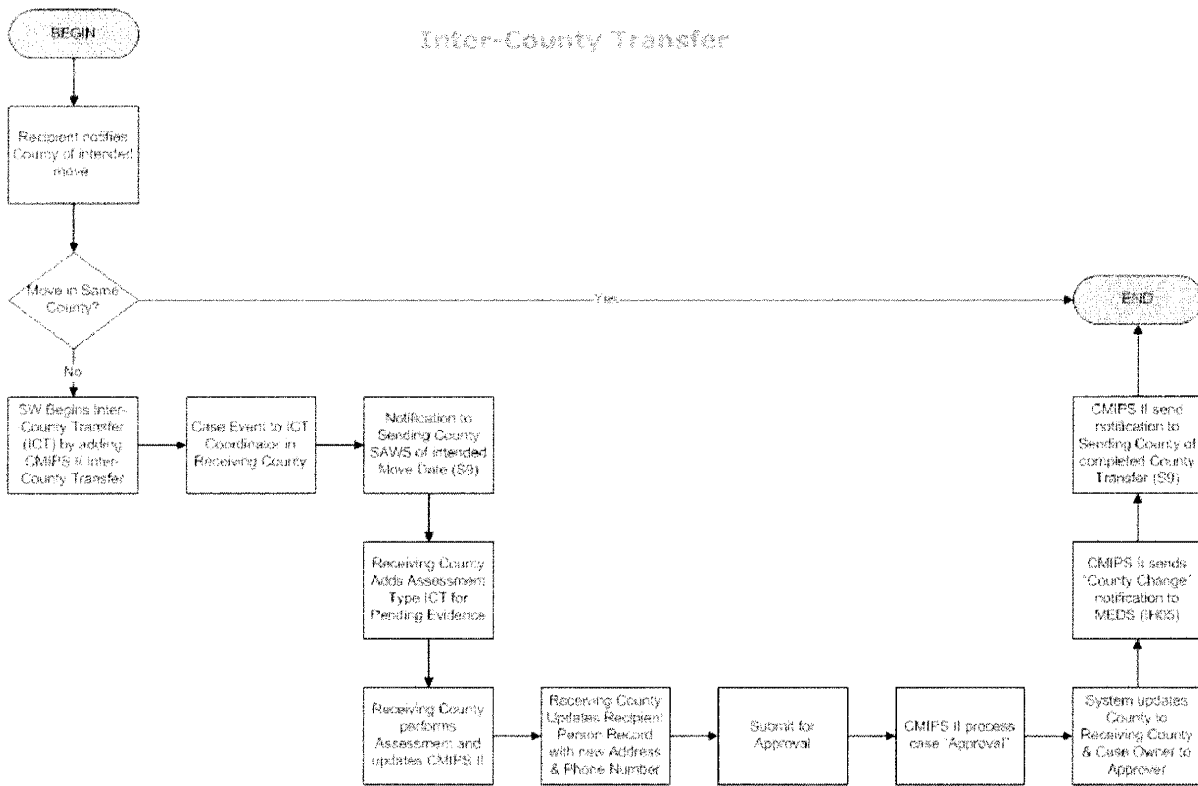
CMIPS II has functionality to support the ICT process including:

- Generating a referral from the transferring to receiving county;
- An assessment specific to ICT;
- Updating county and case owner upon receiving county authorization;
- Notifications to transferring county SAWS system;
- Not allowing an ICT when the case has an open state hearing record in the system; and
- Allowing an ICT to be canceled when necessary.



Although most ICT activities will be conducted within CMIPS II, the transferring county will still be required to fax or mail to the receiving county all completed forms/documents that are retained outside of CMIPS II, such as the Request for Order and Consent – Paramedical Services (SOC 321) form.

If the recipient moves from the receiving county to a third county during the transfer period, the original transferring county is responsible for canceling the transfer to the first receiving county and initiating the transfer to the second receiving county (MPP 30-759.922). The flow chart below documents the steps of the ICT process in CMIPS II. The CMIPS II ICT process is displayed in the flow chart below.



**Inter-County Transfer (ICT) Process during CMIPS II Implementation Phase**

During the period of statewide rollout of CMIPS II, ICTs may occur between two Legacy CMIPS counties, two CMIPS II counties or a Legacy CMIPS county and a CMIPS II county. The following chart provides the possible scenarios and the action to be taken in each scenario.

SCENARIO	ACTION TO BE TAKEN
Legacy CMIPS county is receiving an ICT from a Legacy CMIPS county	Follow current (pre-CMIPS II) procedure
Legacy CMIPS county is receiving an ICT from a CMIPS II county	Follow current (pre-CMIPS II) procedure
CMIPS II county is receiving an ICT from a Legacy CMIPS county	Open new application in CMIPS II
CMIPS II county is receiving an ICT from a CMIPS II county	Follow CMIPS II process to review ICT in CMIPS II and assign to worker (See flow chart above.)
CMIPS II county is sending an ICT to a Legacy CMIPS county	Terminate the case in CMIPS II and follow current (pre-CMIPS II) procedure
Legacy CMIPS county is sending ICT to a CMIPS II county	Follow current (pre-CMIPS II) procedure

**Funding of the Case during Inter-County Transfer (ICT)**

In accordance with existing regulations, the transferring county is responsible for the county share of the case funding until the effective date of authorization in the receiving county. MPP section 30-759.921 states, "The transferring county is responsible for authorizing and funding services until the transfer period expires, at which time the receiving county becomes responsible." Which county maintains the Medi-Cal case is irrelevant to which county pays the county share of funding for the IHSS case. Communication between counties to ensure timely transfer of case responsibility is essential. CMIPS II produces a "Monthly Inter-County Transfer Report" to support communication between counties regarding ICT cases to help ensure ICTs are being completed timely.

If you have questions regarding this letter, contact Adult Programs at (916) 651-1069.

Sincerely,

***Original Document Signed By:***

EILEEN CARROLL  
Deputy Director  
Adult Programs Division

c: CWDA

## SOCIAL SECURITY ADMINISTRATION REFERRAL NOTICE

**Instructions:**

- **To CWD:** Please complete Part I. Retain original for your records, copy for recipient/SSA. Client must take this form to SSA.
- **To Recipients:** Read the back of this form. Take the necessary documentation to the Social Security Administration Office listed below in Part I.B.
- **To SSA:** This form is a request for the action noted in Part I.C. Please complete Part II of this form and distribute as noted in Part I.A. If you have any questions, the eligibility worker's name and phone number are provided.

### PART I: TO BE COMPLETED BY THE COUNTY WELFARE DEPARTMENT

A. Please enter the complete county welfare office name and address within the brackets provided.

**SSA, after completion:**

- Mail this form to the county welfare office.
- Return this form to the recipient to be returned to CWD.

<b>B. Social Security Office Information</b>		
Name of SSA District/Regional Office		
Address (number and street)		
City	State	ZIP code
<b>D. Applicant/Recipient Information</b>		
Recipient's name (last, first, middle initial)		
Date of birth (month/day/year)	Sex (M or F)	
County ID per MEDS		
		X
Recipient's SSN (if applicable)		
Case name		
<b>E. CWO Information</b>		
Name of Eligibility Worker		
Date form completed	E.W. Worker	E.W. phone number

<b>C.</b> The bearer of this form is an applicant for, or recipient of, Food Stamps, Cash Aid, or Medi-Cal. The following service is required:
<input type="checkbox"/> Original SSN card
<input type="checkbox"/> Duplicate SSN card      SSN: _____
<input type="checkbox"/> Info on SSA's Numident File needs to be verified.
<input type="checkbox"/> Name <input type="checkbox"/> DOB <input type="checkbox"/> Sex
<input type="checkbox"/> Info on SSA's Numident File needs to be corrected.
<input type="checkbox"/> Name <input type="checkbox"/> DOB <input type="checkbox"/> Sex
<i>Note: Recipient must provide verification of change.</i>
<input type="checkbox"/> Recipient has been assigned two SSNs. Please take action to delete all but one.
<input type="checkbox"/> Two recipients appear to have been assigned the same SSN. Please verify correct number for recipient from Numident File.
<b>F.</b> Comments

### PART II. TO BE COMPLETED BY THE SOCIAL SECURITY ADMINISTRATION DISTRICT/REGIONAL OFFICE

<b>A.</b> Date received
<b>C.</b> Comments
<b>D.</b> SSA Representative—print name

<b>B.</b> Result of Referral
<input type="checkbox"/> 1. Recipient has completed an SSN application (including Form SS-5 and other proof) and application is being processed.
<input type="checkbox"/> 2. Insufficient ID.
<input type="checkbox"/> 3. SSN application is not being processed. (Explain.)
_____
<input type="checkbox"/> 4. Other. (Explain.)
_____
Signature
Telephone number

**SSA REFERRAL INFORMATION SHEET**  
**(For Medi-Cal, Food Stamp, and CalWORKs Recipients)**

**YOU MUST CONTACT SOCIAL SECURITY**

Public Law requires that each person who applies for or receives full-scope Medi-Cal, Food Stamps, or California Work Opportunity and Responsibility to Kids must have or apply for a social security number. For the applicant/ recipient noted on the reverse side, either (1) the Social Security Administration does not have a social security number on file, or (2) the information provided by the Social Security Administration and the information provided to the eligibility worker do not agree. To correct this situation, you must contact the Social Security Office indicated on the reverse side of this referral form. **DO NOT MAIL THESE FORMS TO THEM.**

**NOTE:** *Age, citizenship or alien status, and identity must all be documented.* One of the identification documents must be a **birth or baptismal certificate established BEFORE age 5**. If one is not obtainable, refer to **Column A** for acceptable substitutes. In addition, if the applicant/recipient is a U.S. citizen born outside of the U.S. or an alien, one of the items listed in **Column B** must be presented.

**Column A**

**Column B**

1. Evidence of Age/Citizenship

- School records
- Church records
- Census records (state or federal)
- Insurance policy
- Marriage records
- Draft card
- U.S. passport
- Other records indicating applicant's age or date and place of birth

1. If you are now a U.S. citizen born outside the U.S., take one of the following items in addition to the item(s) required in Column A:

- U.S. citizen identity card
- U.S. passport
- Naturalization certificate
- Certificate of citizenship
- Consular report of birth
- Form I-179 (U.S. citizen card)
- Form I-197 (U.S. citizen resident card)

2. Evidence of Identity

- Driver's license
- State identification card
- Voter's registration
- School records
- Health records (doctor's, hospital's, etc.)
- Any other document which shows applicant's signature, photograph, or description

2. If you are an alien, take one of the following items in addition to the item(s) listed in Column A:

- Form I-151 or I-551 (Alien Registration Receipt Card)
- Form AR3a, I-94, I-95a, I-84, I-85, I-86, or SW-434
- Letters from Immigration and Naturalization Service showing alien status

If you have a question concerning the two identification documents which you must take to the Social Security Office, please contact the Social Security Office.





JOHN A. WAGNER  
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY  
**DEPARTMENT OF SOCIAL SERVICES**  
744 P Street • Sacramento, CA 95814 • www.cdss.ca.gov



EDMUND G. BROWN JR.  
GOVERNOR

February 23, 2011

ALL-COUNTY LETTER (ACL) NO. 11-19

TO: ALL COUNTY WELFARE DIRECTORS  
ALL COUNTY IHSS PROGRAM MANAGERS

SUBJECT: IN-HOME SUPPORTIVE SERVICES (IHSS) PLUS OPTION (IPO)

REASON FOR THIS TRANSMITTAL

- State Law Change
- Federal Law or Regulation Change
- Court Order
- Clarification Requested by One or More Counties
- Initiated by CDSS

REFERENCES: All-County Information Notice (ACIN) I-33-10, dated April 21, 2010; ACL 05-05, dated June 2, 2005; ACL 05-05E, dated July 20, 2005; ACL 07-08, dated January 26, 2007; All-County Welfare Director's Letter (ACWDL) 06-04, dated February 3, 2006; and Welfare and Institutions Code (WIC) section 14132.952

This All-County Letter provides counties with further information regarding implementation of the In-Home Supportive Services Plus Option (IPO) program.

**Background**

In 2004, California implemented a Social Security Act section 1115 Demonstration Waiver, the IHSS Plus Waiver (IPW) program. This Waiver allowed California to move almost all of the IHSS-Residual (IHSS-R) recipients into either the IPW or Personal Care Services Program (PCSP), and receive Federal Financial Participation (FFP) for services to these recipients. The IPW was limited to five years with a possibility of renewal; however, during that time, the US Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) initiated new options to allow recipients in the IPW to be served in the Medicaid State Plan.

CMS approved a Social Security Act section 1915(j) Self-Directed Personal Assistance Services (PAS) State Plan Option (SPO) program for California. Effective October 1, 2009, this SPO replaced the IPW program and, per WIC section 14132.952, is known as the IHSS Plus Option (IPO). FFP continues for the IPO program.

### **Transition of the IPW Population to the IPO**

Effective October 1, 2009, the IPW population was moved into the new IPO program. The transition to the IPO was seamless for IPO recipients and no notices were issued. The Medi-Cal secondary aid code for this population will continue to be 2L.

IPW and IPO program expenditures will be differentiated in the Case Management, Information and Payrolling System (CMIPS) Legacy and CMIPS II systems based upon service date (i.e., service dates through September 30, 2009 are IPW expenditures, and service dates beginning October 1, 2009 are IPO expenditures).

Individuals who are eligible for full scope FFP Medi-Cal, and have their services provided by a spouse or parent (if the individual is a minor child under 18), or receive Restaurant Meal Allowance or Advance Pay are eligible for the IPO program.

### **Medi-Cal Exemptions**

In accordance with ACWDL #06-04, under the new IPO program, IHSS provider wages paid to a spouse or the parent of a minor child under 18 will continue to be exempt as income for Medi-Cal eligibility as under the IPW program.

### **IPO Program Hours**

Non-Severely Impaired (NSI)/Severely Impaired (SI) Cases

- IPO recipients will continue, as in IPW, to receive a maximum of 195 hours for NSI cases and 283 hours for SI cases [WIC section 14132.952(b)].

### **Differences Between the IPW and IPO**

Unlike the Demonstration Waiver IPW, the IPO is a State Plan Option, and therefore follows the State Plan PCSP regarding program eligibility and services.

### **Program Eligibility**

Under IPW eligibility, a recipient must have had a disability determination completed when the linkage to Medi-Cal was not based on the individual being disabled according to Medi-Cal definitions [Manual of Policies and Procedures (MPP) section 30-785(b)(1)].

Under the IPO program, eligibility is the same as for PCSP, i.e., a recipient is eligible when she/he is a categorically or medically needy Medi-Cal beneficiary as defined in WIC section 14050.1, section 14051, and section 14051.5, who has a disabling condition that causes functional impairment that is expected to last at least twelve consecutive months, or that is expected to result in death within twelve months and who is unable to remain safely at home without the services.

- IPO eligibility, therefore, does not require a disability determination in accordance with Medi-Cal definitions.

### **Program Services**

While IPW services included Teaching and Demonstration, services for the IPO program are the same as for the PCSP and will not include Teaching and Demonstration. Please note, however, there are different rules for recipient services when provided by a spouse or parent(s) (of a minor child under 18) based on program regulations.

### **New Program Requirements for IPO Cases**

The following are new program components required by 42 Code of Federal Regulations (CFR) Part 441:

#### **Enhanced Assessment Process**

42 CFR Part 441.464 requires social workers to complete the following enhanced assessment processes during assessments/reassessments (many of which are already standard practice in most counties):

- Inform recipients of the transition from IPW to IPO beginning March 1, 2011
- Inform recipients they will receive a Notice of Action (NOA) indicating each of their services and the hours allotted for each service
- Inform recipients they may request changes to their authorized hours due to a change in their condition
- Inform recipients of their right to request a state hearing if a request for change has been denied or the amount of their authorized hours has been reduced
- Inform recipients of the voluntary disenrollment process
  - If a recipient chooses to voluntarily change one of the IPO program elements (spouse provider, parent of a minor child under 18 provider, Restaurant Meal Allowance and/or Advance Payment), they would then be moved into the traditional State Plan program known as PCSP



- Social Workers will verbally provide notification of the ability to voluntarily disenroll.

### **Social Worker Training**

Social workers shall receive mandatory training on the following:

- Utilizing a person-centered planning philosophy for assessments;
- The risk management process; and
- Completing the Individualized Back-Up Plan and Risk Assessment Form (SOC 864).

### **Risk Management**

The IPW requirement for completion of an Individual Emergency Back-Up Plan (SOC 827) was applied to all IHSS recipients. The IPO also requires an additional risk management process be completed. Thus, a new form was developed for IPO cases, the SOC 864, to help facilitate this new risk management process. Please see detailed instructions on the attached form for completing this process.

This process must be completed every year, but in the event there have been no changes to the Plan from the prior year, the recipient and social worker may sign in the space provided on page three of the form confirming no changes. However, every IPO recipient must have a new form completed every other year.

Social workers will attend training through the Social Worker Training Academy on the risk management process and completing the new form for IPO recipients. All elements of the form will be discussed. Please see the Training section below for more information.

### **Individualized Back-Up Plan and Risk Assessment Form (SOC 864)**

#### **Pilot**

The California Department of Social Services (CDSS) developed the SOC 864 with input from counties and stakeholders. The form was piloted in five counties: San Diego, San Joaquin, Lassen, Mariposa and Tuolumne. Time study data, county averages and operational issues were compiled from all five counties and this information, as well as stakeholders' input, was utilized in finalizing the form.

### **Use of the Form**

Effective March 1, 2011, all recipients in the IPO program shall be required to complete the new SOC 864. Counties are instructed to continue using the existing SOC 827 for all recipients in the IPO program through February 28, 2011. Counties shall continue using the SOC 827 for all recipients in the PCSP and IHSS-R programs.

### **Translation of the New Form**

The SOC 864 will be available in the state threshold languages for the IPO population, English and Spanish, as required by section 7295.2 of the Government Code.

You will find the SOC 864 on the CDSS website at:

<http://www.cdss.ca.gov/cdssweb/PG168.htm#s>

### **Time Study Code**

Counties are instructed to continue using the same IPW time-study code PC 1034 (PCSP/IPO-Case Management) for all IPO activities including completing the new SOC 864.

### **What to Expect in the Future**

#### **Training**

CDSS and California State University, Sacramento (CSUS) are currently developing an IPO training curriculum to include utilizing a person-centered planning philosophy for assessments; the risk management process; and completing the SOC 864. The IPO training will begin as a pilot and is tentatively scheduled to commence in the spring of 2011. After the pilots and possible regional trainings, CSUS will offer this mandatory training in various counties throughout the State. More information will follow specifying the training details for each county. The IPO training will ultimately be incorporated into the IHSS Training Academy, *IHSS 101 Training*.

#### **Regulations**

CDSS is in the process of developing regulations for the IPO and an ACL regarding IPO regulations will be issued in the near future.

All County Letter No. 11-19  
Page Six

**CMIPS II**

Legacy CMIPS currently does not have the capacity to generate the new SOC 864; however, the form will be generated and auto populated in CMIPS II.

If you have questions regarding any of this information, please call the Waiver and Policy Development Unit, at (916) 651-5350 or email to [APBpolicy@dss.ca.gov](mailto:APBpolicy@dss.ca.gov).

Sincerely,

***Original Document Signed By:***

EILEEN CARROLL  
Deputy Director  
Adult Programs Division

Attachment

## IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM INDIVIDUALIZED BACK-UP PLAN AND RISK ASSESSMENT

### SECTION 1 – RECIPIENT'S INFORMATION

RECIPIENT'S NAME:

CASE NUMBER:

### INDIVIDUALIZED BACK-UP PLAN

### SECTION 2 – SUPPORT CONTACTS

If you need non-emergency assistance, and/or your IHSS care provider has not arrived as scheduled, call:

	Name	Phone
Family Member:		
Friend/Neighbor:		
County Social Services Worker:		
County IHSS Social Services Office:		
Public Authority:		
Other:		

#### Other important numbers available to you, if needed:

Doctor's Office:		
Advocacy Group(s):		
Police Department:		
Fire Department:		
Other:		

#### If you need to report abuse, fraud and/or neglect, call:

Adult Protective Services:	
Child Protective Services:	
Deaf or Hard of Hearing Resource Hotline:	(916) 558-5670
Fraud & Elder Abuse Hotline:	(800) 722-0432
Medi-Cal Fraud Hotline:	(800) 822-6222
Social Security Administration Fraud Hotline:	(800) 269-0271

**If you have an emergency, call: 911**  
An emergency is an immediate threat to your health, welfare and/or safety.

Distribution:

Original/Case File

Copy/Recipient

Page 1 of 4

**IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM  
INDIVIDUALIZED BACK-UP PLAN AND RISK ASSESSMENT**

RECIPIENT'S NAME:

CASE NUMBER:

**RISK ASSESSMENT**

**SECTION 3 – GENERAL RISK ASSESSMENT**

**A. IHSS Assessment**

During this IHSS assessment process, you and your social worker identified risks based on those personal care and domestic and related services for which you may need assistance. Assistance may be met through IHSS or with other formal or informal services.

**B. Additional Risk Areas**

The following are additional risk areas that you and your social worker discussed that may be outside the scope of the IHSS program (check all that apply):

**Comments**

<p><b>B1. Living Arrangements</b></p> <p><input type="checkbox"/> Lives with others who may assist</p> <p><input type="checkbox"/> Lives alone, relatives/friends nearby who may assist</p> <p><input type="checkbox"/> Lives alone, no relatives/friends nearby</p>	
<p><b>B2. Evacuation/Environmental Factors</b></p> <p><input type="checkbox"/> Can evacuate independently</p> <p><input type="checkbox"/> Can evacuate, but only with supervision/verbal direction</p> <p><input type="checkbox"/> Needs physical assistance to evacuate home in an emergency</p> <p><input type="checkbox"/> Able to access food/water independently</p> <p><input type="checkbox"/> Aware of emergency or crisis numbers/contacts</p> <p><input type="checkbox"/> Able to control lights, heat, cooling or other utilities</p>	
<p><b>B3. Communication</b></p> <p><input type="checkbox"/> Communicates without difficulty</p> <p><input type="checkbox"/> Hearing impairment, communication limited</p> <p><input type="checkbox"/> Speech impairment, communication limited</p> <p><input type="checkbox"/> Can speak or hear with the use of assistive device(s) Assistive device(s): _____</p> <p><input type="checkbox"/> Able to place and receive calls independently</p> <p><input type="checkbox"/> Can use telephone only with assistive device(s) Assistive device(s): _____</p>	

**SECTION 4 – DISASTER PREPAREDNESS**

In preparation for a disaster, such as hot and cold weather emergencies, fires, floods, and earthquakes, you and your social worker discussed the following:

- Your individual health needs that will be listed in the County's Disaster Preparedness Assessment Plan (if utilized by your county).

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**IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM  
INDIVIDUALIZED BACK-UP PLAN AND RISK ASSESSMENT**

RECIPIENT'S NAME: \_\_\_\_\_

CASE NUMBER: \_\_\_\_\_

**AGREEMENT AND SIGNATURES**

**SECTION 5 – AGREEMENT AND SIGNATURES**

By signing below, you, your social worker, and any other individual(s) you have chosen to be involved in this process, are confirming you discussed and agree with the information contained in this Individualized Back-Up Plan and Risk Assessment.

**Recipient**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**County Staff**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Title: \_\_\_\_\_

**Authorized Representative**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Relationship: \_\_\_\_\_

**Other**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Relationship: \_\_\_\_\_

In the event there have been no changes in the Individualized Back-Up Plan and Risk Assessment from the prior year, the Recipient/Social Worker can sign below confirming no change.

**Recipient /Authorized Representative**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**County Staff**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Title: \_\_\_\_\_

Distribution:

Original/Case File

Copy/Recipient

**IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM  
INDIVIDUALIZED BACK-UP PLAN AND RISK ASSESSMENT**

RECIPIENT'S NAME:

CASE NUMBER:

**INSTRUCTIONS**

Use this form to work with the recipient to allow him/her independence and choice in decisions related to his/her Individualized Back-Up Plan and Risk Assessment.

Ensure that discussion and negotiation occurs between the social worker, the recipient, and any others whom the recipient wants involved while working through this process. **After completion, a copy of the Individualized Back-Up Plan and Risk Assessment shall be provided to the recipient. The original form shall be filed in the recipient's case file. Social worker shall encourage the recipient to post page 1 in an easily accessible area.**

**SECTION 1:** Fill in the recipient's name, and case number. This information will need to be added to each page until CMIPS II can auto-fill.

**SECTION 2:** Through discussion with the recipient/others involved in the development of this plan, fill in the recipient's choices and preferences of back-up contacts, as well as other important numbers identified, if needed. Discuss abuse, fraud and neglect with the recipient, the process to report abuse, fraud and neglect, and include the local APS/CPS numbers in their area. Reinforce with the recipient to call 911 if he/she has an emergency.

**SECTION 3A:** If assistance will be met through other formal or informal services, complete the SOC 450, Voluntary Services Certification, as needed. Identified risks may be mitigated through the authorization of hours in the service plan. If the recipient refuses any service, clearly document the service refused and the identified risks, and that the recipient elects to assume the risks associated with not receiving the service.

**SECTION 3B:** Also, discuss with the recipient additional risk areas that could be mitigated or improved through discussion and planning (Back-Up Plan).

**SECTION 4:** Discuss disaster preparedness with the recipient/others involved in the development of the plan. Include a discussion of how individual health needs may be addressed in the event of a disaster.

**Section 5:** With the recipient's/others' participation, review all sections verifying that each area was discussed during the process. Ensure that all appropriate individuals sign the form to confirm agreement with the information on the form.

**Comments/Notes:**

Distribution:

Original/Case File

Copy/Recipient



WILL LIGHTBOURNE  
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY  
**DEPARTMENT OF SOCIAL SERVICES**  
744 P Street • Sacramento, CA 95814 • [www.cdss.ca.gov](http://www.cdss.ca.gov)



EDMUND G. BROWN JR.  
GOVERNOR

May 16, 2011

ALL-COUNTY INFORMATION NOTICE: I-27-11

TO: ALL COUNTY WELFARE DIRECTORS  
ALL COUNTY IHSS PROGRAM MANAGERS

SUBJECT: IN-HOME SUPPORTIVE SERVICES (IHSS) PLUS OPTION (IPO)  
COUNTY WELFARE DIRECTOR'S ASSOCIATION OF  
CALIFORNIA (CWDA) REGIONAL MEETING  
QUESTIONS/COMMENTS AND ANSWERS

REFERENCES: All-County Letter (ACL) 11-19, dated February 23, 2011

This All-County Information Notice (ACIN) provides clarification to questions and comments (Attachment A) raised during the County Welfare Directors Association of California (CWDA) Regional Meetings that took place in February 2011. A chart (Attachment B) is also included to show the maximum hours for each IHSS program.

If you have questions regarding any of this information, please call the Waiver and Policy Development Unit, at (916) 651-5350 or email [APBpolicy@dss.ca.gov](mailto:APBpolicy@dss.ca.gov).

Sincerely,

**Original Document Signed By:**

EILEEN CARROLL  
Deputy Director  
Adult Programs Division

Attachments

<u>REASON FOR THIS TRANSMITTAL</u>
<input type="checkbox"/> State Law Change
<input type="checkbox"/> Federal Law or Regulation Change
<input type="checkbox"/> Court Order
<input checked="" type="checkbox"/> Clarification Requested by One or More Counties
<input type="checkbox"/> Initiated by CDSS



## ATTACHMENT A

### CWDA REGIONAL MEETINGS FEBRUARY 2011 ANSWERS TO QUESTIONS/COMMENTS

1. **Q: Clarification was requested regarding the maximum hours for each IHSS program, including IPO and especially protective supervision cases. Can CDSS provide some information on maximum hours for each program?**

A: Attached is a chart that shows the maximum hours for each IHSS program (see Attachment B).

2. **Q: Unlike IPW, the IPO disability requirement is the same as for PCSP. Can APB provide counties with the ACL reference that discussed PCSP disability determinations?**

A: ACL 93-21 provides information on PCSP disability determinations. This ACL may be found at:

<http://www.dss.cahwnet.gov/lettersnotices/entres/getinfo/ac193/93-21.PDF>.

3. **Q: Will CDSS send a mass mailing of Notices of Action (NOAs) to IPO recipients to inform them of the transition from IPW to IPO?**

A: No, a notice is not required and would likely cause confusion for recipients.

#### SOC 827 vs. SOC 864

4. **Q: Who will be required to use the SOC 827 and the SOC 864? ACL 11-19 states that counties shall use the new SOC 864 for all IPO cases, and shall continue using the SOC 827 (Individual Emergency Back-Up Plan) for all PCSP and IHSS-R cases. Some counties would like to use the new SOC 864 for all cases and would like assurance from APB that APB QA will not cite the counties for using the SOC 864 for PCSP/IHSS-R cases.**

A: The SOC 864 must be used for all IPO recipients. Counties may use the SOC 827 or the SOC 864 for PCSP & IHSS-R recipients. APB QA staff will inform county QA staff that the SOC 864 is acceptable for all IHSS cases.

**5. Q: Should social workers fill out both forms (i.e., SOC 827 & SOC 864) for intake assessments if the case cannot be identified as IPO during the initial application process? Or should an SOC 827 be completed and if it turns out the case is IPO eligible, the SOC 864 can be completed at the next reassessment?**

A: Social workers can bring the SOC 864 to all intake assessments when the applicant has a spouse who may potentially be the IHSS provider or if the applicant is a child with a potential parent-provider. If the social worker determines the case is not IPO eligible and is PCSP or IHSS-R eligible during or after the initial assessment, the completed SOC 864 is sufficient as it includes the individualized back-up plan. An SOC 827 may be completed at the next reassessment for those IHSS-R/PCSP recipients. Counties also have the option of using the SOC 864 for all cases.

**6. Q: If a recipient has a change of address that does not require a new face-to-face (i.e., a phone reassessment is adequate), can the SW update the existing SOC 864, mail recipient a new 864 to complete, or not worry about it until the next face-to-face assessment?**

A: Update the existing SOC 864 if necessary. It is not necessary to mail the recipient a new SOC 864 to complete. A new SOC 864 does not need to be completed until the next face-to-face assessment.

#### **From IPO to PCSP**

**7. Q: What if a PCSP case changes to an IPO case before the next reassessment is due?**

A: Counties can wait until the next reassessment to complete an SOC 864.

**8. Q: If a recipient voluntarily disenrolls from IPO and is now PCSP, is the SOC 864 an acceptable substitute for the SOC 827? What if he/she moves from PCSP to IPO? Can he/she wait until the next face-to-face to complete an 864?**

A: The SOC 864 is an acceptable substitute for the SOC 827 under all circumstances. If a recipient moves from PCSP to IPO, the social worker can wait until the next face-to-face to complete an SOC 864.

**9. Q: If a recipient chooses to no longer have one of the IPO options (parent or spouse provider, Restaurant Meal Allowance or Advance Pay), and moves into PCSP, how will this change be reflected in CMIPS?**

A: Once a recipient informs the county of his/her requested change and county staff makes the appropriate change in CMIPS, the recipient's aid code (2L) will automatically update to 2M (PCSP).

#### **Use of Form**

**10. Q: Will the SOC 864 need to be completed for all IPO recipients by 3/1/11?**

A: No, counties should start using the form for all IPO assessments and reassessments beginning in March 2011.

**11. Q: CDSS' forms are password protected. Can CDSS provide an unlocked version of the SOC 864 so that counties may fill in the fields and save the document for future use?**

A: The online version of the SOC 864 is an Adobe PDF, and can be filled in and saved. You can fill in the information for individual recipients and save the document for future use. You can also fill in a county specific template with information to speed up the process, or both. This information can be saved on the form for future use.

**12. Q: A copy needs to be given to the recipient. Will the form have to be filled out twice?**

A: Social workers may complete two forms during the assessment, or bring the completed form back to the office to photocopy and then mail a copy to the recipient. Counties can also have this form reproduced on NCR paper.

**13. Q: Should the information collected in Sections B1-B3 of the SOC 864, pg. 2, be consistent with the SOC 293, D (2) Disaster Preparedness and the Functional Impairment (FI) rankings on the H-line?**

A: Although there is no direct correlation between the information, this form should be consistent with the Assessment information captured on the SOC 293.

**14.Q: Some counties distribute CMIPS print-outs to emergency responders (county disaster preparedness is part of the IPO Risk Assessment form). Is a recipient release form/signature needed before counties can distribute these print-outs with recipient's information?**

A: No, a recipient release form or recipient signature is not needed in order for authorized county staff to release IHSS recipients' names and addresses to emergency agencies in the event of a public safety emergency. [Welfare & Institutions Code (WIC) 10850.9; ACIN I-54-00]

**15.Q: If a recipient participates in completing the Risk Assessment form (SOC 864) but refuses to sign it, should he/she be taken off the IPO program?**

A: Not as long as the recipient participates in the process and agrees with the information on the form. The federal IPO statute does not require that a signature be obtained on the Risk Assessment form, but the statute does require the recipient to participate in the Risk Assessment process in order to be eligible for IPO. If the recipient refuses to participate in the Risk Assessment process, he/she will not be eligible for IPO (i.e., the recipient will not have the option to have a parent or spouse provider, Advance Pay or Restaurant Meal Allowance). A recipient is not required to participate in the Risk Assessment process to be eligible for IHSS/PCSP, as the Risk Assessment is a requirement only for IPO.

## **CMIPS**

**16.Q: Will the SOC 864 be tracked in CMIPS?**

A: No.

**17.Q: Is there a systematic way to identify IPO recipients in CMIPS so that county social workers may highlight these cases to identify that an SOC 864 is needed for the reassessment?**

A: Counties can use the Adhoc Tool to run a report of all 2L cases each month. We encourage each county to set up a process that best suits their needs.

## ATTACHMENT B

### Maximum Hours for In-Home Supportive Services (IHSS) Programs

Type of Case	In-Home Support Services-Residual (IHSS-R)	Personal Care Services Program (PCSP)	In-Home Supportive Services Plus Waiver (IPW)	In-Home Supportive Services Plus Option (IPO)***
Non-Severely Impaired (NSI)	195 hours [WIC 12303.4(a); MPP 30-765.12] <ul style="list-style-type: none"> <li>• The entire 195 hours can be for protective supervision.</li> </ul>	283 hours [WIC 12303.4(b); MPP 30-765.11] <ul style="list-style-type: none"> <li>• Only up to 195 hours can be for protective supervision.**</li> <li>• Additional service-hours, up to a maximum of 283, can be used for other PCSP services.</li> </ul>	195 hours [IPW Application Utilization Controls] <ul style="list-style-type: none"> <li>• The entire 195 hours can be for protective supervision.</li> </ul>	195 hours [IPW Application Utilization Controls] <ul style="list-style-type: none"> <li>• The entire 195 hours can be for protective supervision.</li> </ul>
Severely Impaired (SI)	283 hours [WIC 12303.4(b); MPP 30-765.11] <ul style="list-style-type: none"> <li>• The entire 283 hours can be for protective supervision.*</li> </ul>	283 hours [WIC 14132.95(g)] <ul style="list-style-type: none"> <li>• The entire 283 hours can be for protective supervision.*</li> </ul>	283 hours [IPW Application Utilization Controls] <ul style="list-style-type: none"> <li>• The entire 283 hours can be for protective supervision.*</li> </ul>	283 hours [IPW Application Utilization Controls] <ul style="list-style-type: none"> <li>• The entire 283 hours can be for protective supervision.*</li> </ul>
<p>*Although unlikely, this can occur; the 20 hours or more per week assessed in specific areas as required in the SI definition [MPP 30-701(s)(1); WIC 12303.4(b)], could be provided as an alternate resource.</p> <p>**In the IPW application, CDSS requested to provide all services, including protective supervision, in the IPW with the same NSI/SI hours-restrictions that are in IHSS-R. Per DHCS, CMS informed California that protective supervision can now be considered a State-Plan service under the PCSP. CMS further stated that a State Plan Amendment was not necessary, and that we could provide protective supervision in the PCSP “as described in the Waiver application.” Under Utilization Controls in the Waiver application, the maximum hours for NSI recipients for Protective Supervision are 195 (the same as for IHSS-R).</p> <p>***Maximum hours for IPO are the same as for the IPW, and for IHSS-R [WIC 14132.952(b) states “the IPO shall incorporate the ...benefits...of the IHSS program pursuant to Article 7 (commencing with Section 12300) of Chapter 3.”]</p>				

Amend Section 30-700 to read:

30-700                    PROGRAM DEFINITIONS                    30-700

- .1 The In-Home Supportive Services (IHSS) Program provides assistance to those eligible aged, blind and disabled individuals who are unable to remain safely in their own homes without this assistance. IHSS is an alternative to out-of-home care. Eligibility and services are limited by the availability of funds.
- .2 The Personal Care Services Program (PCSP) provides personal care services to eligible Medi-Cal beneficiaries pursuant to Welfare and Institutions Code Section 14132.95 and Title 22, California Code of Regulations, Division 3 and is subject to all other provisions of Medi-Cal statutes and regulations. The program is operated pursuant to Division 30.
- .3 The IHSS Plus Waiver (IPW) program ~~provides~~ provided IHSS Plus services, to eligible Medi-Cal beneficiaries, subject to Medi-Cal provisions, statutes and regulations, pursuant to Welfare and Institutions Code Section 14132.951 and Title 22, California Code of Regulations, Division 3, and is operated pursuant to Division 30.
  - .31 These services ~~are~~ were available as described in MPP Section 30-757, when services ~~are~~ were provided by a parent of a minor child recipient or a spouse; and/or when the recipient ~~receives~~ received a Restaurant Meal Allowance; and/or when the recipient ~~receives~~ received Advance Payment for in-home care services.
  - .32 Recipients in any one of the categories described in Section 30-700.31, who ~~have~~ had been determined eligible for Medi-Cal, qualify for the IHSS Plus Waiver program.
  - .33 The IHSS Plus Waiver program is a Section 1115 Demonstration Project. This demonstration project ~~has been~~ was approved for 5 years, beginning August 1, 2004. Eligibility and services ~~are~~ were limited to the availability of funds and potential extensions to the demonstration.
    - .331 The IHSS Plus Waiver was extended for 60 days and expired on September 30, 2009.
- .4 The IHSS Plus Option (IPO) program provides self-directed personal assistance services as described and limited in Supplement 5 to Attachment 3.1-A and 3.1-B of the California's Medicaid State Plan and pursuant to Welfare and Institutions Code Section 14132.952, to eligible Medi-Cal beneficiaries, subject to Medi-Cal provisions, statutes and regulations, pursuant to Welfare and Institutions Code Section 14132.952 and Title 22. The IPO program is administered pursuant to Division 30.
  - .41 The IPO program is a State Plan Option as described and limited in Supplement 5 to Attachment 3.1-A and 3.1-B of the California's Medicaid State Plan. Eligibility and services are limited to the availability of funds.

4.5 Individuals who qualify for ~~both IHSS and PCSP funding shall be funded by PCSP, the PCSP or IPO Program shall not be eligible to receive services under the State and county-funded IHSS program (IHSS-Residual). Individuals who are eligible to receive services under the PCSP qualify for IPO shall not be eligible to receive services under PCSP the IPO.~~

5.6 All civil rights laws, rules, and regulations of Division 21 shall be complied with in administering IHSS, PCSP, IPW and IPO program regulations.

Authority Cited: Sections 10553, 10554, 12300, ~~and 14132.95~~, 14132.951, 14132.952, Welfare and Institutions Code; Chapter 939, Statutes of 1992; Section 1115(a); 1915(j) of the Social Security Act; and 42 CFR Part 441.

Reference: Sections 12300, ~~and 14132.95~~, 14132.951, and 14132.952 Welfare and Institutions Code.

Adopt Section 30-786 to read:

30-786 IN-HOME SUPPORTIVE SERVICES (IHSS) PLUS OPTION (IPO) PROGRAM  
30-786

.1 IPO Program Special Definitions

The IHSS Plus Option (IPO) program follows the IHSS Program Definitions and Special Definitions, specified in MPP Sections 30-700 and 30-701, unless otherwise specified.

.11 Voluntary Disenrollment

.111 Counties must permit a participant to voluntarily disenroll from the IPO program at any time and return to PCSP.

.112 Voluntary disenrollment is choosing to no longer receive services from a spouse provider or from a parent-provider of a minor-child recipient, or receive Restaurant Meal Allowance or Advance Payment.

.12 Personal Assistance Services (PAS) means personal care and related services that are provided to an individual who has been determined eligible for the IHSS Plus Option (IPO) program in accordance with MPP 30-786.2.

.13 Risk Management means risk assessment methods used to identify potential risks to the participant, tools or instruments used to mitigate identified risks, and risks that a participant is willing and able to assume.

.14 Self-Direction means that participants or their representatives exercise choice and control over the planning and purchase of IPO services.

.15 Use of Representative means an appointed representative, chosen by the participant, to direct the provision of IPO services on their behalf.

.2 Eligibility

.21 A person is eligible for the IPO who:

.211 is a California resident, living in his/her own home,

.212 is a categorically or medically-needy Medi-Cal beneficiary as defined in Welfare and Institutions Code §14050.1, §14051, and §14051.5 who has a chronic disabling condition that causes functional impairment that is expected to last at least 12 consecutive months, or that is expected to result in death within 12 months, and

.213 who is unable to remain safely at home without the services.



.214 who has an assessed need, based upon a needs assessment as described in MPP Section 30-761, and;

.215 who receives at least one of the following:

- (a) Restaurant Meal Allowance as specified in MPP Section 30-757.133;
- (b) Advance Pay as specified in MPP Section 30-769.73 and 30-769.731;
- (c) Service(s) provided by his/her spouse as allowed in MPP Section 30-763.41; or
- (d) Service(s) as a minor child provided by his/her parent as allowed in MPP Section 30-763.45. and

.216 Any applicable share of cost obligation has been met.

(a) In determining the applicable share of cost the following shall apply:

- (i) Medi-Cal rules regarding share of cost will be followed for purposes of determining Medi-Cal eligibility in accordance with Title 22, CCR, Division 3, Chapter 2, Articles 10, 11 and 12.

### .3 IPO Program Services

.31 Personal care services include:

.311 Assisting with ambulation, including walking or moving around (i.e. wheelchair) inside the home, changing locations in a room, moving from room to room to gain access for the purpose of engaging in other activities. Ambulation does not include movement solely for the purpose of exercise.

.312 Bathing and grooming including cleaning the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub, or shower, reaching head and body parts for soaping, rinsing, and drying. Grooming includes hair combing and brushing, shampooing, oral hygiene, shaving and fingernail and toenail care.

.313 Dressing includes putting on and taking off, fastening and unfastening garments and undergarments, and special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.

.314 Bowel, bladder and menstrual care including assisting the person on and off toilet or commode and emptying commode, managing clothing and wiping and cleaning body after toileting, assistance with using and emptying bedpans, ostomy and/or catheter receptacles and urinals, application of diapers and disposable barrier pads.

.315 Repositioning, transfer, skin care, and range of motion exercises.

(a) Includes moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, chair, or sofa, and the like, coming to a standing position and/or rubbing skin and repositioning to promote circulation and prevent skin breakdown. However, if decubiti have developed, the need for skin and wound care is a paramedical service.

(b) Such exercises shall include the carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function, improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities; and assistive walking.

.316 Feeding, hydration assistance including reaching for, picking up, grasping utensil and cup; getting food on utensil, bringing food, utensil, cup to mouth, manipulating food on plate. Cleaning face and hands as necessary following meal.

.317 Assistance with self-administration of medications. Assistance with self-administration of medications consists of reminding the beneficiary to take prescribed and/or over-the-counter medications when they are to be taken and setting up Medi-sets.

.318 Respiration limited to nonmedical services such as assistance with self-administration of oxygen, assistance in the use of a nebulizer, and cleaning oxygen equipment.

.32 Paramedical services are defined in Welfare and Institutions Code Section 12300.1 as follows:

.321 Paramedical services include the administration of medications, puncturing the skin or inserting a medical device into a body orifice, activities requiring sterile procedures, or other activities requiring judgment based on training given by a licensed health care professional.

.322 Paramedical services are activities which persons could perform for themselves but for their functional limitations.

.323 Paramedical services are activities which, due to the beneficiary's physical or mental condition, are necessary to maintain the beneficiary's health.

.33 Domestic and Related Services, which are subject to time per task guidelines in Section 30-757 and are limited to the following:

.331 Domestic services are limited to the following:

(a) Sweeping, vacuuming, washing and waxing of floor surfaces.

(b) Washing kitchen counters and sinks.

(c) Cleaning the bathroom

- (d) Storing food and supplies.
- (e) Taking out the garbage.
- (f) Dusting and picking up.
- (g) Cleaning oven and stove.
- (h) Cleaning and defrosting refrigerator.
- (i) Bringing in fuel for heating or cooking purposes from a fuel bin in the yard.
- (j) Changing bed linen.
- (k) Miscellaneous domestic services (e.g., changing light bulbs and wheelchair cleaning, and changing and recharging wheelchair batteries) when the service is identified and documented by the case worker as necessary for the beneficiary to remain safely in his/her home.

.332 Laundry services include washing and drying laundry, and is limited to sorting, manipulating soap containers, reaching into machines, handling wet laundry, operating machine controls, hanging laundry to dry if dryer is not routinely used, mending, or ironing, folding, and storing clothing on shelves, in closets or in drawers.

.333 Reasonable food shopping and errands limited to the nearest available stores or other facilities consistent with the beneficiary's economy and needs; compiling a list, bending, reaching, and lifting, managing cart or basket, identifying items needed, putting items away, phoning in and picking up prescriptions, and buying clothing.

.334 Meal preparation and cleanup including planning menus; e.g., washing, peeling and slicing vegetables; opening packages, cans and bags, mixing ingredients; lifting pots and pans; reheating food, cooking and safely operating stove, setting the table and serving the meals; cutting the food into bite-size pieces; washing and drying dishes, and putting them away.

.335 Assistance by the provider is available for accompaniment when the beneficiary's presence is required at the destination and such assistance is necessary to accomplish the travel limited to:

(a) Accompaniment to and from appointments with physicians, dentists and other health practitioners. This accompaniment shall be authorized only after staff of the designated county department has determined that no other Medi-Cal service will provide transportation in the specific case.

(b) Accompaniment to the site where alternative resources provide in-home supportive services to the beneficiary in lieu of IHSS. This accompaniment shall be authorized only after staff of the designated county department have determined that neither accompaniment nor transportation is available by the program.

- .34 Heavy Cleaning, which involves thorough cleaning of the home to remove hazardous debris or dirt.
- .35 Yard hazard abatement, which is light work in the yard which may be authorized for:
- .351 removal of high grass or weeds and rubbish when this constitutes a fire hazard.
  - .352 removal of ice, snow or other hazardous substances from entrances and essential walkways when access to the home is hazardous.
- .36 Protective Supervision, which consists of observing recipient behavior and intervening as appropriate in order to safeguard the recipient against injury, hazard, or accident.
- .361 Protective Supervision is available for observing the behavior of nonself-directing, confused, mentally impaired, or mentally ill persons only.
  - .362 Protective Supervision may be provided through the following, or combination of the following arrangements.
    - (a) In-Home Supportive Services program;
    - (b) Alternative resources such as adult or child day care centers, community resource centers, Senior Centers; respite centers;
    - (c) Voluntary resources;
    - (d) Repealed by Manual Letter No. SS-07-01
  - .363 Protective Supervision shall not be authorized:
    - (a) For friendly visiting or other social activities;
    - (b) When the need is caused by a medical condition and the form of the supervision required is medical.
    - (c) In anticipation of a medical emergency;
    - (d) To prevent or control anti-social or aggressive recipient behavior.
    - (e) To guard against deliberate self-destructive behavior, such as suicide, or when an individual knowingly intends to harm himself/herself.
  - .364 Protective Supervision is only available under the following conditions as determined by social service staff:
    - (a) At the time of the initial assessment or reassessment, a need exists for twenty four- hours-a-day of supervision in order for the recipient to remain at home safely.

(1) For a person identified by county staff to potentially need Protective Supervision, the county social services staff shall request that the form SOC 821 (3/06), "Assessment of Need for Protective Supervision for In-Home Supportive Services Program," which is incorporated by reference, be completed by a physician or other appropriate medical professional to certify the need for Protective Supervision and returned to the county.

(A) For purposes of this regulation, appropriate medical professional shall be limited to those with a medical specialty or scope of practice in the areas of memory, orientation, and/or judgment.

(2) The form SOC 821 (3/06) shall be used in conjunction with other pertinent information, such as an interview or report by the social service staff or a Public Health Nurse, to assess the person's need for Protective Supervision.

(3) The completed form SOC 821 (3/06) shall not be determinative, but considered as one indicator of the need for Protective Supervision.

(4) In the event that the form SOC 821 (3/06) is not returned to the county, or is returned incomplete, the county social services staff shall make its determination of need based upon other available information.

### **HANDBOOK BEGINS HERE**

(5) Other available information can include, but is not limited to, the following:

(A) A Public Health Nurse interview;

(B) A licensed health care professional reports;

(C) Police reports;

(D) Collaboration with Adult Protective Services, Linkages, and/or other social service agencies;

(E) The social service staff's own observations.

### **HANDBOOK ENDS HERE**

(b) At the time of reassessment of a person receiving authorized Protective Supervision, the county social service staff shall determine the need to renew the form SOC 821 (3/06).

(1) A newly completed form SOC 821 (3/06) shall be requested if determined necessary, and the basis for the determination shall be documented in the recipient's case file by the county social service staff.

(c) Recipients may request protective supervision. Recipients may obtain documentation (such as the SOC 821) from their physicians or other appropriate medical

professionals for submission to the county social service staff to substantiate the need for protective supervision.

.365 Social Services staff shall explain the availability of protective supervision and discuss the need for twenty-four-hours-a-day supervision with the recipient, or the recipient's parent(s), or the recipient's guardian or conservator, the appropriateness of out-of-home care as an alternative to Protective Supervision.

.366 The services shall be provided in the recipient's home or other locations as may be authorized by the Director subject to federal approval.

#### .4 IPO Program Administration

All benefits, with the exception of Teaching and Demonstration services, and all operational requirements, will be the same as those of the IHSS program pursuant to MPP Division 30-700.

#### .5 Use of Representative

.51 Participants of the IPO program are permitted to appoint a representative to direct the provision of self-directed PAS on their behalf.

.52 A person acting as a representative for a participant receiving self-directed PAS is prohibited from acting as a provider of self-directed PAS to the participant.

#### .6 Risk Management

.61 All IPO recipients shall have a risk assessment completed during their initial assessment and all reassessments.

.611 The risk assessment process shall utilize the Risk Management form provided by CDSS.

Authority Cited: Sections 10553, 10554, 12300, 14132.95 14132.951, and 14132.952 Welfare and Institutions Code; 1915(j) of the Social Security Act; and 42 CFR Part 441.

Reference: Sections 12300, 12305.1, 14132.95, 14132.951, and 14132.952 Welfare and Institutions Code.



SAMPLE A

## IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM INDIVIDUALIZED BACK-UP PLAN AND RISK ASSESSMENT

### SECTION 1 – RECIPIENT'S INFORMATION

RECIPIENT'S NAME:

Doe, Jane

CASE NUMBER:

34-1234567

### INDIVIDUALIZED BACK-UP PLAN

### SECTION 2 – SUPPORT CONTACTS

If you need non-emergency assistance, and/or your IHSS care provider has not arrived as scheduled, call:

	Name	Phone
Family Member:	John Doe (spouse)	(916) 343-1254
Friend/Neighbor:	Lily Smith (friend)	(916) 258-1722
County Social Services Worker:	Janice Williams	(916) 874-2485
County IHSS Social Services Office:	In-Home Supportive Services	(916) 874-2357
Public Authority:	Public Authority	(916) 874-4131
Other:	James Doe (adult son)/ Mary doe (adult dtr)	(916) 213-1598/ (916) 357-4587

#### Other important numbers available to you, if needed:

Doctor's Office:	Dr. Avery	(916) 331-4501
Advocacy Group(s):	Alta Regional - Allison Brown	(916) 929-8145
Police Department:	Sacramento Police Department	(916) 320-1651
Fire Department:	Sacramento Fire Department	(916) 920-1475
Other:	Sacramento Sheriff's Department	(916) 578-1542

#### If you need to report abuse, fraud and/or neglect, call:

Adult Protective Services:	(916) 245-2684
Child Protective Services:	(916) 354-1598
Deaf or Hard of Hearing Resource Hotline:	<b>(916) 558-5670</b>
Fraud & Elder Abuse Hotline:	<b>(800) 722-0432</b>
Medi-Cal Fraud Hotline:	<b>(800) 822-6222</b>
Social Security Administration Fraud Hotline:	<b>(800) 269-0271</b>

**If you have an emergency, call: 911**

An emergency is an immediate threat to your health, welfare and/or safety.

Distribution:

Original/Case File

Copy/Recipient

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**IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM  
INDIVIDUALIZED BACK-UP PLAN AND RISK ASSESSMENT**

SAMPLE A

RECIPIENT'S NAME:

Doe, Jane

CASE NUMBER:

34-1234567

**RISK ASSESSMENT**

**SECTION 3 – GENERAL RISK ASSESSMENT**

**A. IHSS Assessment**

During this IHSS assessment process, you and your social worker identified risks based on those personal care and domestic and related services for which you may need assistance. Assistance may be met through IHSS or with other formal or informal services.

**B. Additional Risk Areas**

The following are additional risk areas that you and your social worker discussed that may be outside the scope of the IHSS program (check all that apply):

**Comments**

<p><b>B1. Living Arrangements</b></p> <p><input checked="" type="checkbox"/> Lives with others who may assist</p> <p><input type="checkbox"/> Lives alone, relatives/friends nearby who may assist</p> <p><input type="checkbox"/> Lives alone, no relatives/friends nearby</p>	<p>Jane lives with her spouse and two adult children in the home.</p>
<p><b>B2. Evacuation/Environmental Factors</b></p> <p><input type="checkbox"/> Can evacuate independently</p> <p><input type="checkbox"/> Can evacuate, but only with supervision/verbal direction</p> <p><input checked="" type="checkbox"/> Needs physical assistance to evacuate home in an emergency</p> <p><input type="checkbox"/> Able to access food/water independently</p> <p><input type="checkbox"/> Aware of emergency or crisis numbers/contacts</p> <p><input type="checkbox"/> Able to control lights, heat, cooling or other utilities</p>	<p>Jane uses a walker and needs help from spouse to get out of the house during an emergency. Spouse stated he is usually available and if he is not there, one of his two adult children will be available: James and Mary Doe. Contact information on page 1.</p>
<p><b>B3. Communication</b></p> <p><input type="checkbox"/> Communicates without difficulty</p> <p><input checked="" type="checkbox"/> Hearing impairment, communication limited</p> <p><input checked="" type="checkbox"/> Speech impairment, communication limited</p> <p><input checked="" type="checkbox"/> Can speak or hear with the use of assistive device(s) Assistive device(s): <u>video relay &amp; ASL</u></p> <p><input type="checkbox"/> Able to place and receive calls independently</p> <p><input checked="" type="checkbox"/> Can use telephone only with assistive device(s) Assistive device(s): <u>video relay</u></p>	<p>Jane's phone is connected to a video relay service so when SW dials phone number, relay service will connect to client's video relay phone. Jane requires an ASL interpreter.</p>

**SECTION 4 – DISASTER PREPAREDNESS**

In preparation for a disaster, such as hot and cold weather emergencies, fires, floods, and earthquakes, you and your social worker discussed the following:

- Your individual health needs that will be listed in the County's Disaster Preparedness Assessment Plan (if utilized by your county).

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**IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM  
INDIVIDUALIZED BACK-UP PLAN AND RISK ASSESSMENT**

SAMPLE A

RECIPIENT'S NAME:

Doe, Jane

CASE NUMBER:

34-1234567

**AGREEMENT AND SIGNATURES**

**SECTION 5 – AGREEMENT AND SIGNATURES**

By signing below, you, your social worker, and any other individual(s) you have chosen to be involved in this process, are confirming you discussed and agree with the information contained in this Individualized Back-Up Plan and Risk Assessment.

**Recipient**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**County Staff**

Signature: \_\_\_\_\_ Date: 3/11/11

Print Name and Title: Janice Williams, Human Services Social Worker

**Authorized Representative**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Relationship: \_\_\_\_\_

**Other**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Relationship: \_\_\_\_\_

In the event there have been no changes in the Individualized Back-Up Plan and Risk Assessment from the prior year, the Recipient/Social Worker can sign below confirming no change.

**Recipient /Authorized Representative**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**County Staff**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Title: \_\_\_\_\_

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**IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM  
INDIVIDUALIZED BACK-UP PLAN AND RISK ASSESSMENT**

SAMPLE A

RECIPIENT'S NAME:

Doe, Jane

CASE NUMBER:

34-1234567

**INSTRUCTIONS**

Use this form to work with the recipient to allow him/her independence and choice in decisions related to his/her Individualized Back-Up Plan and Risk Assessment.

Ensure that discussion and negotiation occurs between the social worker, the recipient, and any others whom the recipient wants involved while working through this process. **After completion, a copy of the Individualized Back-Up Plan and Risk Assessment shall be provided to the recipient. The original form shall be filed in the recipient's case file. Social worker shall encourage the recipient to post page 1 in an easily accessible area.**

**SECTION 1:** Fill in the recipient's name, and case number. This information will need to be added to each page until CMIPS II can auto-fill.

**SECTION 2:** Through discussion with the recipient/others involved in the development of this plan, fill in the recipient's choices and preferences of back-up contacts, as well as other important numbers identified, if needed. Discuss abuse, fraud and neglect with the recipient, the process to report abuse, fraud and neglect, and include the local APS/CPS numbers in their area. Reinforce with the recipient to call 911 if he/she has an emergency.

**SECTION 3A:** If assistance will be met through other formal or informal services, complete the SOC 450, Voluntary Services Certification, as needed. Identified risks may be mitigated through the authorization of hours in the service plan. If the recipient refuses any service, clearly document the service refused and the identified risks, and that the recipient elects to assume the risks associated with not receiving the service.

**SECTION 3B:** Also, discuss with the recipient additional risk areas that could be mitigated or improved through discussion and planning (Back-Up Plan).

**SECTION 4:** Discuss disaster preparedness with the recipient/others involved in the development of the plan. Include a discussion of how individual health needs may be addressed in the event of a disaster.

**Section 5:** With the recipient's/others' participation, review all sections verifying that each area was discussed during the process. Ensure that all appropriate individuals sign the form to confirm agreement with the information on the form.

**Comments/Notes:**

SW discussed risk assessment with Jane. Jane and spouse stated they understood the risks involved with Jane's need to use a walker in case of an emergency. Spouse stated he or his two children will assist Jane, if needed. SW informed Jane and spouse to post page one of this form in an easily accessible area such as the refrigerator or by the telephone. Jane has several throw rugs in the home which may be hazardous as she uses a walker to ambulate safely in the home. SW suggested to Jane and spouse that removing the throw rugs or taping them down may reduce the risk of Jane tripping on the rugs. Jane and spouse declined suggestion, stating they prefer the rugs to be in their home and did not want to remove the rugs or tape them down.

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SAMPLE B

## IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM INDIVIDUALIZED BACK-UP PLAN AND RISK ASSESSMENT

### SECTION 1 – RECIPIENT'S INFORMATION

RECIPIENT'S NAME:  
Smith, Johnny

CASE NUMBER:  
34-4378679

### INDIVIDUALIZED BACK-UP PLAN

### SECTION 2 – SUPPORT CONTACTS

If you need non-emergency assistance, and/or your IHSS care provider has not arrived as scheduled, call:

	Name	Phone
Family Member:	Annie Smith (mom)	(916) 258-7845
Friend/Neighbor:	Maggie Johnson (grandma)	(916) 458-4598
County Social Services Worker:	Tom Brown	(916) 874-4518
County IHSS Social Services Office:	In-Home Supportive Services	(916) 874-1125
Public Authority:	Public Authority	(916) 874-7854
Other:	Amy Smith (sister)/ Kaylee Smith (sister)	(916) 327-5214/ (916) 213-6241

#### Other important numbers available to you, if needed:

Doctor's Office:	Dr. Thompson	(916) 627-4581
Advocacy Group(s):	Alta Regional - Wendy Lee	(916) 929-4512
Police Department:	Sacramento Police Department	(916) 320-1651
Fire Department:	Sacramento Fire Department	(916) 920-1475
Other:	Sacramento Sheriff's Department	(916) 578-1542

#### If you need to report abuse, fraud and/or neglect, call:

Adult Protective Services:	(916) 245-2684
Child Protective Services:	(916) 354-1598
Deaf or Hard of Hearing Resource Hotline:	<b>(916) 558-5670</b>
Fraud & Elder Abuse Hotline:	<b>(800) 722-0432</b>
Medi-Cal Fraud Hotline:	<b>(800) 822-6222</b>
Social Security Administration Fraud Hotline:	<b>(800) 269-0271</b>

**If you have an emergency, call: 911**  
An emergency is an immediate threat to your health, welfare and/or safety.

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**IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM  
INDIVIDUALIZED BACK-UP PLAN AND RISK ASSESSMENT**

SAMPLE B

RECIPIENT'S NAME:  
Smith, Johnny

CASE NUMBER:  
34-4378679

**RISK ASSESSMENT**

**SECTION 3 – GENERAL RISK ASSESSMENT**

**A. IHSS Assessment**

During this IHSS assessment process, you and your social worker identified risks based on those personal care and domestic and related services for which you may need assistance. Assistance may be met through IHSS or with other formal or informal services.

**B. Additional Risk Areas**

The following are additional risk areas that you and your social worker discussed that may be outside the scope of the IHSS program (check all that apply):

**Comments**

<p><b>B1. Living Arrangements</b></p> <p><input checked="" type="checkbox"/> Lives with others who may assist</p> <p><input type="checkbox"/> Lives alone, relatives/friends nearby who may assist</p> <p><input type="checkbox"/> Lives alone, no relatives/friends nearby</p>	<p>Johnny (12-year-old child) lives with his mom and two adult sisters.</p>
<p><b>B2. Evacuation/Environmental Factors</b></p> <p><input type="checkbox"/> Can evacuate independently</p> <p><input type="checkbox"/> Can evacuate, but only with supervision/verbal direction</p> <p><input checked="" type="checkbox"/> Needs physical assistance to evacuate home in an emergency</p> <p><input type="checkbox"/> Able to access food/water independently</p> <p><input type="checkbox"/> Aware of emergency or crisis numbers/contacts</p> <p><input type="checkbox"/> Able to control lights, heat, cooling or other utilities</p>	<p>Johnny is wheelchair bound and needs help from his mom to get out of the house during an emergency. Mom stated she is available and if she is not there, one of her adult daughters can help Johnny. Mom also stated Johnny's grandma comes over a few times a week and may be available too. Contact information listed on page 1.</p>
<p><b>B3. Communication</b></p> <p><input type="checkbox"/> Communicates without difficulty</p> <p><input type="checkbox"/> Hearing impairment, communication limited</p> <p><input checked="" type="checkbox"/> Speech impairment, communication limited</p> <p><input checked="" type="checkbox"/> Can speak or hear with the use of assistive device(s) Assistive device(s): <u>American Sign Language (ASL)</u></p> <p><input type="checkbox"/> Able to place and receive calls independently</p> <p><input type="checkbox"/> Can use telephone only with assistive device(s) Assistive device(s): _____</p>	<p>Johnny is non-verbal. He communicates using ASL. His mom and two sisters are verbal but also can communicate using ASL. Johnny needs an ASL interpreter.</p>

**SECTION 4 – DISASTER PREPAREDNESS**

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**IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM  
INDIVIDUALIZED BACK-UP PLAN AND RISK ASSESSMENT**

SAMPLE B

RECIPIENT'S NAME:  
Smith, Johnny

CASE NUMBER:  
34-4378679

**AGREEMENT AND SIGNATURES**

**SECTION 5 – AGREEMENT AND SIGNATURES**

By signing below, you, your social worker, and any other individual(s) you have chosen to be involved in this process, are confirming you discussed and agree with the information contained in this Individualized Back-Up Plan and Risk Assessment.

**Recipient**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**County Staff**

Signature: \_\_\_\_\_ Date: 5/25/11

Print Name and Title: Tom Brown, Social Worker I

**Authorized Representative**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Relationship: \_\_\_\_\_

**Other**

Signature: \_\_\_\_\_ Date: 5/25/11

Print Name and Relationship: Annie Smith, mother/provider

In the event there have been no changes in the Individualized Back-Up Plan and Risk Assessment from the prior year, the Recipient/Social Worker can sign below confirming no change.

**Recipient /Authorized Representative**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**County Staff**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name and Title: \_\_\_\_\_

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**IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM  
INDIVIDUALIZED BACK-UP PLAN AND RISK ASSESSMENT**

SAMPLE B

RECIPIENT'S NAME:  
Smith, Johnny

CASE NUMBER:  
34-4378679

**INSTRUCTIONS**

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**SECTION 3A:** If assistance will be met through other formal or informal services, complete the SOC 450, Voluntary Services Certification, as needed. Identified risks may be mitigated through the authorization of hours in the service plan. If the recipient refuses any service, clearly document the service refused and the identified risks, and that the recipient elects to assume the risks associated with not receiving the service.

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**Comments/Notes:**

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## THINGS TO CONSIDER WHEN ASSESSING

### **AA Domestic Services** [MPP 30-757.11]

Sweeping, vacuuming, and washing/waxing floors; washing kitchen counters and sinks; cleaning the bathroom; storing food and supplies; taking out garbage; dusting and picking up; cleaning oven and stove; cleaning and defrosting refrigerator; bringing in fuel for heating or cooking purposes from a fuel bin in the yard; changing bed linen; changing light bulbs; and wheelchair cleaning and changing/recharging wheelchair batteries.

- What is the living arrangement? How many people live in the home? Does the consumer have a separate bedroom and bathroom? How many people use the rooms used in common? Are there any rooms not being used by the consumer? What are the proration rules that apply?
- What is the consumer's mental status? Is he/she alert? Are there cognitive issues that prevent the consumer from completing tasks?
- Avoid judging the suitability of the living situation based on your own standards versus the safety of the situation. The social worker may not believe this is the best condition, but the check is if it is SAFE?
- What physical or mental limitations exist that contribute to the consumer's need for assistance?
- Look at the number and size of rooms to be cleaned. The assessed need for a studio apartment should usually be less than for a larger dwelling.
- If the consumer suffers from incontinence, frequent changes of bed linen may be necessary if the consumer does not have protective pads that protect linens. Extra changing of the sheets should be assessed as domestic services but the washing of them is assessed as laundry.

#### **Common Authorization Mistakes:**

- *Everyone is assessed 6.00 hours per month regardless of FI score.*
- *Size of residence or lifestyle choices are not taken into consideration.*
- *Service is authorized when the consumer resides with Able/Available spouse or is a minor child with parent provider.*
- *The total need is divided by the number of persons living in the household without taking into consideration shared living regulations.*
- *Social workers are sometimes not familiar with how to document "refused services".*

## THINGS TO CONSIDER WHEN ASSESSING

### **BB & CC Meal Preparation and Clean-Up** [MPP 30-757.131 and .132]

Meal Prep: Planning menus; removing food from the refrigerator or pantry; washing/drying hands before and after meal preparations; washing, peeling, and slicing vegetables; opening packages, cans and bags; measuring and mixing ingredients; lifting pots and pans; trimming meat; reheating food; cooking and safely operating the stove; setting the table; serving the meals; pureeing food; and cutting the food into bite-sized pieces.

Meal Clean-up: Loading and unloading dishwasher; washing, rinsing, and drying dishes, pots, pans, utensils, and culinary appliances, and putting them away; storing/putting away leftover foods/liquids; wiping up tables, counters, stoves/ovens, and sinks; and washing/drying hands.

- Are there health or safety issues that prevent the consumer from preparing their own meals?
- What is the living arrangement? In shared living situations, are the meals prepared together with other family members? Some meals may be prepared separately and others may be shared.
- What are the consumer's specific medical dietary requirements? Are they requirements that preclude the housemates from sharing meals? For example, a diabetic diet or heart diet are healthy diets that can be shared by housemates.
- What types of meals does the consumer typically eat?
- Can the consumer chew? Do they need pureed foods?
- Does the consumer need help cutting up food?
- What alternative resources are available? Do they get Meals on Wheels or go to a day care center that provides meals? Are there voluntary resources such as family or neighbors who bring food to the consumer?
- Is the consumer able to use the kitchen?
- How often is meal preparation needed? How often does the consumer eat?
- What is their Functional Index rank for Meal Preparation?
- Observe if the consumer's movements are impaired. Do they have poor strength and endurance? Can they lift pots/pans? Can they bend or stoop? Can they reach stored food or utensils?
- Ask if they can stand long enough to prepare a meal, help with clean up, wash the dishes or load the dishwasher.
- Is the consumer safe around a stove? Do they use oxygen?
- Does the consumer have a microwave? Can s/he use it? A consumer who is otherwise unable to use the stove to prepare a meal may be able to reheat meals in the microwave.
- Authorization of Restaurant Meals Allowance may be appropriate for some consumers.

#### **Common Authorization Mistakes:**

- *Needs are assessed for meals that consumers are able to prepare/clean-up without any assistance.*
- *Consumers are assessed the same amount of time regardless of what type of meals they eat (frozen dinner vs. full meal).*
- *Everyone gets the same amount of time for meal prep/clean-up regardless of what they eat or their FI score.*
- *Alternative resources such as Meals on Wheels or meals received at ADHCs are not taken into consideration in the authorized hours.*

## THINGS TO CONSIDER WHEN ASSESSING

### **DD Laundry** [MPP 30-757.134]

Washing and drying laundry, mending, ironing, folding, and storing clothes on shelves or in drawers.

- Provider should accomplish other tasks while clothes are washing and drying if done in the home.
- If the consumer has a washer and the capability to dry clothes on the premises, laundry facilities are considered to be in the home. Per CDSS policy “on the premises” means available within an apartment complex or mobile home park.
- If the consumer is able to do some laundry, their assessed need may be less than the 1 or 1.5 hours per week guideline.
- If the consumer has incontinence or other issues which creates extra laundry, justification for the extra hours is required in the case file. (Not everyone who is incontinent requires extra laundry as some consumers wear pads or underwear to prevent soiling clothing and bedding and use protective pads on beds.)
- Does the consumer have the capability to hand wash some items? If so, the need for laundry may be decreased.
- Is the consumer’s laundry washed separately? What is the living arrangement? If the consumer’s laundry is done with laundry of other household members, proration rules apply.

#### **Common Authorization Mistakes:**

- *Consumers routinely are assessed at the guideline of 1.00 or 1.50 hours per week without taking into consideration things that the consumer is able to do, such as gathering clothes, folding clothes, etc.*
- *Consumers are assessed extra hours for out of home laundry facilities when laundry facilities exist on the premises of apartment buildings, mobile home parks, etc.*

### **EE Shopping for Food** [MPP 30-757.135(b)]

Making a grocery list, travel to/from the store, shopping, loading, unloading, and storing food.

- What is the living arrangement? Is shopping for groceries for the entire household? Is there a reason the shopping must be done separately?
- Observe the consumer’s ability to move around the home. Observe the consumer’s ability to reach, grasp, and lift.
- Are they physically/mentally able to perform all tasks related to shopping?
- If the consumer “prefers” items from a particular distant store but there are comparable items at a nearby store, extra time is not allowed for the provider to shop at the preferred store. An exception would be if the nearby store is not consistent with the consumer’s economic needs.
- Although the consumer may want to accompany the provider shopping, extra time should not be approved.

#### **Common Authorization Mistakes:**

- *A need is assessed for services the consumer is able to perform independently, such as going to a nearby store for small items.*
- *Consumers are assessed extra time to go to distant stores when there is a nearby store that is consistent with their economic needs.*
- *Extra time is allowed for the consumer to accompany the provider shopping.*

## THINGS TO CONSIDER WHEN ASSESSING

### **FF Other Shopping and Errands** [MPP 30-757.135(c)]

Making a shopping list, travel to/from store, shopping, loading, unloading, and storing supplies purchased, and/or performing reasonable errands such as delivering a delinquent payment to avert an imminent utility shut-off or picking up a prescription, etc.

- What is the living arrangement? Is other shopping and errands done for the entire household?
- In some cases, the other errands may be completed when the food shopping is done, e.g. superstore which has a pharmacy, clothing, etc., and additional time for shopping and errands may not be needed.
- Purpose of other shopping and errands is for picking up prescriptions, going to the bank, shopping for clothing, getting a haircut, etc.
- What alternative resources are available or could be obtained to help with shopping and errands?
- Although the consumer may want to accompany the provider shopping, extra time should not be approved.

### **GG Heavy Cleaning** [MPP 30-757.12]

Involves thorough cleaning of the home to remove hazardous debris or dirt.

- Heavy cleaning can be authorized at the time IHSS is initially granted to enable the provider to perform continuous maintenance; or if a lapse in eligibility occurs, eligibility is re-established, and IHSS has not been provided within the previous 12 months. Can also be authorized when living conditions are a threat to his/her safety or when the consumer is at risk for eviction for failure to prepare his/her home for fumigation as required by statute or ordinance.
- An APS referral might be appropriate to develop a corrective plan so that the heavy cleaning service can occur (so that the hoarder doesn't take things back out of the dumpster during the cleanup process). This may increase the potential that a provider can maintain the home after heavy cleaning.
- Health factors should be considered when authorizing this service. Is there human or animal waste, garbage lying around, clutter that prevents the consumer from moving around the house safely, etc.? Referral to APS or Public Health may be indicated in some cases.
- Are the extreme conditions the result of lifestyle choice or the consumer's disability? Referral for a new provider might be needed if the current provider is not performing authorized services. If this is a lifestyle choice, this service would not benefit the consumer because it would not make a difference in his/her future living conditions.

#### **Common Authorization Mistakes:**

- *Justification for allowing the service is not documented in the case file.*
- *A plan has not been developed to assure that the housing unit can be maintained after heavy cleaning has been completed.*
- *A need is assessed for reasons that are not consistent with regulations which specify when the service can be authorized.*

## THINGS TO CONSIDER WHEN ASSESSING

### **HH Respiration** [MPP 30-757.14(b)]

Limited to non-medical services such as assistance with self-administration of oxygen and cleaning IPPB machines.

- Observe the home for breathing equipment. Does the consumer cough or wheeze excessively during the interview? Is their breathing labored? Always ask regarding the need for breathing equipment. May be used intermittently and not in plain sight.
- What type of apparatus does the consumer use? Is the consumer physically and mentally able to hold a nebulizer or inhaler without assistance for the required time?
- Ask if they have been instructed on how to use their equipment and if they are able to manage cleaning it.
- If the consumer has an oxygen machine but can hook it up and clean it themselves, they should be considered independent with respiration.
- If the provider or others assist with the administration of oxygen and/or cleaning of the equipment, how often is the assistance provided and how long does it take?
- Is there a service that does maintenance? If the consumer has a service that assists them with the cleaning of their equipment, those needs should be assessed and shown as being met through an alternative resource on the SOC 293.
- Does the consumer have a portable tank?
- Does the consumer need help putting the apparatus on? How often is this needed and how long does it take?

#### **Common Authorization Mistakes:**

- *Alternative resources that the consumer receives (such as cleaning equipment by vendor) are often not identified.*
- *Consumer is capable of performing the services for which a need is assessed.*

## THINGS TO CONSIDER WHEN ASSESSING

### **II Bowel and Bladder** [MPP 30-757.14(a)]

Assistance with using, emptying, and cleaning bed pans/bedside commodes, urinals, ostomy, enema and/or catheter receptacles; application of diapers; positioning for diaper changes; managing clothing; changing disposable barrier pads; putting on/taking off disposable rubber gloves; wiping and cleaning recipient; assistance with getting on/off commode or toilet; and washing/drying recipient's and provider's hands.

- Does the consumer have difficulty getting to the bathroom in time?
- Can you smell urine/feces in the home?
- Are there other signs of bowel/bladder incontinence, such as supplies of diapers in the bedroom/bathroom or pads on the bed to prevent soiling bedding?
- Observe for signs that the consumer is not making it to the bathroom in time or missing the toilet.
- Does the consumer have a medical condition or take medications which contribute to the need for assistance with bowel and bladder care?
- Is the need expected to be ongoing or time limited? Example: Consumer normally can get to the bathroom and does not require assistance, but due to a recent injury/surgery, cannot get into the bathroom.
- What assistive devices does the consumer have? What devices would help minimize the need for assistance? Examples: Elevated toilet seat or bars that can assist on/off the toilet.
- Does the consumer use a urinal or bedside commode?
- Can the consumer complete cleaning and maintenance of the commode? If the consumer uses a bedside commode or urinal but can empty or clean it by themselves, they should be assessed as Rank 1 (independent).
- Can the consumer stay on the commode/toilet once assisted to get on?
- Is the consumer able to change diapers/pads?
- Is the consumer able to wipe himself?
- Is the consumer incontinent? How many times a day? Some cleaning will need to occur after each episode of incontinence. Can the consumer manage that cleaning?
- How many times a day does the consumer use toilet/commode if they need an assist, and how long for each assist? (Separate answers for bowel movement and for urination.)
- What impact does bowel and bladder issues have on needs for extra laundry and/or an increased need for Domestic services? Also consider need to have laundry done separately.
- If the consumer has ostomy bag, and the provider is only emptying the bag, services are assessed as bowel/bladder.

#### **Common Authorization Mistakes:**

- *Service is assessed when the consumer experiences some difficulty performing task, however, it does not put them at risk for injury, hazard or accident.*
- *A need is assessed for consumers who wear diapers but are able to manage without assistance from another person.*
- *Consumer needs assistance but is too embarrassed to discuss the need and the social worker does not ask.*

## THINGS TO CONSIDER WHEN ASSESSING

### **JJ Feeding** [MPP 30-757.14(c)]

Assistance with consumption of food and assurance of adequate fluid intake consisting of feeding or related assistance to recipients who cannot feed themselves or who require other assistance with special devices in order to feed themselves or to drink adequate liquids.

- Does the consumer have physical conditions that prevent him/her from grasping/holding utensils, cups, etc.? Is it difficult or impossible? Look for paralysis, tremors, weakness, arthritis, pain, or physical deformity.
- A consumer's hands may be deformed and they may have restricted ability to grasp but if they are able to feed themselves, they would still be considered independent.
- Does the consumer have a special device or brace on his hand or available for feeding?
- Is the consumer's condition consistent throughout the day? Does it improve after medication? Is their independence better for some meals?
- Look for cognitive issues that may interfere with focus during eating, i.e., psychotic disorder, severe depression, mental confusion, or dementia. If such disorders exist, does the consumer eat if reminded? Does the provider need to sit with the consumer, encouraging him/her throughout the meal?
- Does the provider need to feed the consumer?
- How many times a day does the consumer eat and how much time does it take for each meal?
- Are there some meals that the consumer can eat independently while others require more hands on help? Example: Consumer can eat toast or sandwich independently, but requires hands on help for dinner.
- How willing is the consumer to eat? Will they eat once you've set food in front of them, or do they need constant attention?
- When the consumer greets you, how do they shake hands with you? Do they appear extremely frail? Shaky?
- Does the consumer appear undernourished? Observe if their clothes appear too large, possibly indicating a recent weight loss. Ask them what they have eaten that day. If the consumer didn't eat that day, ask follow-up questions to determine the reason.
- If the consumer is able to feed themselves and does not need the provider's constant presence, the provider can often remind them to eat while they are doing other IHSS tasks such as meal cleanup or housework.
- If the consumer feeds self, do they spill food on clothing, table, etc. which results in increased need for dressing, laundry, meal cleanup?

### **Common Authorization Mistakes:**

- *Often services are assessed for reminding the consumer to eat, which in many cases can be done while the provider is accomplishing other tasks.*
- *A need is assessed for cutting food, which should be assessed as part of meal preparation.*

## THINGS TO CONSIDER WHEN ASSESSING

### **KK Bed Baths** [MPP 30-757.14(d)]

Includes cleaning basin or other materials used for bed sponge baths and putting them away; obtaining water and supplies; washing, rinsing, and drying body; applying lotion, powder and deodorant; and washing/drying hands before and after bathing.

- Is the shower or tub too narrow for the consumer to access?
- Are there steps or other barriers leading to the bathroom that prevent the consumer from going into the bathroom?
- Is the consumer recovering from an injury or surgery? If so, their needs will probably be different than the long-term bed bound consumer. Consider a time-limited assessment, or flag the case for follow-up at time of expected recovery.
- Does the consumer need to be bathed daily to prevent skin breakdown and pressure sores?
- How many times a week does a consumer need to be bathed to maintain safety?
- Can the consumer assist with the process at all? If so, this should be encouraged to maximize independence and promote self-esteem.
- The assessed need for consumers who are unable to assist in changing positions or participate in washing their body, etc. will be greater than that of consumers who can change positions and assist.
- How long does it take to bathe the consumer?

#### **Common Authorization Mistakes:**

- *A need is assessed for bed baths when the consumer is able to safely bathe in the bathroom.*



## THINGS TO CONSIDER WHEN ASSESSING

### **LL Dressing** [MPP 30-757.14(f)]

Washing/drying of hands; putting on/taking off, fastening/unfastening, buttoning/unbuttoning, zipping/unzipping, and tying/untying of garment, undergarments, corsets, elastic stockings and braces; changing soiled clothing; and bringing tools to the recipient to assist with independent dressing.

- If the consumer dresses self, observe if he/she is appropriately dressed for their environment.
- Consider lifestyle choices. Do they prefer to spend the day in pajamas or sweats? Consider that even if they prefer to spend the day in pajamas or sweats, they will probably dress in other clothing when they leave the house for medical appointments, etc.
- Is the consumer bed bound?
- Does the consumer use specialized garments, braces, splints, etc.?
- Do they frequently soil their clothing causing frequent changes?
- Does the consumer have uncontrollable tremors in extremities or medical problems such as arthritis that affect the hands/fingers making fastening or lacing garments difficult?
- Does the consumer have devices that assist with dressing? Could they use devices that would assist them in dressing? If not, suggest these items to the consumer/family/provider. These may lessen the need for assistance.
- Remember that one of the goals should be to foster independence so the consumer should be encouraged to do whatever they are capable of doing to dress self or assist in dressing.
- Do they look and appear comfortably dressed?
- Are all buttons buttoned correctly? Zippers zipped? Shoes tied or fastened?
- If the consumer only changes clothing in the morning and evening or only requires occasional assistance, the assessed time should reflect that.
- If the consumer only requires assistance on “bad days” such as after dialysis treatments, the need should reflect this.

#### **Common Authorization Mistakes:**

- *Consumer changes clothes only once a day, however, assessed need reflects numerous clothing changes.*
- *Consumer has minor need, however, assessed need reflects full clothing changes.*
- *Consumer needs only occasional assistance, however, need reflects daily assistance.*

## THINGS TO CONSIDER WHEN ASSESSING

### **MM Menstrual Care** [MPP 30-757.14(j)]

Limited to external application of sanitary napkins and external cleaning and positioning for sanitary napkin changes; using and/or disposing of barrier pads; managing clothing; wiping and cleaning; and washing/drying hands before and after performing these tasks.

- Limited to external application of sanitary napkin and cleaning.
- Does the consumer menstruate? Regardless of the consumer's age, it is vital to ask questions as spotting might indicate a possible serious medical condition. Is her period regular? What is the duration?
- Ask what kinds of personal assistance she requires.
- Are there any mental/physical issues? Why does the consumer require assistance?
- Determine whether the task is still needed at each reassessment. Stop authorization when the consumer has gone through menopause or has had a hysterectomy.
- Determine amount of daily time assistance is required by asking about the number of times pad is changed daily and how long it takes each time. Determine weekly time by multiplying daily time by number of days the period lasts. Divide weekly time by 4.33, as time entered on the SOC 293 is weekly.

#### **Common Authorization Mistakes:**

- *A need is assessed when the consumer is able to perform the task without assistance.*
- *Need is typically monthly, however assessed need does not reflect it as such (menstrual cycles are normally only once a month, however, time is sometimes assessed as a weekly need).*
- *Authorization continues even after the consumer goes through menopause.*
- *The social worker is too embarrassed to discuss menstrual care so there is no discussion about the reason assistance is needed, the frequency changes are needed, or the duration of the period.*

## THINGS TO CONSIDER WHEN ASSESSING

### **NN Ambulation** [MPP 30-757.14(k)]

Assisting the recipient with walking or moving from place to place inside the home, including to and from the bathroom; climbing or descending stairs; moving and retrieving assistive devices, such as a cane, walker, or wheelchair, etc.; and washing/drying hands before and after performing these tasks. Also includes assistance to/from the front door to the car (including getting in and out of the car) for medical accompaniment and/or alternative resource travel.

- How much difficulty does the consumer have in moving around the house or from the front door to the car (and in and out of car for medical appointments or travel to alternative resources)? Ask the consumer to show you around the house and observe their mobility.
- Does the consumer need help maneuvering the wheelchair from one room to another?
- Ask if they feel safe walking around their home and if they have a history of falls when ambulating.
- Can the person move around more safely using a walker/cane? Do they know how to use them properly? Do they remember to use the assistive device or leave it next to the chair when they get up and walk?
- If the consumer does not have assistive devices and it appears they are needed to make the consumer safer and more independent, suggest that the consumer or his/her representative discuss this with their physician.
- Will the consumer use assistive devices?
- If they use a wheelchair, walker or cane but can do so safely without assistance, they should be considered independent.
- Is the consumer at risk if they are unassisted? Consider the amount of assistance needed to keep the consumer safe – stand-by versus hands-on.
- How often does the consumer move around the home? How long does it take them to get from place to place?
- Are there stairs the consumer must maneuver?
- Consider whether the consumer needs someone to bring assistive devices to them and put them away. If so, time should be assessed under ambulation.

### **Common Authorization Mistakes:**

- *A need is assessed for assistance moving around outside of the home – time should be related to daily activities which the consumer needs to walk (or use a wheelchair/walker) to perform, such as walking to and from the bathroom, bedroom, and kitchen. Ambulation is not authorized for general exercise purposes or for assistance walking outside of the home.*
- *Need is often based solely on the fact that the consumer uses an assistive device. Assistive devices often make the consumer independent or less dependent on the need for human assistance.*

## THINGS TO CONSIDER WHEN ASSESSING

### **OO Moving In/Out of Bed (Transfers)** [MPP 30-757.14(h)]

Transfers: Assisting from standing, sitting, or prone position to another position and/or from one piece of equipment or furniture to another. This includes transfer from a bed, chair, couch, wheelchair, walker, or other assistive device generally occurring within the same room.

- Assess the consumer's strength, balance, flexibility, and stability on their feet.
- Does the consumer use any assistive devices to assist in transfer or would such devices increase safety and improve independence?
- Does the consumer need the assistance of a Hoyer or other type of lift to transfer them from the bed to the wheelchair?
- Does the provider need to do a pivot transfer? Does the consumer have an appropriate belt to assist in this process?
- Can the consumer use furniture safely to get in and out of a position for transfer?
- Ask the consumer if s/he gets dizzy upon standing up and if s/he has ever fainted or fallen when that happens. Ask if this was reported to the consumer's physician and if not, suggest they report this at the next visit.
- Do they nap during the day? Do they need help every time they get in and out of bed?
- Does the consumer have trouble getting out of a chair? If so, getting out of bed would probably be even more difficult.
- Ask them if they need help getting out of bed in the morning or back in at night. It may be more difficult for the consumer to get out of bed in the morning due to joint stiffness, etc., but may be able to get back into bed without assistance.

#### **Common Authorization Mistakes:**

- *Assessed need reflects more time than is actually required.*
- *Consumer is allowed time daily, however, only requires assistance on bad days.*
- *Need is assessed when assistive device allows the consumer to move in and out of bed without assistance.*

## THINGS TO CONSIDER WHEN ASSESSING

### **PP Bathing, Oral Hygiene, Grooming** [MPP 30-757.14(e)]

**Bathing:** Cleaning the body in a tub or shower; obtaining water/supplies and putting them away; turning on/off faucets and adjusting water temperature; assistance with getting in/out of tub or shower; assistance with reaching all parts of the body for washing, rinsing, drying and applying lotion, powder, deodorant; and washing/drying hands.

**Oral hygiene:** Applying toothpaste, brushing teeth, rinsing mouth, caring for dentures, flossing, and washing/drying hands.

**Grooming:** Hair combing/brushing; hair trimming when the recipient cannot get to the barber/salon; shampooing, applying conditioner, and drying hair; shaving; fingernail/toenail care when these services are not assessed as “paramedical” services for the recipient; and washing/drying hands.

- Consider a medical condition that would increase the need for frequent bathing, i.e., diabetes (sweating), incontinence, skin allergies, or lesions which need to be kept clean. Note that the care of open lesions would be a paramedical service.
- What is the consumer’s activity level? The more active they are, the more frequent the need for bathing.
- How often is the consumer currently being bathed? Does the consumer look clean?
- Does the consumer resist bathing (frequently with people with Alzheimer’s disease)?
- How much assistance does the consumer need? What can they do to maximize their independence?
- Does the consumer need assistance to get in/out of tub for safety, but able to bathe himself once in the tub or on a shower stool?
- Assess the need for a grab bar or shower chair to maximize safety and promote independence.
- Frequent bathing of the elderly can cause dry skin leading to itchiness, lesions, or skin breakdown.
- Elderly people who are not active frequently do not bathe on a daily basis.
- Time for application of lotion/powder to the skin after bathing can be included here.
- Does the consumer need shaving? How often and how long does it take? Can the consumer shave himself with an electric shaver?
- How often does the consumer need hair washing?
- Can the consumer brush their own teeth? Floss?
- Can the consumer do their own denture care?
- Can the consumer do their own hair (comb/brush)? Check out range of motion of their arms.
- If toenail care is medically contraindicated, it is evaluated as a paramedical service.

#### **Common Authorization Mistakes:**

- *A need is assessed for services that the consumer is able to perform without assistance.*
- *Services are assessed daily and it is apparent that they are not being performed (consumer is not clean).*
- *Services are assessed daily, however, the provider provides services less frequently.*

## THINGS TO CONSIDER WHEN ASSESSING

### **QQ Repositioning and Rubbing of Skin** [MPP 30-757(g)(1) & (2)]

Repositioning and Rubbing of Skin: Rubbing skin to promote circulation and/or prevent skin breakdown; turning in bed and other types of repositioning; and limited range of motion exercises.

- Is the consumer's movement unimpaired?
- Are they able to get out of a chair unassisted?
- Are they able to reposition themselves as necessary in a wheelchair or in bed?
- How often does the consumer move around? If bed bound, medical repositioning standard is every 2-3 hours. Discuss with consumer/responsible person what physician has indicated is needed. If necessary, get clarification from physician's office.
- Does the consumer need skin rubbing to promote circulation and prevent skin breakdown?
- Range of motion exercises must have been taught to the consumer by a licensed health care professional.
- If pressure sores have developed, the need for care of them is evaluated as a paramedical service.
- Range of motion must be needed to restore mobility restricted because of injury, disuse, or disease, not for comfort or esthetic reasons.
- A need for maintenance therapy which is consistent with the consumer's capacity and tolerance may be authorized. This consists of carrying out the performance of repetitive exercises required to maintain function, improve gait, maintain strength or endurance; passive exercises to maintain range of motion in paralyzed extremities; and assistive walking.

#### **Common Authorization Mistakes:**

- *A need is assessed when the consumer can safely perform transfers without assistance from another person.*
- *Assessed need does not accurately reflect number of times assistance is required.*

## THINGS TO CONSIDER WHEN ASSESSING

### **RR Care and Assistance with Prosthesis** [MPP 30-757.14(i)]

Assistance with taking off/putting on and maintaining and cleaning prosthetic devices, vision/hearing aids and washing/drying hands before and after performing these tasks. Reminding the recipient to take prescribed and/or over-the-counter medications when they are to be taken and setting up medi-sets.

- How long does it take to set up a mediset? How many times a week? Consider packaging of pills from the pharmacy.
- Does the consumer’s cognitive impairment make it unsafe to do self-meds setup? Can the consumer remember to take meds from the filled medi-set? Is the consumer mentally competent to manage their own meds?
- If assistance with medication is more complicated, for example administering injections, the time should be assessed as a paramedical service.
- If the consumer requires prosthetic devices, ask what types of assistance they require. May be assessed as “dressing” versus “care & assistance with prosthesis”. For example, if the consumer uses a leg brace, putting it on would be “Dressing” rather than “Care and Assistance with Prosthesis.”
- When a provider must physically put the medication into a consumer’s mouth or orifice, this should be assessed as a paramedical service rather than assistance with prosthesis.

#### **Common Authorization Mistakes:**

- *Assessed need reflects daily set up of medications; however provider sets up medications one time weekly.*
- *Time is authorized when consumer requires only “reminding” to take meds which is done while provider is performing other tasks.*

### **SS Accompaniment to Medical Appointments** [MPP 30-757.15]

Transportation to and from appointments with physicians, dentists, and other health practitioners. Transportation necessary for fitting health related appliances/devices and special clothing. Authorized only after social service staff have determined that Medi-Cal will not provide transportation in the specific case.

- Accompaniment is only authorized when the consumer needs the help of a provider because of mobility problems or because the consumer gets disoriented. It is not just to fill the consumer’s need for transportation. It is not to act as an interpreter because the consumer does not speak or understand English.
- Does not include time waiting for an appointment to finish.
- If the consumer takes a bus to appointments, time should be authorized only if the consumer cannot ambulate **outside** of the home without assistance.
- If the consumer uses taxi scripts or is driven to appointments, time should be authorized only if the consumer cannot ambulate **inside** the home without assistance.
- Consumers using medi-vans should not be authorized accompaniment time unless they are confused or disoriented.
- Transportation should be authorized only after it is determined that Medi-Cal will not provide transportation in the specific case. Suggest that the consumer be asked if they ever use Medi-vans that use their Medi-Cal card for.

#### **Common Authorization Mistakes:**

- *Assessed need includes time waiting for the consumer while they are in the appointment.*
- *Assessed need does not reflect the total time needed during the month because the monthly need was not converted to a weekly need when completing the SOC 293.*
- *Assessed need includes accompaniment to locations not consistent with regulations.*
- *Assessed need is authorized on a weekly or monthly basis when the consumer only goes to the physician twice a year.*

## THINGS TO CONSIDER WHEN ASSESSING

### **TT Accompaniment to Alternative Resources** [MPP 30-757.15]

Transportation to the site when alternative resources provide in-home supportive services to the recipient in lieu of IHSS.

- Accompaniment to alternative resources should only be authorized if the alternative resource does not provide its own transportation (most adult one-day health centers provide their own transportation) and when the consumer is going to receive some service at the alternative resource site that is an alternative to IHSS.
- Also see SS above.

#### **Common Authorization Mistakes:**

- *Need is assessed for transportation to a location which provides services which are not an alternative to IHSS.*
- *Need is assessed for transportation to practitioners other than physicians, such as chiropractors, dentists, and podiatrists. Transportation to physicians, dentists, and other health practitioners should be assessed as Accompaniment to Medical Appointments.*

### **UU Remove Grass, Weeds, Rubbish** [MPP 30-757.16]

Removal of high grass or weeds, and rubbish when this constitutes a fire hazard.

- This is not gardening. Need for the service must constitute a fire or safety hazard.
- Has the consumer received a citation from the fire department or other agency?
- How long will it reasonably take to eliminate the yard hazard? Consider the size of the yard, amount of weed growth, and time of year.

#### **Common Authorization Mistakes:**

- *Services are allowed for merely enhancing the appearance of the yard.*
- *Type of living arrangement has not been taken into consideration.*

### **VV Remove Ice, Snow** [MPP 30-757.16]

Removal of ice, snow from entrances and essential walkways when access to the home is hazardous.

- Must constitute a safety hazard.
- Must be from entrances and essential walkways.
- Must be stopped when the season changes.

#### **Common Authorization Mistakes:**

- *Calendar controls are not set.*
  - *Service allowed during summer months.*



## THINGS TO CONSIDER WHEN ASSESSING

### **WW Protective Supervision** [MPP 30-757.17]

Observing recipient behavior and intervening as appropriate in order to safeguard nonself-directing recipients who are confused, mentally impaired or mentally ill against injury, hazard or accident.

- Protective supervision consists of observing the consumer's behavior in order to safeguard them against injury, hazard or accident.
- This service is available for monitoring the behavior of non-self-directing, confused, mentally impaired or mentally ill persons.
- Not in anticipation of a medical emergency (seizure, heart attack, there might be a fire and the consumer couldn't get out of the house if this were to happen) or to control anti-social or aggressive behavior (consumer might break neighbor's windows, has a tendency of smearing feces, may take drugs). Not to prevent suicide.
- A 24-hour need must exist which can be met through IHSS and alternative resources.
- Ask for a description of incident(s) that have occurred during which the consumer placed him/herself at risk for injury, hazard and accident and date(s) of the incidents. Do they wander? Do they attempt to turn on the stove or operate appliances?
- What does the consumer do when confronted with danger, crisis or hazard?
- Has the provider voluntarily instituted measures such as taking knobs off stoves, putting locks/alarms on doors which have eliminated the ability of consumer to put him/herself at risk? (Cannot require this, but should be considered if this was done voluntarily.)
- Do they know how to act in a way that is appropriate to the situation?
- Never having an "accident" is not cause to deny services.
- Even if the consumer says that they know what to do, can they act on it?
- Is the consumer physically capable of placing themselves at risk for injury, hazard or accident? Are they bed or wheelchair bound?
- What is their mental functioning? How alert are they? Consider progression of dementia may lesson need. Need must be reassessed yearly.
- Is the consumer ever left alone? If so, how long are they able to be alone?
- Not being able to get self out of the home in case of fire or other emergency is, in itself, not a basis for authorizing protective supervision.

#### **Common Authorization Mistakes:**

- *Hours are not calculated correctly.*
- *Documentation in the case file does not indicate how the consumer places themselves in danger for injury, hazard or accident.*
- *Protective supervision is assessed when the primary purpose is one of the following:*
  - *Friendly visiting.*
  - *The need is caused by a medical condition and the form of supervision required is medical.*
  - *In anticipation of a medical emergency or to prevent or control anti-social or aggressive consumer behavior.*
- *The need is not reassessed when a reassessment is conducted.*
- *The authorized hours are not removed when the consumer's condition changes and they are no longer able to physically put themselves at risk for injury, hazard or accident.*

## THINGS TO CONSIDER WHEN ASSESSING

### **XX Teaching & Demonstration** [MPP 30-757.18]

- Limited to instruction in domestic tasks, related services, non-medical personal care services and yard hazard abatement.
- Provider must possess skills to effectively and safely train the consumer.
- There must be a reasonable expectation that the consumer will no longer require IHSS assistance with the task after the training, or assistance will be at a reduced level.

#### **Common Authorization Mistakes:**

- *Services authorized longer than three months.*
- *Results of service not sent to CDSS.*

### **YY Paramedical** [MPP 30-757.19]

Activities which include the administration of medications, puncturing the skin, or inserting a medical device into a body orifice, activities requiring sterile procedures or other activities requiring judgment based on training given by a licensed health care professional.

- Does the consumer require injections? Are they able to safely self-administer them?
- Do they require a bowel program or other invasive medical type procedure?
- Is the consumer physically or mentally able to perform the function?
- Life support is usually not paramedical because it doesn't meet the definition of "...are activities which persons would normally perform for themselves but for their functional limitations." Consider a referral for In Home Medical Care through DHS' In Home Operations. Perhaps the doctor should be referring for Home Health Agency care and/or hospice, if indicated.
- Paramedical services cannot be authorized prior to obtaining a medical order (SOC 321) from the consumer's physician confirming the provider has been trained in the required procedures.

#### **Common Authorization Mistakes:**

- *Paramedical services are authorized before SOC 321 has been obtained.*
  - *Services should not be authorized until SOC 321 is correctly completed and in the case file.*
- *Services approved are not always paramedical in nature.*
- *The time period for which the services are ordered by the physician has expired.*
- *The authorization for services continue indefinitely without reassessment. The need for services should be reassessed at each assessment.*