

# AGENDA PROGRAM INTEGRITY / STATE HEARING

## DAY 1

Time	Topic	Notes
8:30 – 8:45 (15 min)	<b>Welcome/Introductions</b>	<ul style="list-style-type: none"> <li>Welcome</li> <li>Housekeeping</li> <li>Introductions</li> <li>Pre-Evaluations</li> </ul>
	<b>Overview of the Day</b>	<ul style="list-style-type: none"> <li>Review slide content/discussion</li> </ul>
8:45 – 9:15 (30 min)	<b>Activity: The Young Woman and the Sailor</b>	<ul style="list-style-type: none"> <li>Bias and perspective activity</li> <li>Follow up discussion related to assumptions</li> </ul>
9:15 – 10:45 (90 min including a 15 min break)	<b>The State Hearing Process</b>	<ul style="list-style-type: none"> <li>Focus on content, roles, and process of state hearings</li> </ul>
	<b>Break</b>	<b>15 minutes</b>
10:45 – 11:30 (45 min)	<b>Scenario: Marjorie</b>	<ul style="list-style-type: none"> <li>Scenario-based exercise</li> </ul>
<b>11:30 – 12:30</b>	<b>Lunch</b>	<b>60 minutes</b>
12:30 – 1:00 (30 min)	<b>Program Integrity Overview</b>	<ul style="list-style-type: none"> <li>Focus on program integrity</li> <li>Ways program integrity issues are identified</li> </ul>
1:00 – 1:10 (10 min)	<b>Flipchart Activity</b>	<ul style="list-style-type: none"> <li>Activity: What is the social worker’s role in prevention and detection of program integrity issues?</li> </ul>
1:10 – 3:10 (120 min including a 15 min break)	<b>Definition of Fraud, The Social Worker’s Role</b>	<ul style="list-style-type: none"> <li>What is fraud?</li> <li>What is the social worker’s role?               <ul style="list-style-type: none"> <li>✓ Video: <i>The Social Worker’s Role</i> (3:00)</li> </ul> </li> <li>Preparing for the home visit</li> <li>The home visit               <ul style="list-style-type: none"> <li>✓ Video: <i>The Home Visit</i> (6:02)</li> </ul> </li> <li>Red flags               <ul style="list-style-type: none"> <li>✓ Video: <i>Red Flags</i> (6:50)</li> </ul> </li> <li>Communication               <ul style="list-style-type: none"> <li>✓ Video: <i>Communication</i> (4:02)</li> </ul> </li> <li>Documentation               <ul style="list-style-type: none"> <li>✓ Video: <i>Documentation</i> (5:50)</li> </ul> </li> <li>Exercise: Red Flags (30 min)</li> </ul>
	<b>Break</b>	<b>15 minutes</b>

<p>3:10 – 4:10 (60 min)</p>	<p><b>Complaints / Referrals, Program Integrity Protocols and Forms</b></p>	<ul style="list-style-type: none"> <li>• Complaints / referrals               <ul style="list-style-type: none"> <li>✓ Video: <i>Referrals</i> (7:12)</li> <li>✓ Fraud referral procedures</li> <li>✓ Complaint of Suspected Fraud Form (SOC 2248)</li> <li>✓ Scenario-based exercise</li> <li>✓ Data Reporting Form (SOC 2245)</li> </ul> </li> <li>• Directed mailing</li> <li>• Unannounced home visit and UHV Findings Report Form (SOC 2247)</li> </ul>
<p>4:10 – 4:30 (20 min)</p>	<p><b>Wrap-up</b></p>	<ul style="list-style-type: none"> <li>• Post-Evaluations</li> </ul>

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

During this training, participants will learn about program integrity, the state hearing process, and the social worker's role in each of these areas. This course utilizes lecture, discussion, group, and individual activities to deliver course content.

This one-day training will cover the following topics:

- Error and Fraud Prevention and Detection
  - Program Integrity Overview
  - Social Worker's Role
  - Red Flags
  - Communication
  - Documentation
  - Referrals
  - Directed Mailings
  - Unannounced Home Visits
- State Hearing Process
  - Content, roles, and process of state hearings
  - The social worker's role as a witness

## Objectives:

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

1. Define fraud and explain how it differs from inadvertent mistakes.
2. Identify the social worker's role and responsibilities in IHSS fraud and error prevention, detection, referral, investigation, and prosecution.
3. Identify the rationale for directed mailings and unannounced home visits as part of the state's and counties' efforts to deter fraud and ensure program integrity and be familiar with the process for each.
4. Describe why documentation is important in the fraud investigation process, and key information to include in documentation.
5. Identify the importance of understanding individual biases when preparing for a state hearing.
6. Describe the state hearing process showing understanding of the rules and regulations that govern it.
7. Identify the roles of those involved in the state hearing process and how the social worker interacts with each.

8. Define burden of proof and how that applies to removing services and what the county must prove and the importance of thorough documentation.
9. State the strategies for successfully presenting information which will enhance the social worker's credibility.

## WELCOME TO THE IHSS TRAINING ACADEMY PROGRAM INTEGRITY / STATE HEARING

### TABLE OF CONTENTS

#### Front Pocket

Questions to Ask My County  
Video Notes  
Home Visit Checklist for Fraud and Error Prevention  
Flowchart for Unannounced Home Visits

#### Tab

##### 1: Day 1 Slides

##### 2: State Hearing

Division 22 Regulations  
State Hearing Roles  
DPA 315: Conditional Withdrawal of Request for Hearing  
Decreasing IHSS Hours – County Responsibility at State Hearings  
Rules of Evidence  
ACL 09-68 [IHSS Provider Appeals Process]  
ACL 10-42 [IHSS Provider Disqualification Appeal Decisions]

##### 3: Program Integrity

ACIN I-13-13 [Release of the Uniform State wide Protocols for Program Integrity  
Activities in the In-Home Supportive Services (IHSS) Program]  
ACL 13-83 [Implementation of the Uniform State wide Protocols for Program Integrity  
Activities in the In-Home Supportive Services (IHSS) Program]  
CMIPS Reports  
Educating about Errors and Fraud at the Home Visit  
Acknowledgement Forms: SOC 332 and SOC 846  
Interview Skills  
The Interview  
Red Flags  
IHSS Complaint of Suspected Fraud Form (SOC 2248)  
Prosecution 101: An Overview of the Life of a Criminal Case  
IHSS Fraud Data Reporting Form (SOC 2245)  
IHSS UHV Findings Report (SOC 2247)  
ACIN I-17-15 Entry of fraud complaints and aps/cps/fraud referrals into case management,  
information and payroll system (CMIPS)

#### **4: Scenarios**

Activity: The Young Woman and the Sailor

Scenario: Marjorie

Prior Assessment Worksheet

HTG Documentation Worksheet

Addendum

Scenario: SOC 2248 Completion

## HOME VISIT CHECKLIST FOR ERROR AND FRAUD PREVENTION

- Advised consumer/provider that I would be going over several forms that they would need to sign. Told them to ask questions about any items that were not clear.
- Advised consumer that a physician's certification would be requested or needed to be updated to verify the need for services.
- Advised that only providers who have gone through the provider enrollment and cleared a background check can be paid by IHSS.
- Advised consumer that they were considered the "employer" and that they are responsible for keeping track of the hours that the provider works.
- Advised consumer that they must sign the timesheet and should check their records (i.e., calendar, other tracking method) to make sure that the provider has worked all hours on the timesheet.
- Advised consumer that they should never sign a blank timesheet.
- Advised consumer that the provider can only be paid for performing services authorized by IHSS and for hours actually worked.
- Advised consumer that they should always check the NOAs to see which services are authorized and how much time should be spent on each service.
- Informed consumer of some types of services not covered by IHSS (i.e., pet care, routine gardening, taking consumer on social outings).
- Advised consumer that if the provider wished to provide services not covered by IHSS voluntarily, these services cannot be put on the timesheet as hours worked.
- Advised consumer that they must report all of the following changes to their social worker:
  - ✓ When someone moves in or out of the household.
  - ✓ Any changes in marital status.
  - ✓ When there is a change in the type or amount of services they need.
  - ✓ When they go into and are discharged from a hospital, nursing home, or board and care facility.
  - ✓ If their provider is incarcerated, on vacation, or otherwise unavailable to provide services. Provided information about how they could obtain another provider if this happens (e.g. Public Authority).
  - ✓ If they start or stop receiving services from other agencies that provide some of the services that are authorized by IHSS (e.g. Meals On Wheels).



## **OTHER QUESTIONS - WHO TO CONTACT:**

**Please direct any IHSS program policy questions to the appropriate Policy manager as follows:**

- IHSS assessment-related questions  
Shawntel Bush: [Shawntel.Bush@dss.ca.gov](mailto:Shawntel.Bush@dss.ca.gov)
- IHSS provider-policy questions  
Adam Quintana: [Adam.Quintana@dss.ca.gov](mailto:Adam.Quintana@dss.ca.gov)
- Program eligibility and protective supervision policy questions  
Vicki Cescato: [Victoria.Cescato@dss.ca.gov](mailto:Victoria.Cescato@dss.ca.gov)

**Program Integrity questions:**

[IHSS-PI@dss.ca.gov](mailto:IHSS-PI@dss.ca.gov)

**Quality Assurance/Monitoring questions:**

[IHSS-QAMU@dss.ca.gov](mailto:IHSS-QAMU@dss.ca.gov)

**Training and Development questions:**

[IHSS-Training@dss.ca.gov](mailto:IHSS-Training@dss.ca.gov)

**CMIPS II and systems-related questions:**

[CMIPSII-Requests@dss.ca.gov](mailto:CMIPSII-Requests@dss.ca.gov)

# FLOWCHART FOR UNANNOUNCED HOME VISITS

## PREPARATION:

Prior to conducting the home visit, the Unannounced Home Visit Social Worker (UHV-SW) shall:

- Review the case file and note pertinent information.
- Consult with the IHSS case worker or supervisor.
- Gather the IHSS UHV Findings Report (SOC 2247) and the UHV Follow-Up Letter to take to the UHV.
- Take your ID badge.

Whether or not the UHV-SW successfully completes a UHV, all efforts and findings must be documented using the SOC 2247. This form must be maintained with the case file.

The UHV-SW completes the SOC 2247 as thoroughly as possible, documenting each attempted contact with the recipient. Document the following:

- Dates and times of contact attempts,
- The results of contact attempts,
- Whether or not they left a message, the content of any messages left, and
- Any contact received from the recipient or authorized representative.

## UHV Not Accomplished:

If recipient is not available or refuses to cooperate, the UHV-SW shall:

- Hand deliver/leave the UHV Follow-Up Letter at the recipient's home in an obvious location, such as in the door or in an area otherwise likely to be seen by the recipient upon their return.
- Document the attempted UHV and letter left on the SOC 2247.
- **Remember 3-2-1:** 3 Visit Attempts, 2 Phone Calls, 1 Letter



## UHV Accomplished:

When entry is granted, the UHV-SW shall:

- Provide verification of staff ID and visit.
- Inform the purpose of the visit.
- Provide information regarding program requirements.
- Explain consequences for failure to adhere to requirements.
- Ask questions regarding recipient's services and the quality of those services.
- Observe plain-view areas of the home to help determine whether the recipient is receiving appropriate levels of quality care to remain safely in the home.
- Make referrals.
- Complete the SOC 2247.
- Return the completed UHV list and SOC 2247 to the point of contact, within the specified timeframe.

End

Within 60 calendar days from **the date of the initial UHV attempt**, complete the following steps, in order:

### Step 1:

#### **(Not to be done on the same day as the failed UHV)**

Call the recipient or authorized representative at the primary phone number in the case file. The telephone call must address:

- The recipient's current address (confirm whether or not the recipient still resides at the address visited).
- The recipient's wellbeing.
- The purpose of a UHV and the requirement for recipients to cooperate with the UHV.
- Any recurring commitments in the recipient's schedule that should be considered by the UHV-SW when planning future visits.

The telephone call must not be used to schedule a UHV.

### Step 2:

- Attempt a second time to conduct a UHV. To the extent possible, the second attempt should be made at a different time and/or day of the week than the first attempt.
- Document on the SOC 2247. If the UHV is successful, return the list and completed SOC 2247 to the point of contact, within the specified timeframe.

### Step 3:

- If the second attempt is unsuccessful, the UHV-SW will make a second call to the recipient or authorized representative at the primary phone number in the case file.
- This is to be done on a different day than the second failed UHV attempt.**
- Document on the SOC 2247.

### Step 4:

- Attempt a third time to conduct a UHV. To the extent possible, the third attempt should be made at a different time and/or day of the week than the previous two attempts.
- Document on the SOC 2247. If the UHV is successful, return the list and completed SOC 2247 to the point of contact, within the specified timeframe.

### Step 5:

**At the end of the 60 calendar day period** – After the minimum follow-up procedures have been completed, if the UHV-SW has been unable to complete the UHV because the recipient has been unavailable or uncooperative:

- Send the recipient a Notice of Action (NOA) indicating termination from the IHSS program. Make sure to use a NOA Code specific to this circumstance; appeal rights and aid paid pending remain in full effect.
- Document on the SOC 2247.
- Once the NOA is sent, an offer from the recipient to cooperate is not sufficient to stop the termination.
- Whether the UHV is successful or not, return the list and completed SOC 2247 to the point of contact, within the specified timeframe.

End

**VIDEO NOTES**

**The Social Worker's Role:**

**The Home Visit:**

**Red Flags:**

**VIDEO NOTES**

**Communication:**

**Documentation:**

**Referrals:**

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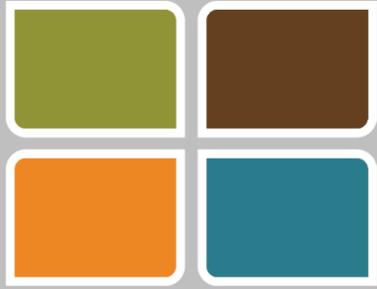
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**IHSS**

IN-HOME SUPPORTIVE SERVICES

**TRAINING ACADEMY**

# State Hearing and Program Integrity Training



**SAN DIEGO STATE  
UNIVERSITY**

# AGENDA

## **PART 1 - State Hearings**

## **PART 2 - Program Integrity – Preventing Errors and Fraud**

- **Program Integrity Overview**
- **Social Worker's Role**
- **Red Flags**
- **Communication**
- **Documentation**
- **Referrals**
- **Directed Mailings**
- **Unannounced Home Visits**



# State Hearings



**STATE HEARINGS**

# **The Young Woman and the Sailor**



# STATE HEARINGS

## The State Hearings Process How to *Survive* and *Thrive*



## Keeping Things in Perspective

Data of number of cases per year that go to state hearing:

Number of  
hearing requests  
in FY 13-14

**8,016**

Number of written  
decisions after  
hearings in FY 13-14

**2,800**

# STATE HEARINGS

## The Purpose of State Hearings

Focus of the hearing is to determine if the county correctly applied regulations and considered all available information in assessing the consumer's needs.



## Things to Keep in Mind

- It is not about how good a SW you are
  - Don't take it personally
- Procedures are
  - Claimant friendly
  - Claimant oriented



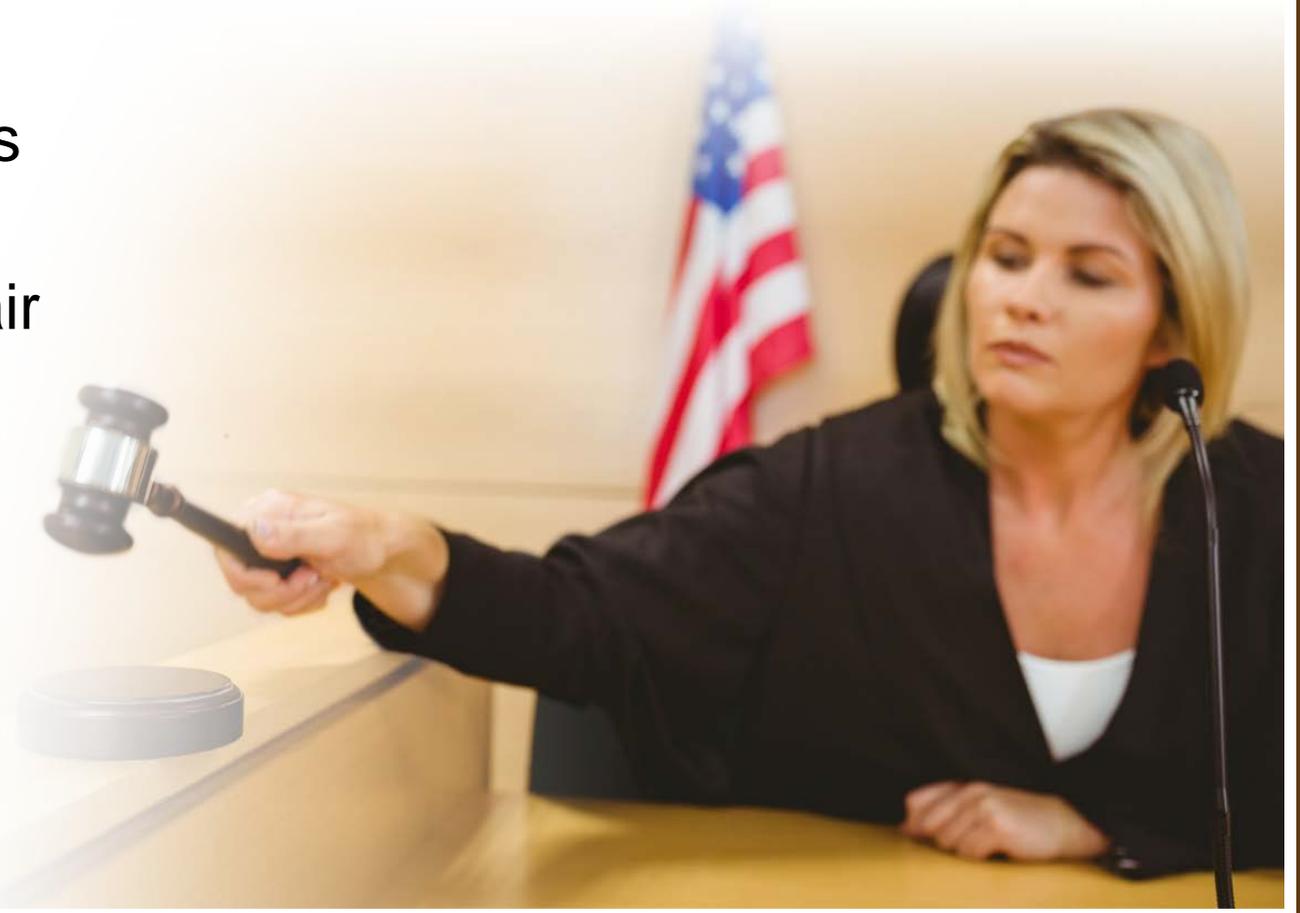
## Roles and Responsibilities

- Administrative Law Judge (ALJ)
- County Representative
- Claimant / Consumer
- Authorized Representative



## ALJ

- Manages the hearing.
- Is the only trier of fact, acting as both judge and jury.
- Ensures each side is given a fair opportunity to be heard.
- Renders legally complete and correct decision.



## County Representative (Appeals Specialist)

- A county employee
- Responsible for preparing and/or presenting a case
- Narrows focus, identifies issues and evaluates strength of county's position
  - May negotiate a Conditional Withdrawal
  - May ask for a postponement



## Claimant



**The person who has requested a state hearing and is or has been either:**

- An applicant for or recipient of aid
- A representative of the estate of a deceased applicant or recipient
- The caretaker relative of a child
- The guardian or conservator of an applicant or recipient

## Authorized Representative

- An individual or organization
- Authorized by the claimant or designated by the ALJ
- Acts for the claimant in any and all aspects of the state hearing



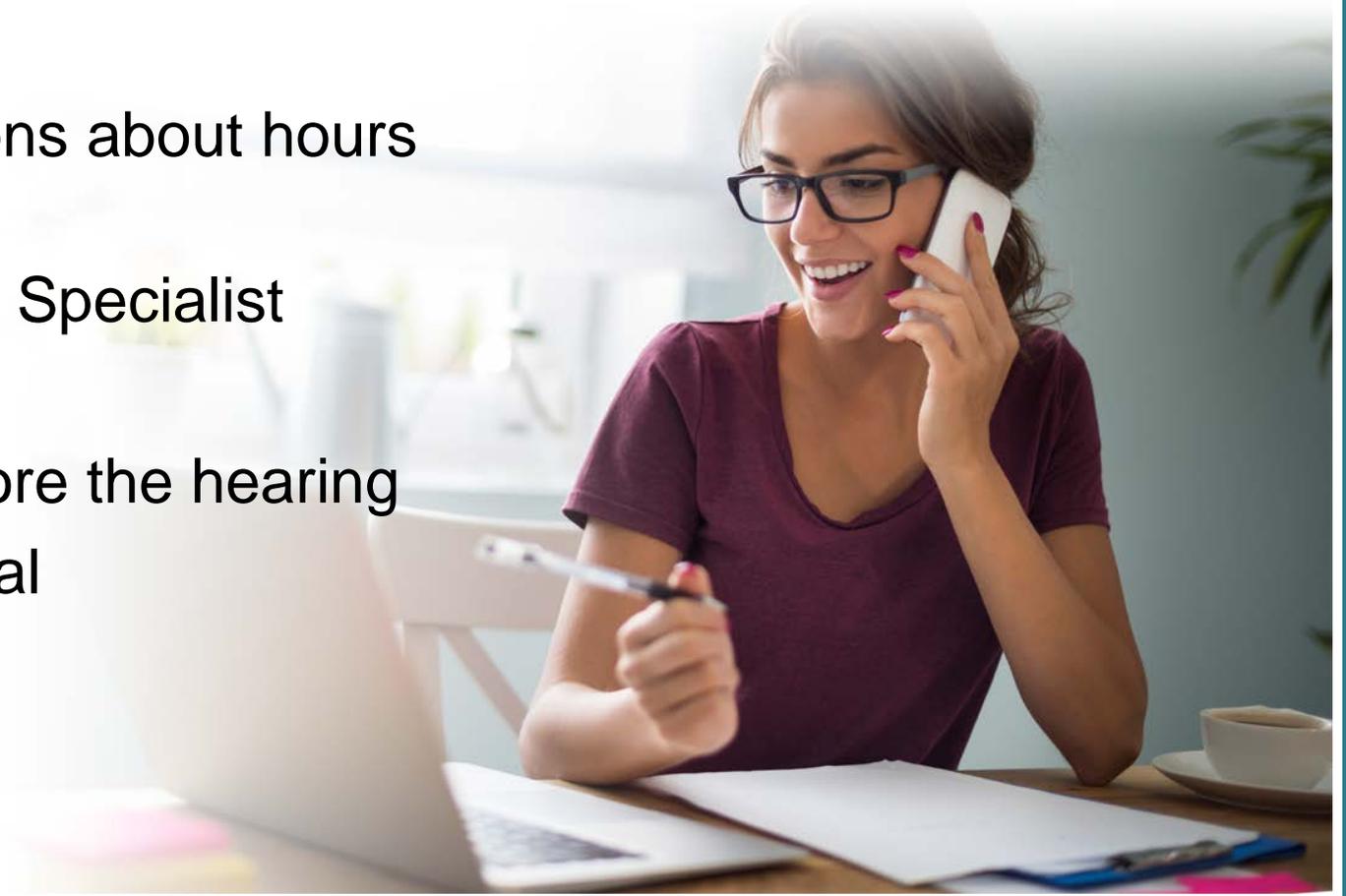
# What is the Social Worker's Role?



## Social Worker's Role

### Before the hearing

- Answer recipient questions about hours authorized
- Partner with the Appeals Specialist
  - Prepare the case
  - Review the case before the hearing
  - Conditional withdrawal



## Social Worker's Role

### At the hearing

- Appeals specialist is your partner
  - Working together
- Critical witness
  - Presenting the case as requested



## Being a Credible Witness

- Show up
- Establish your **expertise**
- Do your **homework**
- Know the consumer's usual functional **abilities** and **impairments**
- Bring your **complete** file
- Give **data**, not judgments
- Avoid **generalizations**
- Avoid becoming **defensive**
- Pick your **battles**
- Admit if you don't know and request **more time** to find out

# STATE HEARINGS



## Defining the Issues

- ALJ identifies the issues and decides order of evidence
- The issues at the hearing are limited to:
  - Those issues which are reasonably related to the request for hearing, or
  - Other issues identified by either the county or claimant which they have jointly agreed, prior to or at the state hearing to discuss.



## Evidence: Burden of Proof

- The initial burden is on the county to support its action.
- It is your job to help the county meet that burden.
- This is where your testimony is crucial.



## Documentation of Evidence

- Understand supporting documents
  - Annotated Assessment Criteria
  - Hourly Task Guidelines
  - Age Appropriate Guidelines
  - Regulations
  - Medical Certification



## Evidence: Focus on Areas of Need

**Observations** of the claimant.

- Was this your first meeting with the claimant?

**Interviews** with the claimant and other household members.

- How much time did you spend at the claimant's home?
- What kind of questions and in what detail did you ask?
- Did you consider good days and bad days?

**Review** of documentation, such as medical reports.

- Did you ask for a medical report?
- Did you receive one?
- Did you rely on it for your assessment?

**Application** of Hourly Task Guidelines.

- Was there an exception?
- If so, how and why is this recipient different from the norm?

## Reducing Hours

Evidence should show:

- There was an error in prior assessment
- There was a change in circumstances
- Data to support your decision
  - Be specific
  - Include medical data if necessary
- There was a change in the law, regulation or policy

## Shifting Burdens

- Once the initial burden is met, burden will shift to the claimant.
- Claimant to testify about how much additional time or services he/she believes is needed.



## Rebuttal

- Does the evidence presented change the county's position?
- Be ready to respond to all evidence presented if necessary.
- Don't be afraid to change your position if the evidence warrants a change.



## Close of Hearing

- Opportunity to address items not covered.
- The task belongs to the county representative.



## The Decision

- Once an issue is heard, the ALJ makes a decision.
- Decision is based on the **preponderance of the evidence**.
- Neither side is presumed to be correct.



## After the Decision

- After the hearing
- After the hearing decision is received



# STATE HEARINGS

## Hearing Decision Exercise: Marjorie



# Part 2 AGENDA

- **IHSS Social Worker Role in Program Integrity**
  - Program Integrity Overview
  - Social Worker's Role
  - Red Flags
  - Communication
  - Documentation
  - Referrals
  - Directed Mailings
  - Unannounced Home Visits



# Program Integrity



## Focus on Program Integrity

- Legislation
  - Assembly Bills X4 and X4 19 (2009 Fourth Extraordinary Legislative Session)
- Clarify the social worker's role in error and fraud prevention and detection
- Increase awareness and detection of errors and fraud
- Improve the referral process
- Consistency in understanding of program integrity forms and protocols

## Ways Program Integrity Issues are Identified

- Social worker
- Other county or state resources
  - APS / CPS
  - PA
- Quality Assurance
  - Case reviews
  - Error rate studies
  - Home visits
- Unannounced home visit (UHV)
- Directed mailing process (DM)
- Public referral

*What is the  
Social Worker's Role  
in Prevention and Detection of  
Program Integrity Issues?*



## What is Fraud?

- The intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person.
- Includes any act that constitutes fraud under applicable federal or state law.

[WIC 12305.8(a)]



## Video



## Program Integrity Issues: Preparing for the Home Visit

Review case documentation

- Narrative notes
- Case notes
- Exception documentation
- Evidence screens
- Forms
- Medical reports
- APS / CPS involvement
- Information from data matches

Look for

*INCONSISTENCIES*



## Video



## Program Integrity Issues: During the Home Visit

- Use a consistent process
- Inform consumer of IHSS program rules
- Observe environment and consumer's functioning
- Ask follow-up questions
- Document what you see



## Video



## *RED FLAGS*

- Provider
- Consumer
- Collusion between provider and consumer
- Living arrangement
- Household composition
- Provider information / behaviors
- Environment



# PROGRAM INTEGRITY

## Video



## Communication

- Clarify situations observed
  - Ask the 'next question'
- Ask open-ended questions
- Be professional and matter of fact



# PROGRAM INTEGRITY

## Video



## Documentation

- Document what you see and what you hear that you believe are red flags
- Keep notes clear and concise
- Document the facts – not your opinions
- Document for future
  - to jog your memory
  - so the next person will understand what you observed
  - at the time of the event
- Capture contact with consumer or provider – include names



# PROGRAM INTEGRITY

## Video



## What to Do if There are Program Integrity Issues

- Follow-up on concerns
- Report an incident of suspected fraud (SOC 2248)
- Utilize supervisor and other county staff (QA staff) as resources
- Consult with law enforcement as necessary
- County differences

## Fraud Referral Procedures

### 1. Fraud Complaints

- Any program integrity concern/allegation identified or received by the state or county
- Complete the Complaint of Suspected Fraud form (SOC 2248) through Section D

**COMPLAINT OF SUSPECTED FRAUD FORM**  
Please fill in as much information as possible.

Provider relationship to recipient: \_\_\_\_\_  
IHSS recipient name: \_\_\_\_\_  
IHSS recipient SSN: \_\_\_\_\_  
IHSS recipient DOB: \_\_\_\_\_  
IHSS recipient address: \_\_\_\_\_

Complaint against recipient  
**A. REPORTING PARTY**  
Name: \_\_\_\_\_ County: \_\_\_\_\_  
Relationship to IHSS recipient: \_\_\_\_\_ IHSS provider name: \_\_\_\_\_  
How did you become aware of this information? \_\_\_\_\_ IHSS provider SSN: \_\_\_\_\_  
Name of person and agency making complaint: \_\_\_\_\_ IHSS provider DOB: \_\_\_\_\_  
Date: \_\_\_\_\_  
Phone no.: \_\_\_\_\_  
File in hospital: \_\_\_\_\_

**B. REASON FOR COMPLAINT**  
 Deceased  
Date of death: \_\_\_\_\_  
 In Jail  
Recipient: \_\_\_\_\_ Provider: \_\_\_\_\_  
Provider Issues: \_\_\_\_\_  
 Billing paid for services not provided  
 Clearly employee in IHSS provider  
 Does not appear to need services  
 Seen performing otherwise activities (such as yard work, sports, lifting heavy object, etc.)  
 Seen driving  
 Seen working  
 Other (Specify): \_\_\_\_\_

Recipient residing in a care facility or hospital  
Name of facility: \_\_\_\_\_  
Dates of stay: \_\_\_\_\_  
Date: \_\_\_\_\_  
Abuse/neglect/abuse of recipient: \_\_\_\_\_

**C. NARRATIVE DESCRIPTION** (Attach attached, date observed, etc.)  
If yes, where: \_\_\_\_\_

## Fraud Referral Procedures

### 2. Triage

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

### 3. Referral

A complaint that has been triaged by designated county staff and referred to law enforcement

The image shows a sample of the 'IHSS COMPLAINT OF SUSPECTED FRAUD FORM'. The form is titled 'IHSS COMPLAINT OF SUSPECTED FRAUD FORM' and includes the instruction 'Please fill in as much information as possible'. It is divided into several sections: 'A. REPORTING PARTY' (with fields for name, address, phone, and email), 'B. REASON FOR COMPLAINT' (with checkboxes for deceased, in jail, recipient, provider, or other), and 'C. NARRATIVE DESCRIPTION' (with a text area for details and a date field). The form also includes checkboxes for 'Complaint against recipient' and 'Complaint against provider'. The bottom of the form has a footer: '© NARRATIVE DESCRIPTION (Admin assigned, site observed, etc.)'.

# PROGRAM INTEGRITY

## IHSS Complaint of Suspected Fraud Form (SOC 2248)



STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY  
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

### IHSS COMPLAINT OF SUSPECTED FRAUD FORM

Please fill in as much information as possible

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

Complaint against recipient  
 Complaint against provider

#### A. REPORTING PARTY

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Phone no.: \_\_\_\_\_  
Email: \_\_\_\_\_ No. in household: \_\_\_\_\_  
Relationship to IHSS participant: \_\_\_\_\_

How did you become aware of this information: \_\_\_\_\_  
Name of person and Agency taking complaint: \_\_\_\_\_

#### B. REASON FOR COMPLAINT

Deceased  Recipient  Provider  Recipient residing in a care facility or hospital  
Name of facility: \_\_\_\_\_  
Date of death: \_\_\_\_\_ Dates of stay: \_\_\_\_\_

In Jail  Recipient  Provider Dates: \_\_\_\_\_

**Provider Issues**  
 Being paid for services not provided  Stealing from recipient  
 County employee is IHSS provider  Other (specify) \_\_\_\_\_  
 Abuse/neglect/maltreatment of recipient

**Recipient Issues**  
 Does not appear to Need Services  
 Seen performing strenuous activities (such as yard work, sports, lifting heavy object, etc.)  
 Seen driving  
 Seen working  
 Other (specify) \_\_\_\_\_ If yes, where: \_\_\_\_\_

#### C. NARRATIVE DESCRIPTION (Actions observed, date observed, etc)

\_\_\_\_\_

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY  
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

#### D. CASE FILE INFORMATION (for County use ONLY)

IHSS recipient name: \_\_\_\_\_ Authorized no. hours: \_\_\_\_\_  
Case no.: \_\_\_\_\_ Date of last F2F: \_\_\_\_\_  
No. in household: \_\_\_\_\_ Who conducted last F2F: \_\_\_\_\_

Severely Impaired  Protective Supervision  Married  SSN verified

Program service(s) in question: \_\_\_\_\_  
Rank in service(s): \_\_\_\_\_

Caseworker contacted for information  
Name of person completing: \_\_\_\_\_

Enclosures:  
 Pay warrants (copy of front and back)  Other (specify) \_\_\_\_\_  
 Timesheets

#### E. INITIAL REFERRAL (for County use ONLY)

Sent to DHCS  Sent to DA/SIU for investigation  
 APS/CPS  No action (provide explanation in section G)  
 Sent for administrative action

Date referred: \_\_\_\_\_ Approximate case amount \$: \_\_\_\_\_

If referred to other than DHCS:  MOU with DHCS  Under \$500

#### F. DETERMINATION (for County use ONLY)

Administrative action  Reassessment Date: \_\_\_\_\_  
 Reduced hours \_\_\_\_\_ hours reduced  
 Termination of services \_\_\_\_\_ hours saved in termination  
 Overpayment recovery in the amount of: \$ \_\_\_\_\_

To DA for prosecution for violation of PC(s):  
 To DOJ for prosecution for violation of PC(s):  
 No action - Case not viable (provide explanation in section G)

#### G. EXPLANATION OF NON-VIABILITY (Add information obtained that rendered case non-viable)

\_\_\_\_\_

Investigator signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Attach additional case file information.  
Copy of complaint must be retained in county case file.

## After the Referral

- Administrative remedies
- Civil penalty actions
- Criminal penalty actions



## After the Referral: The Social Worker's Role

- Investigation
  - Communication between departments
  - Working with investigative agencies
  - Identifying actions needed on the case while fraud investigation is underway
- Prosecution
- Feedback loop



# PROGRAM INTEGRITY

## IHSS Data Reporting Form (SOC 2245)

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

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

County: **Select County Name**

Reporting Quarter and State Fiscal Year: **Select Quarter and Year**

Date Completed:

**Section I. Fraud Complaints**

**A Total Number of Complaints Received**

**A.1. Number of Complaints Received By Source**

Recipient	1
Provider	2
Family member	3
County staff	4
Neighbor	5
Data matches	6
Anonymous- phone	7
Anonymous- mail	8
Anonymous- website	9
Other (Explain in Comments- section VI.1.)	10

**A.2. Number of Complaints By Outcome - Initial Review**

Referred for county investigation	11
Referred for state investigation	12
Referred for administrative action	13
Referred to APS/CPS	14
Dropped, no action	15

**Section II. Early Detection Savings**

**A Total Number of Cases Terminated/Reduced**

**A.1. Number of Cases Terminated/Reduced as a Result of:**

Data matches	16
Entirely overstated disability	17
Partially overstated disability	18
Household composition/proration	19
Misrepresented program eligibility	20

**B Total Number of Hours Terminated/Reduced as a Result of:**

**B.1. Number of Authorized Hours Terminated/Reduced as a Result of:**

Data matches	21
Entirely overstated disability	22
Partially overstated disability	23
Household composition/proration	24
Misrepresented program eligibility	25

**Section III. Fraud Investigations - Completed**

**A Total Number of Investigations Completed**

**A.1. Number of Investigations By Type**

Collusion (Provider & Recipient)	26
Provider fraud	27
Recipient fraud	28
County staff	29
Other (Explain in Comments - section VI.2.)	30

SOC 2245 (7/13)

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

**A.2. Number of Investigations By Outcome**

Dropped, no action	31
Referred for admin. action to IHSS	32
Referred for prosecution to County DA	33
Referred for prosecution to DOJ	34

**A.3. Amount Estimates by Outcome (\$)**

Estimated amount referred for admin. action to IHSS	35
Estimated amount referred for prosecution	36

**Section IV. Prosecutions - County**

**A Total Number of Cases Received for Prosecution**

**A.1. Number of Cases by Outcome**

Cases declined by DA	37
Plea deal, no conviction	38
Cases dismissed	39
Number of cases - with convictions	40
Number of felony convictions	41
Number of misdemeanor convictions	42
Number of defendants prosecuted	43
Number of Referrals to suspended and ineligible list	44

**Section V. Totals (\$)**

**A Loss Identified to IHSS Program**

**B Total Amount Identified for Collection through Court Ordered Restitution**

**C Total Amount Identified for Collection through County Overpay Recovery**

**Section VI.1. Comments**

**Section VI.2. Comments**



## Directed Mailing (DM)

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

ACIN I-13-13



## Purpose of DM

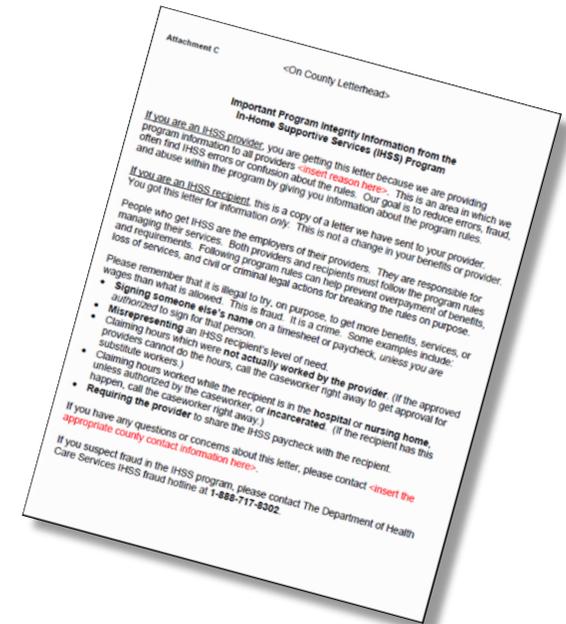
- Convey program integrity concerns
- inform IHSS providers of appropriate program rules and requirements
- express the consequences for failing to adhere to them

*The goal is to increase the participants' knowledge and create a better informed provider of IHSS services in an effort to reduce errors, fraud, and abuse in the IHSS program*



## Overview of the DM Process

- Template developed with customizable areas
- Indicators chosen for targeting the mailings
- Counties coordinate mailings with CDSS to minimize unintentional duplication
- Counties send mailings
- CDSS conducts periodic post-mailing analysis and reports results to counties



# PROGRAM INTEGRITY

## Directed Mailing Letter Template

- Addressed to the IHSS provider
- Copied to the IHSS consumer
- Provides the reason the letter was sent
- Provides important program integrity reminders
- Provides an opportunity for the provider to contact the county



Attachment C

<On County Letterhead>

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

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

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

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

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

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

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

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

# PROGRAM INTEGRITY

## Unannounced Home Visit (UHV)

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



## Purpose of UHV

To ensure that the services authorized are being provided at a level that meets the recipient's needs, allowing him/her to remain safely in his/her home, and to validate the information in the case file.



## The UHV visit

- Conducted by designated county staff that have completed appropriate training
- Preparation completed to understand the consumer's conditions and/or needs
- Conducted in documented primary language, if possible
- Communication and coordination



## UHV Entry Granted

- Verification of staff ID and visit
- Inform of purpose of visit
- Provide information regarding program requirements
- Explain consequences for failure to adhere to requirements
- Ask questions regarding service provision
- Referrals
- Follow-up and reporting



WELCOME

## UHV No Contact or Entry Denied

- In the event that **contact is not made or entry is denied**, UHV staff must perform all of the following activities in the following order to make contact within **45-60 calendar days**:
  1. A letter to the recipient
  2. A telephone call to the recipient
  3. A second UHV attempt
  4. A second telephone call
  5. A third UHV attempt
  6. Termination Notice of Action





# PROGRAM INTEGRITY

## IHSS UHV Findings Report (SOC 2247)

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY  
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

### IHSS UHV FINDINGS REPORT

GENERAL INFORMATION (Attach additional sheets if necessary)

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

**A. CASE FILE INFORMATION**

Primary language: \_\_\_\_\_ No. of providers: \_\_\_\_\_  
No. in household: \_\_\_\_\_ Date of last F2F: \_\_\_\_\_  
Authorized no. hours: \_\_\_\_\_ Who conducted last F2F: \_\_\_\_\_  
 Severely Impaired  Minor  
 Protective Supervision  
 FI rank 5 service(s) (specify): \_\_\_\_\_  
 Case/Narrative notes reviewed

**B. RECORD OF ATTEMPTS TO CONTACT THE RECIPIENT** (Provide details in Section E)

Visits	Phone calls to recipient		Completed visit	
	(date)	(time)	1st (date)	(time)
1st	(date)	(time)	2nd (date)	(time)
2nd	(date)	(time)	Letter	NOA
3rd	(date)	(time)	(date)	(date)

Recipient ID verified  
 Provider present  
 Provider ID verified  
Provider name: \_\_\_\_\_

**C. FINDINGS OF THE UHV** (Provide details in Section F)

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

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

Program Integrity concerns appear valid

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

**D. REPORT OF RECOMMENDATIONS** (Provide details in Section F)

Recommend reassessment to:

- Increase hours
- Decrease hours
- Terminate services

Provided Information and/or Referral (specify): \_\_\_\_\_

Overpay recovery / Administrative action \_\_\_\_\_

Refer IHSS complaint to:

- APS
- CPS
- DA/SIU
- DHCS
- DOJ
- Other

Against:

- Recipient
- Provider (number) \_\_\_\_\_
- Other: \_\_\_\_\_

Termination for non-compliance with program requirements  
 Other follow-up (specify in Section F)  
 No further action

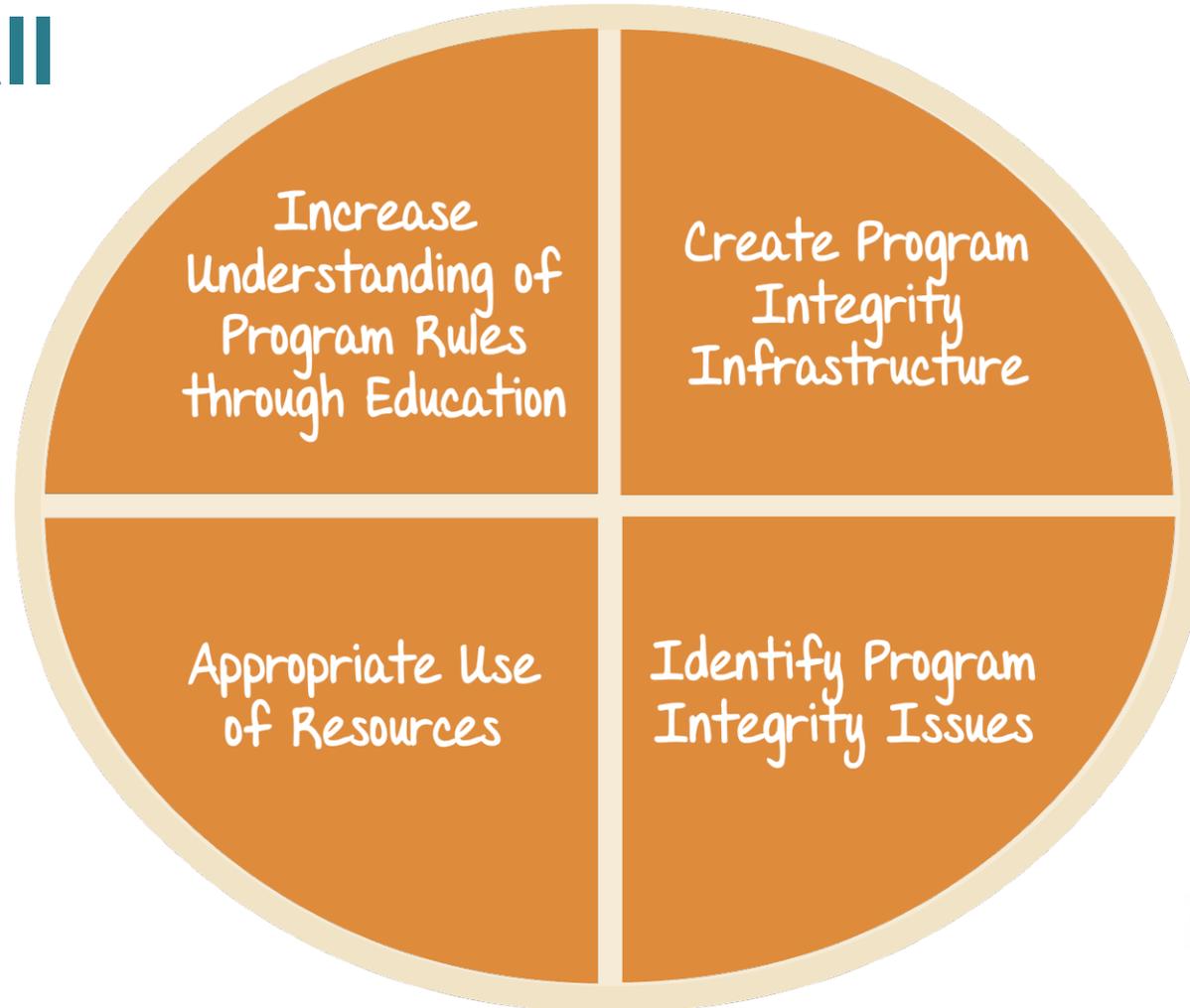
UHV staff signature: \_\_\_\_\_ Date of report: \_\_\_\_\_

**E. CASE FILE AND VISIT SUMMARY**

**FINDINGS AND RECOMMENDATIONS**



## Putting it All Together





*Congratulations!*

You have completed  
State Hearing and Program  
Integrity Training



## DIVISION 22 REGULATIONS

### 22-000 STATE HEARING - GENERAL

- .1 The responsibility for providing a full and impartial hearing to the claimant rests jointly with the county and the state department.

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#### HANDBOOK BEGINS HERE

- .11 The state department is responsible for the overall administration of the hearing process and the conduct of each hearing.
- .12 Since the right to request a state hearing belongs to the claimant, the regulations in this chapter shall be interpreted in a manner which protects the claimant's right to a hearing.
- .13 Although the specific duties and responsibilities of each agency are set forth in the following regulations, these rules shall not be used to suppress the claimant's right to a hearing. For example, although the county shall justify its action when appropriate, the county shall not discourage the claimant from proceeding with the hearing request nor relinquish its responsibility to assist the claimant in this process. The Administrative Law Judge shall conduct the hearing according to applicable procedures and the claimant shall be allowed to present evidence relevant to his/her own case.

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#### HANDBOOK ENDS HERE

### 22-001 DEFINITIONS

The following definitions shall apply wherever the terms are used throughout Division 22.

- a. (2) Administrative Law Judge - A person designated by the Director and thereafter assigned by the Chief Administrative Law Judge to conduct state hearings and administrative disqualification hearings. **HANDBOOK:** The Administrative Law Judge shall prepare fair, impartial and independent decisions.
  
- a. (5) Authorized Representative - An individual or organization that has been authorized by the claimant or designated by the Administrative Law Judge or Department pursuant to Sections 22-085 and 22-101 to act for the claimant in any and all aspects of the state hearing or administrative disqualification hearing.
  - (A) An authorized representative may include legal counsel, a relative, a friend, or other spokesperson.
  
- c. (2) Claimant - The person who has requested a state hearing and is or has been either:
  - (A) An applicant for or recipient of aid, as defined in Section 22-001a.(3).
  - (B) A foster parent or foster care provider who requests a hearing on behalf of the foster child where the CWD takes action to affect the child's aid and the child resides with or has resided with the foster parent or foster care provider.
  - (C) A representative of the estate of a deceased applicant or recipient (see Sections 22-004.4 and .5).
  - (D) The caretaker relative of a child with regard to the child's application for or receipt of aid.
  - (E) The guardian or conservator of an applicant or recipient.
  - (F) The sponsor of an alien, see MPP Sections 43-119, 44-353, and 63-804.1.
  - (G) A Transitional Child Care provider who receives direct payments for child care services on behalf of a Transitional Child Care family.
  
- c. (7) County or CWD Representative - An employee who is assigned the major responsibility for preparing and/or presenting a hearing case on behalf of the CWD. (See Section 22-073.13.)

## **22-004 REQUEST FOR A STATE HEARING**

- .1 A request for a state hearing may be either written or oral.
- .2 A written request concerning county administered state aid programs shall be filed with the CWD, and for all other state aid programs, the request shall be filed with the California State Department of Social Services in Sacramento.
  - .21 A written request for hearing may be made in any form.
    - .211 Claimants are encouraged to use the reverse side of the Notice of Action (NA) or DFA 377 form series or other CDSS-approved forms.
    - .212 The county agency shall assist the claimant in filing a request for a state hearing. The request for a state hearing should identify the aid program involved, as well as, the reason for dissatisfaction with the particular action or inaction involved in the case. If an interpreter will be necessary, the claimant should so indicate on the hearing request.
  - .22 When a written request for a state hearing is received by the CWD, a copy shall be forwarded to the State Hearings Division in Sacramento no later than three working days after its receipt.

## **22-009 TIME LIMIT ON REQUEST FOR A STATE HEARING**

- .1 The request for a state hearing shall be filed within 90 days after the date of the action or inaction with which the claimant is dissatisfied.
  - .11 If the claimant received adequate notice of the action (see Section 22-001a.(1)), the date of the action shall be the date on which the notice was mailed to the claimant.
  - .12 Where a request for a state hearing concerns the current amount of aid the request shall be filed within 90 days, but the period of review shall extend back to the first of the month in which the first day of the 90 day period occurred.

## **22-049 THE HEARING - GENERAL RULES AND PROCEDURES**

- .1 Attendance at the hearing is ordinarily limited to the claimant, authorized representative (as defined in Section 22-001a.(5)), county representative, legal counsel, authorized interpreter, and witnesses relevant to the issue. Other persons may attend the hearing if the claimant agrees to or requests their presence and the Administrative Law Judge determines that their presence will not be adverse to the hearing.
  - .11 Appearance by the claimant (in person or by the authorized representative) shall be required at the hearing, unless the hearing is a rehearing or further hearing.
  - .12 The Administrative Law Judge shall be permitted to exclude a witness during the testimony of other witnesses.
  - .13 Both the county and the claimant shall have the right to have a representative present throughout the hearing. Both the county representative and the claimant's authorized representative shall have the right to designate another person to be present and advise the representative throughout the hearing. This individual may be a witness who testifies on behalf of the county or claimant and in this circumstance, Section 22-049.12 would not apply. If this individual is a witness, he/she may not be present as an advisor until after he/she has testified.
  - .14 The Administrative Law Judge shall have the authority to exclude persons who are disruptive of the hearing.
- .2 The hearing shall be conducted in an impartial manner.
- .3 All testimony shall be submitted under oath, affirmation, or penalty of perjury.
- .4 The proceedings at the hearing shall be reported by tape recorder or otherwise perpetuated by mechanical, electronic, or other means capable of reproduction or transcription.
- .5 The issues at the hearing shall be limited to those issues which are reasonably related to the request for hearing or other issues identified by either the county or claimant which they have jointly agreed, prior to or at the state hearing, to discuss.
  - .51 If the rights of any party will be prejudiced by the consideration of a reasonably related issue raised at the hearing, the hearing shall be continued or the record held open subject to the provisions of Section 22-053.3 so that such party may prepare his/her case.

- .52 If the claimant contends that he/she is not adequately prepared to discuss the issues because he/she did not receive adequate notice required by Section 22-071.1, this issue shall be resolved by the Administrative Law Judge at the hearing.
- .521 If the Administrative Law Judge determines that adequate notice was provided, the claimant shall agree to discuss the substantive issue or issues or the case will be dismissed.
- .522 If the Administrative Law Judge determines that adequate notice was not provided, the case shall be postponed unless the claimant waives the adequate notice requirement for purposes of proceeding with the hearing, and agrees to discuss the substantive issue or issues at the hearing.
- .523 If the notice was not adequate and involved a discontinuance, suspension, cancellation, termination or reduction of aid, other than those referred to in Sections 22-072.1 through .13 aid shall be reinstated retroactively and the provisions of Section 22-072.5 shall apply.
- .53 In cases in which a jurisdictional issue is raised, either by one of the parties or by the Administrative Law Judge, the parties must be prepared to submit evidence on the substantive issues except as provided in Sections 22-049.532 and 22-054.4.
  - .531 No determination of the timeliness of the hearing request or of any other jurisdictional issue will ordinarily be made at the hearing. The request will be dismissed by a written decision if the Administrative Law Judge determines that jurisdiction does not exist, e.g. request untimely or no subject matter jurisdiction.
  - .532 If, prior to or at the hearing, both parties agree to discuss only the jurisdictional issue, or the Administrative Law Judge on his/her own motion determines that only the jurisdictional issue will be discussed, the parties need not submit evidence on the substantive issues and the Administrative Law Judge shall take evidence only on the jurisdictional issue. Within ten days from the date of the hearing, the Administrative Law Judge shall:
    - (a) Inform the parties in writing that the hearing will not proceed on the substantive issues and a decision will be prepared solely on the jurisdictional issue, or
    - (b) Inform the parties that an additional hearing will be held on the substantive issues, and provide the parties a minimum of ten days in which to prepare on the substantive issues unless the time is waived by both parties. In this case, the Administrative Law Judge's proposed decision will address both the jurisdictional and substantive issues.
- .6 An interpreter shall be provided by the state if, prior to the hearing, a party requests an interpreter or if at the hearing, the Administrative Law Judge determines that an interpreter is necessary.
  - .61 When the state hearing is to be held with the assistance of an interpreter, the Administrative Law Judge shall determine if the interpreter has been certified by the Department.
    - .611 If the interpreter has been certified, the qualifications and competency of the interpreter need not be further examined.
    - .612 If the interpreter has not been certified, the Administrative Law Judge shall:
      - (a) Examine the qualifications and competency of the interpreter.
      - (b) Disqualify any interpreter determined by the Administrative Law Judge not to be competent for interpretation purposes.
      - (c) Assure objective interpretation by, at his/her discretion, disqualifying interpreters who are:
        - (1) Claimant's relatives, friends, or an authorized representative.
        - (2) County staff who participated in making the decision complained of.
        - (3) The county appeals representative.
        - (4) Any other individual determined by the Administrative Law Judge to be detrimental to the hearing process or having a bias or the appearance of being biased.
  - .62 When the state hearing is held with the assistance of an interpreter the Administrative Law Judge shall assure objective interpretation.
  - .63 A separate oath or affirmation to translate accurately shall be administered to all interpreters.

- .7 The rights of the claimant and the county shall include the right to:
  - .71 Examine parties and witnesses.
  - .72 Conduct such cross-examination as may be required for a full disclosure of the facts.
  - .73 Introduce exhibits.
  - .74 Bring witnesses.
  - .75 Examine all documents prior to and during the hearing.
  - .76 Question opposing witnesses and parties on any matter relevant to the issues even though that matter was not covered in the direct examination.
  - .77 Make oral or written argument.
  - .78 Rebut the evidence.
- .8 The following shall apply to communications concerning the hearing:
  - .81 All documents submitted by either the claimant or the county shall be made available to both parties.
  - .811 Copies of all such documents shall be provided to the claimant free of charge.

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**HANDBOOK BEGINS HERE**

(a) See Section 22-073.25 regarding position statement requirements.

**HANDBOOK ENDS HERE**

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- .82 Merits of a pending state hearing shall not be discussed between the Administrative Law Judge and a party outside the presence of the other party.
- .9 Whenever it is necessary that another county be joined as a party to the action in order to dispose of all issues, the Administrative Law Judge shall so order and shall, subject to Section 22-053.3, postpone the hearing, hold the record of the hearing open, or continue the hearing as necessary.
  - .91 A postponement for this reason shall be deemed a postponement for good cause.

**22-050 EVIDENCE**

- .1 The taking of evidence in a hearing shall be conducted by the Administrative Law Judge in a manner best suited to ascertain the facts and to control the conduct of the hearing.
  - .11 Prior to taking evidence, the Administrative Law Judge shall identify the issues and shall state the order in which evidence shall be received.
- .2 Except as provided below, evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs.
  - .21 The rules of evidence as applicable in judicial proceedings shall not be applicable in state hearings.
  - .22 The Administrative Law Judge shall be permitted to exclude evidence which is irrelevant, cumulative or unduly repetitious.
  - .23 The Administrative Law Judge shall exclude evidence which is privileged under the Evidence Code if the privilege is claimed in accordance with law.
- .3 Although evidence may be admissible under Section 22-050.2, the Administrative Law Judge shall consider the nature of the evidence in assessing its probative value.
- .4 "Official Notice" describes the manner in which an Administrative Law Judge or the Director will recognize the existence and truth of certain facts which have a bearing on the issue in the case, without requiring the actual production of evidence to prove such facts. Official notice may be taken of either a proposition of law or a proposition of fact.
  - .41 The Administrative Law Judge or Director shall take official notice of those matters which must be judicially noticed by a court under Section 451 of the Evidence Code.

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**HANDBOOK BEGINS HERE**

- .411 Generally, Section 451 of the Evidence Code provides that judicial notice must be taken of laws, statutes, regulations, official records, and facts and propositions which are of such universal knowledge that they are not reasonably subject to dispute.

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**HANDBOOK ENDS HERE**

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- .42 The Administrative Law Judge may take official notice of those matters set forth in Section 452 of the Evidence Code.

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**HANDBOOK BEGINS HERE**

- .421 Generally, Section 452 of the Evidence Code provides that official notice may be taken of facts and propositions that are not reasonably subject to dispute and are capable of immediate and accurate determination by resort to sources of reasonably indisputable accuracy.

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**HANDBOOK ENDS HERE**

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- .43 The Administrative Law Judge may take official notice of any generally accepted technical fact relating to the administration of public social service.
- .44 With respect to matters under Subsection .43 above and subdivision (f) of Section 451 and Section 452 of the Evidence Code which are of substantial consequence to the determination of the action, each party shall be given reasonable opportunity, subject to Section 22-053.3, before the decision is submitted, to present information relevant to:
- .441 The propriety of taking official notice, and
- .442 The tenor of the matter to be noticed.

**22-053 POSTPONEMENTS AND CONTINUANCES FOR ADDITIONAL EVIDENCE**

- .1 Postponements shall be granted under limited circumstances.
- .11 A hearing involving the Food Stamp Program shall be postponed upon the initial request of the claimant prior to the hearing for up to 30 days.
- .111 Any aid pending, if appropriate, shall continue at least until the next scheduled hearing. See Section 63-804.64 in the Food Stamp Program.
- .112 In all other programs, a hearing may be postponed upon the request of the claimant only if such request meets the good cause criteria set forth in Section 22-053.16.
- (a) The Department shall have the authority to request verification from the claimant to support the reason why he/she cannot attend the hearing on the scheduled date.
- .12 Upon the request of the county, a hearing shall be permitted to be postponed:
- .121 By the Administrative Law Judge at the hearing.
- .122 Any postponement granted under Section 22-053.12 shall be deemed postponed with good cause.
- .13 The Chief Administrative Law Judge shall have the authority to postpone a hearing prior to the hearing.
- .131 Any postponement granted under Section 22-053.13 shall be deemed postponed with good cause.
- .14 The Administrative Law Judge shall have the authority to postpone a hearing, at the hearing, and continue any applicable aid pending if:
- .141 The claimant establishes good cause as specified in Section 22-053.16.
- .142 The county has failed to furnish adequate notice within the meaning of Sections 22-001.1a.(1) and 22-049.52, and the claimant requests the postponement.
- .15 The Administrative Law Judge shall have the authority to postpone a hearing, for any other reason at his/her discretion.
- .151 The Administrative Law Judge shall order that aid pending be continued only if the postponement is necessary to insure a full and fair hearing and the postponement did not result from any act or omission on the part of the claimant.

- .16 Good cause shall be established if the claimant or authorized representative establishes that the case should be postponed due to:
  - .161 Death in the family.
  - .162 Personal illness or injury.
  - .163 Sudden and unexpected emergencies which prevent the claimant or the authorized representative from appearing.
  - .164 A conflicting court appearance which cannot be postponed.
  - .165 The county, when required, does not make a position statement available to the claimant not less than two working days prior to the date of the scheduled hearing, or the county has modified the position statement (as defined in Section 22-073.252) after providing the statement to the claimant, and the claimant has waived decision deadlines contained in Section 22-060.
- .2 Continuances for additional evidence shall be granted under limited conditions.
  - .21 If the Administrative Law Judge conducting the hearing determines that evidence not available at the hearing is necessary for the proper determination of the case, the Administrative Law Judge shall have the authority to continue the hearing to a later date or close the hearing and hold the record open for a stated period not to exceed 30 days in order to permit the submission of additional documentary evidence.

**22-059 COMMUNICATIONS AFTER HEARING**

- .1 Communications to the Department concerning a case subsequent to the hearing shall be excluded from the record and shall be disregarded prior to the adoption and release of the decision of the Director except that:
  - .11 Oral and written communications after the hearing concerning the status of the decision, or the date of delivery of additional evidence to be submitted under the provisions of Section 22-053.21, or protesting an Administrative Law Judge's determination under Section 22-072.63 with respect to aid pending a hearing or a disqualification request under the provisions of Section 22-055, are not improper; and
  - .12 An Administrative Law Judge shall have authority on his/her own motion or at the request of either party to reopen the record for receipt of additional information, if all parties are notified of the reason for the reopening and the submission of such evidence conforms to the requirements of Sections 22-053.21 and .3.

**22-060 DISPOSITION OF STATE HEARINGS**

- .1 All state hearings shall be decided or dismissed within 90 days from the date of the request for state hearing except in those cases where the claimant waives such requirement or the claimant withdraws or abandons the request for hearing.

**22-061 SUBMISSION OF PROPOSED DECISION/ADOPTION**

- .1 After the hearing has been closed, the Administrative Law Judge shall submit a proposed decision for review by the Chief Administrative Law Judge and submission to the Director, or shall adopt a final decision pursuant to the authority delegated to the Administrative Law Judge by the Director.

**22-069 COUNTY WELFARE RESPONSIBILITY**

- .1 Each county shall furnish to the State Hearings Division the name of an individual who, in coordination with the Chief Administrative Law Judge, is responsible for discharging the requirements of Sections 22-069 through 22-078.

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**HANDBOOK BEGINS HERE**

- .11 Sections 22-069 through 22-078 describe the responsibilities of the county in the state hearing process.

**HANDBOOK ENDS HERE**

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- .12 The county responsibility shall include:

- .121 Investigation of the case and assistance to the claimant prior to the hearing; and
- .122 Presentation of the county's position during the hearing; and
- .123 Compliance with state hearing decisions.

## **22-073 COUNTY WELFARE AGENCY RESPONSIBILITY PRIOR TO THE STATE HEARING**

- .1 Upon receipt of a request for hearing or notice from the Department that a recipient has filed a request for a state hearing, the county shall provide aid pending the state hearing in accordance with Section 22-072, when entitlement exists.
  - .13 Each case for which a state hearing request has been filed shall be assigned to a county representative who shall assume the major responsibility for preparing the case in accordance with the requirements of this Division and/or presenting it at the hearing. The county representative shall not have had immediate prior involvement with the case.
- .2 Prior to the hearing, the county representative shall:
  - .21 Determine the issues raised by the hearing request.
    - .211 If the request for hearing does not clearly set forth the claimant's basis for appeal, the county representative shall immediately contact the claimant for clarification.
  - .22 After determining the issues, the county representative shall review the applicable statutes, regulations and policies in light of the evidence which exists in the case record.
    - .221 In conducting this initial review, the representative shall contact the eligibility worker and other county personnel as appropriate.
    - .222 When assistance of the Department is required to clarify any questions, such assistance shall be sought without delay.
  - .23 After conducting the initial review, the county representative shall make a determination concerning the appropriateness of the county action and the need for and advisability of a hearing. Disagreements and misunderstandings shall be resolved quickly, at the lowest possible administrative level, thereby avoiding unnecessary hearings.
    - .231 If the county representative concludes that the county action was incorrect, the county representative shall contact the claimant and attempt to resolve the case without a hearing.
      - (a) The county representative shall have the authority to make such a decision. The conditional withdrawal procedure described in Section 22-054.21 is usually appropriate in such instances.
    - .232 If the county representative concludes that the county action was correct, the county representative shall contact the claimant and:
      - (a) Inquire if the claimant plans to attend the hearing;
      - (b) Determine if there are any further contentions which the claimant will attempt to raise at the hearing; and
      - (c) Provide any and all information which can be of assistance to the claimant in preparing for the hearing. This shall include revealing to the claimant any and all regulations and evidence including that which might be favorable to the claimant's case. The county representative may explain to the claimant the right to withdraw the request for hearing but shall not be permitted to request such a withdrawal. The claimant shall also be informed of the availability of any free legal representation. If the claimant is not fluent in English and if bilingual services apply as specified in Section 21-115, an explanation of the hearing procedures shall be made in the claimant's language.
  - .24 The county representative shall determine if an interpreter will be necessary at the hearing or if a home hearing will be necessary.
    - .241 The county representative shall notify the State Hearings Division if the claimant has requested an interpreter or home hearing.

- .242 The county representative shall report without delay to the State Hearings Division any changes in the claimant's address or any other circumstances which might affect the necessity for or conduct of the hearing.
- (a) This responsibility to report changes in the claimant's circumstances continues after the hearing until a decision is rendered.
- .25 Prior to each hearing, the county representative shall prepare a typewritten position statement.
- .251 The position statement shall summarize the facts of the case and set forth the regulatory justification for the county's action.
- (a) If the issue concerns the amount of aid, grant adjustment, or a demand for repayment, the county representative shall include in the position statement a complete final budget computation, month by month, for the period in issue.
- (b) The county shall include as attachments to the position statement copies of documentary evidence and a list of witnesses which the county intends to use during the hearing.
- (1) The documents shall be itemized on the last page of the position statement and attached as exhibits.
- .252 If the county has received a 10-day prior notice of the date and time of the scheduled hearing, a copy of the position statement shall be made available to the claimant at the CWD, not less than two working days prior to the date of the scheduled hearing.

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**HANDBOOK BEGINS HERE**

Example:

The hearing is scheduled for Friday. Absent any intervening holidays, the position statement shall be available by the opening of business the preceding Wednesday.

**HANDBOOK ENDS HERE**

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- .253 If the county, when required, does not make the position statement available not less than two working days prior to the date of the scheduled hearing, or if the county modifies the position statement after providing the statement to the claimant, the hearing shall be postponed upon the request of the claimant conditioned upon the waiver of decision deadlines contained in Section 22-060. A modification is defined as a change which substantively revises the position statement.
- .26 While preparing for the hearing, the county representative shall determine if the presence of the eligibility worker or other county witnesses would be helpful for the resolution of the issue.
- .3 At the hearing, the county representative shall assume full responsibility for presentation of the county's case. Such presentation shall include:
- .31 Summarizing the written position statement.
- .32 Examining county witnesses.
- .33 Cross-examining the claimant and the claimant's witnesses.
- .34 Responding to any questions from the claimant or Administrative Law Judge concerning the case; and
- .35 Having the county case record available at the hearing. The county representative shall have authority at the hearing to make binding agreements and stipulations on behalf of the CWD.
- .36 Having the burden of going forward in the hearing to support its determination.

**22-085 AUTHORIZED REPRESENTATIVE**

- .1 The claimant may authorize a person to represent him/her during all aspects of the hearing process by signing and dating a written statement to that effect or by stating at the hearing that the person is so authorized. If the claimant is not present at the hearing, the written statement authorizing a representative to act on behalf of the claimant for hearing purposes shall be signed and dated by the claimant on or after the date of the action or inaction with which the claimant is dissatisfied.
- .11 The authorization may be limited in scope or duration by the claimant, and may be revoked by the claimant at any time. The authorization shall be presumed to be a valid authorization. Such presumption is rebuttable.

- .12 If the claimant is not present at the hearing and the written authorization does not meet the requirements set forth in Section 22-085.1, the Administrative Law Judge may proceed with the hearing if the circumstances indicate that the claimant wishes to proceed with the hearing process. In such cases, an amended authorization shall be submitted after the hearing as described in Sections 22-085.22 and .221.

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**HANDBOOK BEGINS HERE**

- .13 The above requirements are for hearing purposes only. For pre-hearing requirements and the release of information to authorized representatives, see Section 19-005.

**HANDBOOK ENDS HERE**

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- .2 If the claimant has not authorized the representative in writing and is not present at the hearing, the person may be recognized as the authorized representative if he/she is an attorney or if, at the hearing, the person swears or affirms under penalty of perjury that the claimant has so authorized him/her to act as the claimant's authorized representative, and the Administrative Law Judge further determines the person is so authorized.
- .21 The Administrative Law Judge may make the determination by contacting a collateral source (e.g., the claimant).
- .22 In all such cases a written authorization shall be submitted within five days from the hearing unless this time period is extended by the Administrative Law Judge.
- .221 If no written authorization is submitted, the case shall be considered abandoned and shall be dismissed by written decision after the hearing. See Section 22-054.
- .23 If, at the hearing, the person cannot swear or affirm under penalty of perjury that the claimant has authorized him/her to act as the claimant's authorized representative because the claimant is incompetent, in a comatose condition, suffering from amnesia or a similar condition, the hearing may proceed at the Administrative Law Judge's discretion if the person is a relative, or a person who has knowledge of the claimant's circumstances and who completed and signed the Statement of Facts on the claimant's behalf.
- .3 Whenever the claimant is represented by an authorized representative, the authorized representative shall be furnished a copy of all notices and decisions concerning the state hearing which are provided to the claimant.
- .4 After a person or organization has been authorized to represent the claimant, the county, after notification of the authorization, shall send copies of any subsequent correspondence that it has with the claimant regarding the state hearing, to the claimant and the authorized representative simultaneously.

## **EVIDENTIARY PRINCIPLES**

Direct evidence is evidence that directly proves a fact, without an inference or presumption, and which in itself, if true, conclusively establishes the fact. (Evidence Code (Ev. C.) §410) Except where additional evidence is required by statute, the direct evidence of one witness who is entitled to full credit is sufficient for proof of any fact. (Ev. C. §411)

The Evidence Code (Evid. Code) deals with general rules as to the determination of credibility of witnesses. The rule provides as follows: "Except as otherwise provided by statute, the court or jury may consider in determining the credibility of a witness any matter that has any tendency in reason to prove or disprove the truthfulness of his testimony at the hearing, including but not limited to any of the following:

- "(a) His demeanor while testifying and the manner in which he testifies.
- "(b) The character of his testimony.

- "(c) The extent of his capacity to perceive, to recollect, or to communicate any matter about which he testifies.
- "(d) The extent of his opportunity to perceive any matter about which he testifies.
- "(e) His character for honesty or veracity or their opposites.
- "(f) The existence or nonexistence of a bias, interest, or other motive.
- "(g) A statement previously made by him that is consistent with his testimony at the hearing.
- "(h) A statement made by him that is inconsistent with any part of his testimony at the hearing.
- "(i) The existence or nonexistence of any fact testified to by him.
- "(j) His attitude toward the action in which he testifies or toward the giving of testimony.
- "(k) His admission of untruthfulness."

(Evid. Code §780)

"Hearsay evidence" is evidence of a statement that was made other than by a witness while testifying at the hearing and that is offered to prove the truth of the matter stated. (Evidence Code §1200(a))

Evidence of a writing made as a record of an act, condition, or event is not made inadmissible by the hearsay rule when offered to prove the act, condition, or event if:

- (a) The writing was made in the regular course of a business;
- (b) The writing was made at or near the time of the act, condition, or event;
- (c) The custodian or other qualified witness testifies to its identity and the mode of its preparation; and
- (d) The sources of information and method and time of preparation were such as to indicate its trustworthiness.

(Evidence Code §1271)

If weaker and less satisfactory evidence is offered when it was within the power of the party to produce stronger and more satisfactory evidence, the evidence offered should be viewed with distrust. (Evidence Code §412)

In administrative tribunals, the party asserting the affirmative of the issue generally has the burden of proof. (*Cornell v. Reilly* (1954) 127 Cal.App.2d 178, 273 P.2d 572; and California Administrative Agency Practice, California Continuing Education of the Bar (1970) p.183)

The burden of producing evidence is the obligation of a party to produce evidence sufficient to avoid a ruling against him on the issue. (Evidence Code (Evid. Code) §110) The burden of producing evidence as to a particular fact is initially on the party with the burden of proof as to that fact. (Evid. Code §550)

The burden of proof is the obligation of a party to establish by evidence a requisite degree of belief concerning a fact in the mind of the trier of fact or the court. Except as otherwise provided by law, the burden of proof requires proof by a preponderance of the evidence. (Evidence Code §115)

The county has the burden of going forward in the state hearing to support its determination. (§22-073.36)

In the June 1995 UCLA Law Review, Professor Michael Asimow discusses review of California administrative agency actions which allow discretion to the agency.

“In exercising discretion, an agency generally must consider and balance various factors established by statute, constitution or common law. A reviewing court decides independently whether the agency considered all of the legally relevant factors and whether it considered factors that it should not have considered.” [Footnotes omitted] “Within the legal limits constraining an agency's discretion, the agency has power to choose between alternatives. A court must not substitute its judgment for the agency's, since the legislature delegated discretionary power to the agency, not to the court. Nevertheless, a court should reverse if an agency's choice was an abuse of discretion. [Footnotes omitted] Review for abuse of discretion consists of two distinct inquiries: the adequacy of the factual underpinning of the discretionary decision and the rationality of the choice.” [Footnotes omitted] (Asimow, Michael, 42 UCLA Law Review 1157, 1228, 1229, June 1995)

The 9th Circuit Court of Appeals has required that the ALJ in a social security case develop the record, even when the claimant is represented. There is a heightened duty when the claimant is mentally ill. As the Court said:

“The ALJ in a social security case has an independent ‘duty to fully and fairly develop the record and to assure that the claimant's interests are considered.’ *Smolen*, 80 F.3d at 1288 (quoting *Brown v. Heckler*, 713 F.2d 441, 443 (9th Cir. 1983)). This duty extends to the represented as well as to the unrepresented claimant. *Id.* When the claimant is unrepresented, however, the AU must be especially diligent in exploring for all the relevant facts. *Cox v. Califano*, 587 F.2d 988, 991 (9th Cir. 1978). In this case, Tonapetyan was represented, but by a lay person rather than an attorney. The ALJ's duty to develop the record fully is also heightened where the claimant may be mentally ill and thus unable to protect her own interests. *Higbee v. Sullivan*, 975 F.2d 558, 562 (9th Cir.1992). Ambiguous evidence, or the ALJ's own finding that the record is inadequate to allow for proper evaluation of the evidence, triggers the ALJ's duty to ‘conduct an appropriate inquiry.’ *Smolen*, 80 F.3d at 1288; *Armstrong v. Commissioner of Soc. Sec. Admin.*, 160 F.3d 587, 590 (9th Cir.1998). The ALJ may discharge this duty in several ways, including: subpoenaing the claimants physicians, submitting questions to the claimants physicians, continuing the hearing, or keeping the record open after the hearing to allow supplementation of the record. *Tidwell v. Apfel*, 161 F.3d 599, 602 (9th Cir. 1998); *Smolen*, 80 F.3d at 1288.” (*Tonapetyan v. Halter* (2001) 242 F. 3d 1144, 1150)

Although a treating physician's opinion is generally afforded the greatest weight in disability cases, it is not binding on an ALJ with respect to the existence of an impairment or the ultimate determination of disability. *Magallanes v. Bowen*, 881 F.2d 747, 751 (9<sup>th</sup> Cir. 1989). When there is a conflict between the opinions of a treating physician and an examining physician, as here, the ALJ may disregard the opinion of the treating physician only if he sets forth "specific and legitimate reasons supported by substantial evidence in the record for doing so." *Lester v. Chater*, 81 F. 3d 821, 830 (9<sup>th</sup> Cir. 1996); see also *Cotton v. Bowen*, 799 F. 2d 1403, 1408 (9<sup>th</sup> Cir. 1986). Although the contrary opinion of a non-examining medical expert does not alone constitute a specific, legitimate reason for rejecting a treating or examining physician's opinion, it may constitute substantial evidence when it is consistent with other independent evidence in the record. *Magallanes*, 881 F.2d at 752. (*Tonapetyan v. Halter* (2001) 242 F. 3d 1144, 1148,49)

A witness does not have to be a doctor to give expert testimony on certain medical issues. (See, e.g., Longuy v. La Cociete Francaise de Bienfaisance Mutelle (1921) 52 CA 370 [dealing with nurses]; Delia S. v. Torres (1982) 134 CA 3d 471 [dealing with licensed clinical social workers])

Medical opinions are statements from acceptable medical sources that reflect judgments about the nature and severity of a claimant's impairment(s), including symptoms, diagnosis and prognosis, what the claimant can still do despite impairment(s), and physical or mental restrictions. Medical opinions may be received from treating sources, nontreating sources who have examined the claimant (e.g., consulting physicians or psychologists), and nonexamining sources (e.g., physicians and psychologists who work for insurance companies, disability determination services) other than those who work for the disability determination services (DDS) or SSA. (For treatment of DDS or SSA physicians, consult POMS DI 24515.007.) In addition to considering medical opinions, evidence from other sources (e.g., chiropractors) may be used to help understand how the claimant's impairment affects his or her ability to work. (Program Operations Manual System (POMS) DI 24515.002A.)

When the case record contains an opinion from a claimant's treating source, it may be given controlling weight or more weight than an opinion from a nontreating source. Give controlling weight to a treating source's medical opinion regarding the nature and severity of the claimant's impairment(s) if the opinion is well supported by medically acceptable clinical and laboratory diagnostic techniques and it is not inconsistent with the other substantial medical or nonmedical evidence in the case record. (POMS DI 24515.003A.2.) Generally, give more weight to:

- (1) Medical opinions from sources who have examined the claimant than from sources which have not examined the claimant.
- (2) Treating source opinions than nontreating source opinions. (POMS DI 24515.005)
- (3) An opinion from a medical source who provides relevant supporting evidence (e.g., medical signs, laboratory findings) and a better explanation for the opinion.
- (4) An opinion consistent with other evidence of record.
- (5) The opinion of a specialist about medical issues related to the source's specialty.

(Program Operations Manual System (POMS) DI 24515.003A.4.)

## **OTHER**

Provisions of law relating to a public assistance program shall be fairly and equitably construed to affect the stated objects and purposes of the program. (Welfare and Institutions Code §11000)

"Regulation" means every rule, regulation, order, or standard of general application or the amendment, supplement or revision of any such rule, regulation, order or standard adopted by any state agency to implement, interpret, or make specific the law enforced or administered by it, or to govern its procedure, except one which is related only to the internal management of the state agency. "Regulation" does not mean or include any form prescribed by a state agency or any instructions relating to the use of the form, but this provision is not a limitation upon any requirement that a regulation be adopted pursuant to this part when one is needed to implement the law under which the form is issued. (Government Code §11342 b.) (Handbook §17-001.1)

"Handbook" material is informational only; it explains and illustrates regulatory sections by example. It is advisory and interpretive in the sense of illustrating appropriate application of a regulation; it may recommend specific processes or methods of implementation of a regulation. However, in order to provide a single source document for departmental clients (county welfare departments, licensees, etc.), appropriate statutes, regulations of other agencies, and court orders will be incorporated verbatim when the result would be helpful to understanding and full compliance with pertinent mandates in any specific program. In addition, it will include published operational standards by which DSS staff evaluate performance within DSS programs, forms, forms' instructions, and other informational materials. (Handbook §17-001.2)

Manual letters are informational. They are used to transmit new or revised DSS Regulations or "handbook" sections. They describe the material transmitted and explain the reasons for adoption; give the effective date, filing instructions plus any relevant information. (Handbook §17-001.3)

All-County Letters are informational and serve to provide explanatory materials for regulations, material of general interest, or interim procedural information (e.g., new reporting dates). They may be used to clarify statewide questions, but do not change previously-Issued regulatory material. They may also be used to trigger required responses by all counties when the basic authority for such is in regulation. (Handbook §17-001.4)

Information notices or unnumbered letters are used to transmit statewide information of short-term interest, booklets, or other materials (including single advance copies of newly adopted regulations). They serve to explain the purpose in sending the attachment; they may include a brief description or summary. (Handbook §17-001.5)

WITHDRAWAL

CONDITIONAL WITHDRAWALS

### OF REQUEST FOR HEARING

Case Name: \_\_\_\_\_  
State Hearing No: \_\_\_\_\_  
County: \_\_\_\_\_

County Case No: \_\_\_\_\_  
Filing Date: \_\_\_\_\_  
Hearing Date: \_\_\_\_\_  
Hearing Time: \_\_\_\_\_

I, \_\_\_\_\_, the undersigned do hereby:

Withdraw my request for a state hearing before the State Department of Social Services. I understand that by withdrawing my request, I lose my right to a hearing on that request. I also understand that by withdrawing my request for hearing, aid which has been paid because of the request will stop without further notice. I may, however, file a new hearing request raising the identical issue provided that the new request is timely per Manual of Policies and Procedures Section 22-009.

Conditionally withdraw my request for a state hearing before the State Department of Social Services. I understand that by conditionally withdrawing my request for hearing, aid which has been paid because of the hearing request will stop without further notice. I understand that the county will issue a redetermination notice within 30 days and that I must request a hearing within **90 DAYS** of the county's notice if I am not satisfied with the county's reconsideration of my case. Upon such renewal, I shall have the same rights I would have had if I had not signed this conditional withdrawal.

**NOTE:** A conditional withdrawal must provide that the actions of both parties will be completed within 30 days.

The reasons for or conditions of this withdrawal are: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signed

Signed

\_\_\_\_\_  
(County Representative) (Date)  
\_\_\_\_\_  
(County Address)  
\_\_\_\_\_  
(City) (Zip Code)  
\_\_\_\_\_  
(Telephone Number)

\_\_\_\_\_  
(Claimant) (Date)  
\_\_\_\_\_  
(Address)  
\_\_\_\_\_  
(City) (Zip Code)  
\_\_\_\_\_  
(Telephone Number)

**NOTE:** A Conditional Withdrawal must also be signed by a County Representative or it is invalid.

## **DECREASING IHSS HOURS – COUNTY RESPONSIBILITY AT STATE HEARINGS**

If the county wishes to decrease IHSS hours and the consumer or his/her authorized representative requests a state hearing, the burden is on the county to establish why it is authorizing fewer hours. If the county fails to meet its burden, it may not reduce the IHSS hours. It is the position of the State Hearings Division that the county can meet this burden in one of the following ways:

- By establishing that there has been a change in law or misapplication of law requiring that a specific IHSS need(s) that was previously authorized no longer be authorized.

*For example: If the county had authorized protective supervision for a recipient with no mental impairment, the county could correct that error at the next assessment.*

- By establishing that there has been a change or misapplication in State policy requiring that a specific IHSS need no longer be authorized.

*For example: If the county had authorized waiting time in the area of medical transportation contrary to State policy, the county could correct that misapplication of policy at the next assessment.*

- By establishing that there has been a change in the claimant's medical condition requiring the reduction of IHSS hours from the prior assessment of IHSS.

*For example: If four hours weekly had been authorized for ambulation at the prior assessment shortly after the claimant had had a stroke, the county could reduce her need for ambulation at the next annual assessment if her condition had improved and she had less need than previously assessed.*

- By establishing that the claimant or provider told the county social worker at the assessment that fewer hours of IHSS are needed than previously assessed in a particular need area or areas. In such case, the judge will make a finding as to the current need based on testimony at the hearing including testimony about the assessment, county records such as the written record of the assessment, and medical records.
- If the first county social worker was incompetent and biased in favor of the claimant and as a result made a completely unreasonable assessment of hours. The burden would be on the county to prove the incompetence and unreasonableness of the first social worker.

(Excerpt from the notes from the SHD CDSS Training Bureau, March 27, 2000, Item No. 00-03-01A)

## **STATE HEARING ROLES DIVISION 22**

### **Administrative Law Judge (ALJ)**

Division 22 – “A person designated by the Director and thereafter assigned by the Chief Administrative Law Judge to conduct state hearings and administrative disqualification hearings. Handbook: The Administrative Law Judge shall prepare fair, impartial and independent decisions.” [MPP Section 22-001 a. (2)]

- Determines order and manner of proof.
- Decides issues of fact and law, asks questions, makes credibility determinations. The ALJ is the only trier of fact, acting as both judge and jury. (Example: Are meals prepared separately for the claimant and his IHSS housemate? This is an issue of fact. If the meals are prepared separately, can the needs assessment for meal preparation be prorated if there is not a health and safety reason for separate meals? This is an issue of law.)
- Ensures each side is given a fair opportunity to be heard. Must act with courtesy and respect but it's not judge's job to make any of the participants happy with the decision.
- After the hearing, reviews exhibits, considers testimony, renders legally complete and correct decision, exercises judicial independence. When in conflict with program or blazing new or controversial areas, writes proposed decisions. Most of the ALJ's case time is spent in this activity.

Division 22 – “The taking of evidence in a hearing shall be conducted by the Administrative Law Judge in a manner best suited to ascertain the facts and to control the conduct of the hearing.” [MPP Section 22-050.1]

- ALJ gives great discretion in determining the manner of proof and the order of proof and to control the hearing.
- Duty to develop the record at the administrative hearing – ALJs are going to be proactive. They are going to participate by asking questions. The judges have a duty to ask questions to follow through with issues that they determine are important to the case.
- Will get variations in style from one judge to another. For example, some may have the SW take the lead during the hearing, while others will want the information filtered through the Appeals Specialist and want the Appeals Specialist to operate more or less as an attorney.
- How does SW navigate? Know your case backwards and forwards, know your role, be flexible and be adaptable.

### **County Representative / Appeals Specialist**

Division 22 – “An employee who is assigned the major responsibility for preparing and/or presenting a hearing case on behalf of the CWD.” [MPP Section 22-001 (c)(7)]

“Each case for which a state hearing request has been filed shall be assigned to a county representative who shall assume the major responsibility for preparing the case in accordance with the requirements of this Division and/or presenting it at the hearing.” [MPP Section 22-073.13]

“At the hearing, the county representative shall assume full responsibility for presentation of the county's case. Such presentation shall include:

- Summarizing the written position statement.
- Examining county witnesses.
- Cross-examining the claimant and the claimant's witnesses.
- Responding to any questions from the claimant or Administrative Law Judge concerning the case; and
- Having the county case record available at the hearing.
- The county representative shall have authority at the hearing to make binding agreements and stipulations on behalf of the CWD.
- Having the burden of going forward in the hearing to support its determination.” [MPP Section 22-073.3]

- Appeals Specialist is responsible for these things, though the information gathering is a shared responsibility.
- The case should not be ‘turned over’ to the SW at hearing.

### **Claimant**

Division 22 – “The person who has requested a state hearing and is or has been either:

(A) An applicant for or recipient of aid, as defined in Section 22-001a.(3).

(B) A foster parent or foster care provider who requests a hearing on behalf of the foster child where the CWD takes action to affect the child's aid and the child resides with or has resided with the foster parent or foster care provider.

(C) A representative of the estate of a deceased applicant or recipient (see Sections 22-004.4 and .5).

(D) The caretaker relative of a child with regard to the child's application for or receipt of aid.

(E) The guardian or conservator of an applicant or recipient.

(F) The sponsor of an alien, see MPP Sections 43-119, 44-353, and 63-804.1. [MPP Section 22-001c.(2)]

- NOTE: For IHSS (B) and (F) are not likely.
- A provider cannot be a claimant – can be a witness or the Authorized Representative.
- ALJs understand that the provider has interest in outcome because the hours are linked to provider income.

### **Authorized Representative**

Division 22 – “An individual or organization that has been authorized by the claimant or designated by the Administrative Law Judge or Department pursuant to Sections 22-085 to act for the claimant in any and all aspects of the state hearing or administrative disqualification hearing.” [MPP Section 22-001a.(5)]

- How do you know there is an AR? Appeals Specialist should know.
- An Authorized Representative may be a professional such as an attorney or paralegal, or may be a non-professional such as a relative, friend or provider.
- ALJs are aware that a provider’s testimony might be influenced by her desire not to have her wages cut, but also realize that the provider is more aware of daily care needs of a consumer than a SW who visits only at assessment time. ALJs evaluate provider’s testimony considering both those aspects.
- The AR can show up at the hearing – he/she just needs to fill out a form before proceedings begin.

## Social Worker

**There is no Division 22 language addressing the social worker's role directly – so what is their role?**

- The SW is a very important part of the hearing.
- The SW is a critical witness!
- But, the SW might be asked questions to prove that status. Questions might include how long you've been on the job, whether you've had medical training, etc. Be prepared to answer without defensiveness. And remember to mention the Training Academy training you've attended as well as any other pertinent training you've had by your county or other sources.
- It is your specific knowledge of the case and your specific ability to speak to your assessment that creates the dimensions in the case.
- Preparation is key to success – and preparation for hearing starts at the initial assessment.
- When you go into an assessment, you should bring the possibility that there could be questions about the case in the future. Document and assess thoroughly.
- When judges write decisions, they do so recognizing that the losing party may appeal. You may want to do the same, i.e., when you do an assessment, think whether the claimant has said something that they might say in a hearing should they appeal. Think how you would respond.

# RULES OF EVIDENCE

## SOME THINGS TO CONSIDER

### Rules of Evidence

- The rules of evidence as applicable in judicial proceedings are not applicable in state hearings.
- Evidence will be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs.
- The ALJ is permitted to exclude evidence which is irrelevant, cumulative or unduly repetitious.
- The ALJ can exclude evidence which is privileged under the Evidence Code if the privilege is claimed in accordance with the law.
- Although evidence may be admissible, the ALJ considers the nature of the evidence in assessing its probative value. [MPP 22-050.2 & .3]
- Note:
  - This is part of claimant friendly process. Set up to be friendly for non-legal (lay) people.
  - It is also friendly to counties in that neither side is expected to be lawyers.
  - Hearsay evidence is admissible.
  - While formal rules of evidence as practiced in court are relaxed, judges still need to control the hearing and may not admit irrelevant or repetitious evidence.
  - ALJs must balance and weigh the probative value (tendency or reason to prove the fact or issue under dispute) of the evidence.

### Weight versus Admissibility

#### **Hearsay –**

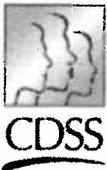
- Definition: "Hearsay evidence" is evidence of a statement that was made other than by a witness while testifying at the hearing and that is offered to prove the truth of the matter stated. [Evidence Code §1200(a)]
- In a state hearing, hearsay may / would be admitted but would be given different weight.
- Note:
  - Be aware of the source of your testimony.
  - Generally, the more direct the evidence, the more reliable.
  - Be aware of the extent to which you are relying on the observations and statements made during the home visit and the extent to which you are relying on supporting documentation.

#### **Credibility –**

- ALJ has to assess credibility in all instances and needs to question both sides to make sure he/she understands how each side arrived at their respective time computations.
- ALJ will resort to demonstrations to test the capacity of the claimant to give that sort of testimony.
- Credibility does not necessarily mean one person is telling the truth and the other is lying. It may be that one person misunderstood the other such as in a needs assessment at a home visit.

#### **Opinion –**

- There will be differences in opinion.
- ALJ must consider all of the evidence.
- You don't have to be a doctor to offer an opinion, but be aware, according to some case law in the disability field, ALJs are to give the greatest weight to the opinions of treating physicians.
- SW has burden to show specifically where and how the treating physician decision isn't correct and shouldn't be followed by the ALJ. It is a big hill to climb...but can be done.
- Look at medical opinion, dissect and respond to it. Be specific!
- Not going to make the case just by stating that the MDs don't understand the program.
- With the exception of Paramedical services and in a different sense Protective Supervision, the opinions of a treating physician will go to need, not time per task.



JOHN A. WAGNER  
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY  
**DEPARTMENT OF SOCIAL SERVICES**  
744 P Street, MS 8-17-12, Sacramento, CA 95814



ARNOLD SCHWARZENEGGER  
GOVERNOR

October 31, 2009

ALL- COUNTY LETTER NO. 09-68

TO: ALL COUNTY WELFARE DIRECTORS  
ALL IHSS PROGRAM MANAGERS

SUBJECT: IHSS PROVIDER APPEALS PROCESS

REFERENCE: WELFARE AND INSTITUTIONS CODE (WIC) SECTION  
12301.6 (E)(2)(b)(ii) AND ALL COUNTY LETTER (ACL) 09-52

REASON FOR THIS TRANSMITTAL

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

Assembly Bill (AB), Fourth Extraordinary Legislative Session (ABX4) 19 (Chapter 17, Statutes of 2009) added a new requirement for the California Department of Social Services (CDSS) to develop a written appeals process for prospective and current providers who are determined ineligible to receive payment for the provision of In-Home Supportive Services (IHSS). This All-County Letter (ACL) provides information to counties regarding the new provider appeals process available to prospective and current IHSS providers whom the county determines are ineligible to serve as IHSS providers. Effective November 1, 2009, counties will be required to:

- Review the findings in the criminal background check and determine if the prospective or current provider is ineligible to be a provider in the IHSS program due to any exclusionary crimes noted on the prospective or current provider's criminal offender record documents.
- Review the Department of Health Care Services Medicaid/Medi-Cal list of ineligible providers resulting from suspension as a licensed health care provider or surrender of his/her license or certificate to provide health care services. The Medi-Cal Suspended and Ineligible Provider List can be found at: [www.Medi-Cal.ca.gov](http://www.Medi-Cal.ca.gov).

If a prospective or current provider disagrees with the county decision which finds him or her ineligible to be paid for providing IHSS services, the provider may appeal to CDSS for review of the county's denial. Any appeal **must be submitted by mail** and received within 60 days from the date of the county's notice that he or she is ineligible to be an IHSS provider.

A prospective or current provider may not appeal the county's decision by telephone. The appeal must be submitted in writing using the attached **APPEAL REQUEST** form (SOC 856) and mailed to:

California Department of Social Services  
Adult Programs Branch  
IHSS Provider Enrollment Appeals Unit, MS 19-04  
P O Box 944243  
Sacramento, CA 94244-2430  
(916) 556-1156

Upon receipt of a valid (timely and complete) request for appeal, the Provider Enrollment Appeals Unit (PEAU) will notify the prospective or current provider and county that the request for appeal has been received and accepted for review. If an appeal is not received timely or complete, the prospective or current provider will be notified by the PEAU (in writing) of the reason the appeal cannot be accepted. The PEAU will request the county forward all information used to support its finding of ineligibility to the PEAU via secured mail within 30 days of receipt of PEAU's request for documents supporting the denial action.

Currently, counties do not have statutory authority to release the Criminal Offender Record Information (CORI) to the PEAU; however, counties will be able to extract information from the provider's criminal record that supports the county's denial action if the provider has been convicted of an exclusionary crime. This information can then be forwarded to the PEAU on a form that is currently being developed for this purpose.

The PEAU may also request additional information from the prospective or current provider or any other pertinent agency. A finding regarding the appeal will be completed by PEAU within 90 days of the receipt of the individual's request for appeal.

The final decision by PEAU will either uphold or overturn the findings of the county. A final notice will be mailed to the applicant and the county social services department advising them of the state's decision. The applicant has the right to request his or her CORI from the Department of Justice (DOJ) and the right to contest the CORI by contacting the DOJ directly.

If the state's decision overturns the findings of the county, the county will be instructed to approve the applicant as a valid provider and make the required necessary changes to his or her records to reflect that decision.

All County Letter No. 09-68  
Page Three

If the county's decision to deny the provider was in error and is overturned by the PEAU, the provider can be paid for services if he or she continued to provide those services during the period in which he or she was deemed ineligible. Should you have any questions regarding this ACL, please contact the PEAU at (916) 556-1156.

Sincerely,

***Original Document Signed By:***

EVA L. LOPEZ  
Deputy Director  
Adult Programs Division

c: CWDA





CDSS

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

September 16, 2010

ALL-COUNTY LETTER (ACL) NO. 10-42

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

SUBJECT: IHSS PROVIDER DISQUALIFICATION APPEAL DECISIONS

REFERENCES: ACL NO. 09-68, DATED OCTOBER 31, 2009; ACL NO. 09-52,  
DATED OCTOBER 1, 2009; ACL NO. 09-70, DATED  
OCTOBER 31, 2009; ACL NO. 09-78, DATED  
NOVEMBER 25, 2009; ACL NO. 10-05, DATED  
FEBRUARY 17, 2010; AND ACL NO. 10-35 DATED JULY 16, 2010

<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 or Settlement Agreement
<input type="checkbox"/>	Clarification Requested by one or More Counties
<input checked="" type="checkbox"/>	Initiated by CDSS

This ACL provides counties with the latest information and instructions regarding the IHSS provider disqualification appeal process. The California Department of Social Services (CDSS) has determined that the time required to complete processing of provider enrollment appeals is taking longer than originally anticipated. As a result, CDSS is advising counties that the timeframe for issuing provider enrollment appeal decisions has been extended to 180 days. Counties are instructed to advise prospective and current providers who file an appeal of the longer processing timeframe for appeal decisions.

**BACKGROUND**

In October 2009, CDSS issued All-County Letter (ACL) No. 09-68, which provided information and instructions to counties regarding the appeal process for prospective and current IHSS providers who were determined ineligible to be enrolled or paid as an IHSS provider. ACL No. 09-68 advised counties that the CDSS Provider Enrollment Appeals Unit (PEAU) would render an appeal decision within 90 days of receipt of the individual's request for appeal. As indicated above, appeal decisions are expected to take up to 180 days to complete. The PEAU will also advise appellants of this extended timeframe for issuing appeal decisions.

All County Letter 10-42  
Page Two

Should you have any questions regarding the information contained in this ACL, please contact the PEAU at (916) 229-4003.

Sincerely,

***Original Document Signed By:***

EILEEN CARROLL  
Deputy Director  
Adult Programs Division

## DIVISION 22 REGULATIONS

### 22-000 STATE HEARING - GENERAL

- .1 The responsibility for providing a full and impartial hearing to the claimant rests jointly with the county and the state department.

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#### HANDBOOK BEGINS HERE

- .11 The state department is responsible for the overall administration of the hearing process and the conduct of each hearing.
- .12 Since the right to request a state hearing belongs to the claimant, the regulations in this chapter shall be interpreted in a manner which protects the claimant's right to a hearing.
- .13 Although the specific duties and responsibilities of each agency are set forth in the following regulations, these rules shall not be used to suppress the claimant's right to a hearing. For example, although the county shall justify its action when appropriate, the county shall not discourage the claimant from proceeding with the hearing request nor relinquish its responsibility to assist the claimant in this process. The Administrative Law Judge shall conduct the hearing according to applicable procedures and the claimant shall be allowed to present evidence relevant to his/her own case.

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#### HANDBOOK ENDS HERE

### 22-001 DEFINITIONS

The following definitions shall apply wherever the terms are used throughout Division 22.

- a. (2) Administrative Law Judge - A person designated by the Director and thereafter assigned by the Chief Administrative Law Judge to conduct state hearings and administrative disqualification hearings. **HANDBOOK:** The Administrative Law Judge shall prepare fair, impartial and independent decisions.
  
- a. (5) Authorized Representative - An individual or organization that has been authorized by the claimant or designated by the Administrative Law Judge or Department pursuant to Sections 22-085 and 22-101 to act for the claimant in any and all aspects of the state hearing or administrative disqualification hearing.
  - (A) An authorized representative may include legal counsel, a relative, a friend, or other spokesperson.
  
- c. (2) Claimant - The person who has requested a state hearing and is or has been either:
  - (A) An applicant for or recipient of aid, as defined in Section 22-001a.(3).
  - (B) A foster parent or foster care provider who requests a hearing on behalf of the foster child where the CWD takes action to affect the child's aid and the child resides with or has resided with the foster parent or foster care provider.
  - (C) A representative of the estate of a deceased applicant or recipient (see Sections 22-004.4 and .5).
  - (D) The caretaker relative of a child with regard to the child's application for or receipt of aid.
  - (E) The guardian or conservator of an applicant or recipient.
  - (F) The sponsor of an alien, see MPP Sections 43-119, 44-353, and 63-804.1.
  - (G) A Transitional Child Care provider who receives direct payments for child care services on behalf of a Transitional Child Care family.
  
- c. (7) County or CWD Representative - An employee who is assigned the major responsibility for preparing and/or presenting a hearing case on behalf of the CWD. (See Section 22-073.13.)

## **22-004 REQUEST FOR A STATE HEARING**

- .1 A request for a state hearing may be either written or oral.
- .2 A written request concerning county administered state aid programs shall be filed with the CWD, and for all other state aid programs, the request shall be filed with the California State Department of Social Services in Sacramento.
  - .21 A written request for hearing may be made in any form.
    - .211 Claimants are encouraged to use the reverse side of the Notice of Action (NA) or DFA 377 form series or other CDSS-approved forms.
    - .212 The county agency shall assist the claimant in filing a request for a state hearing. The request for a state hearing should identify the aid program involved, as well as, the reason for dissatisfaction with the particular action or inaction involved in the case. If an interpreter will be necessary, the claimant should so indicate on the hearing request.
  - .22 When a written request for a state hearing is received by the CWD, a copy shall be forwarded to the State Hearings Division in Sacramento no later than three working days after its receipt.

## **22-009 TIME LIMIT ON REQUEST FOR A STATE HEARING**

- .1 The request for a state hearing shall be filed within 90 days after the date of the action or inaction with which the claimant is dissatisfied.
  - .11 If the claimant received adequate notice of the action (see Section 22-001a.(1)), the date of the action shall be the date on which the notice was mailed to the claimant.
  - .12 Where a request for a state hearing concerns the current amount of aid the request shall be filed within 90 days, but the period of review shall extend back to the first of the month in which the first day of the 90 day period occurred.

## **22-049 THE HEARING - GENERAL RULES AND PROCEDURES**

- .1 Attendance at the hearing is ordinarily limited to the claimant, authorized representative (as defined in Section 22-001a.(5)), county representative, legal counsel, authorized interpreter, and witnesses relevant to the issue. Other persons may attend the hearing if the claimant agrees to or requests their presence and the Administrative Law Judge determines that their presence will not be adverse to the hearing.
  - .11 Appearance by the claimant (in person or by the authorized representative) shall be required at the hearing, unless the hearing is a rehearing or further hearing.
  - .12 The Administrative Law Judge shall be permitted to exclude a witness during the testimony of other witnesses.
  - .13 Both the county and the claimant shall have the right to have a representative present throughout the hearing. Both the county representative and the claimant's authorized representative shall have the right to designate another person to be present and advise the representative throughout the hearing. This individual may be a witness who testifies on behalf of the county or claimant and in this circumstance, Section 22-049.12 would not apply. If this individual is a witness, he/she may not be present as an advisor until after he/she has testified.
  - .14 The Administrative Law Judge shall have the authority to exclude persons who are disruptive of the hearing.
- .2 The hearing shall be conducted in an impartial manner.
- .3 All testimony shall be submitted under oath, affirmation, or penalty of perjury.
- .4 The proceedings at the hearing shall be reported by tape recorder or otherwise perpetuated by mechanical, electronic, or other means capable of reproduction or transcription.
- .5 The issues at the hearing shall be limited to those issues which are reasonably related to the request for hearing or other issues identified by either the county or claimant which they have jointly agreed, prior to or at the state hearing, to discuss.
  - .51 If the rights of any party will be prejudiced by the consideration of a reasonably related issue raised at the hearing, the hearing shall be continued or the record held open subject to the provisions of Section 22-053.3 so that such party may prepare his/her case.

- .52 If the claimant contends that he/she is not adequately prepared to discuss the issues because he/she did not receive adequate notice required by Section 22-071.1, this issue shall be resolved by the Administrative Law Judge at the hearing.
- .521 If the Administrative Law Judge determines that adequate notice was provided, the claimant shall agree to discuss the substantive issue or issues or the case will be dismissed.
- .522 If the Administrative Law Judge determines that adequate notice was not provided, the case shall be postponed unless the claimant waives the adequate notice requirement for purposes of proceeding with the hearing, and agrees to discuss the substantive issue or issues at the hearing.
- .523 If the notice was not adequate and involved a discontinuance, suspension, cancellation, termination or reduction of aid, other than those referred to in Sections 22-072.1 through .13 aid shall be reinstated retroactively and the provisions of Section 22-072.5 shall apply.
- .53 In cases in which a jurisdictional issue is raised, either by one of the parties or by the Administrative Law Judge, the parties must be prepared to submit evidence on the substantive issues except as provided in Sections 22-049.532 and 22-054.4.
  - .531 No determination of the timeliness of the hearing request or of any other jurisdictional issue will ordinarily be made at the hearing. The request will be dismissed by a written decision if the Administrative Law Judge determines that jurisdiction does not exist, e.g. request untimely or no subject matter jurisdiction.
  - .532 If, prior to or at the hearing, both parties agree to discuss only the jurisdictional issue, or the Administrative Law Judge on his/her own motion determines that only the jurisdictional issue will be discussed, the parties need not submit evidence on the substantive issues and the Administrative Law Judge shall take evidence only on the jurisdictional issue. Within ten days from the date of the hearing, the Administrative Law Judge shall:
    - (a) Inform the parties in writing that the hearing will not proceed on the substantive issues and a decision will be prepared solely on the jurisdictional issue, or
    - (b) Inform the parties that an additional hearing will be held on the substantive issues, and provide the parties a minimum of ten days in which to prepare on the substantive issues unless the time is waived by both parties. In this case, the Administrative Law Judge's proposed decision will address both the jurisdictional and substantive issues.
- .6 An interpreter shall be provided by the state if, prior to the hearing, a party requests an interpreter or if at the hearing, the Administrative Law Judge determines that an interpreter is necessary.
  - .61 When the state hearing is to be held with the assistance of an interpreter, the Administrative Law Judge shall determine if the interpreter has been certified by the Department.
    - .611 If the interpreter has been certified, the qualifications and competency of the interpreter need not be further examined.
    - .612 If the interpreter has not been certified, the Administrative Law Judge shall:
      - (a) Examine the qualifications and competency of the interpreter.
      - (b) Disqualify any interpreter determined by the Administrative Law Judge not to be competent for interpretation purposes.
      - (c) Assure objective interpretation by, at his/her discretion, disqualifying interpreters who are:
        - (1) Claimant's relatives, friends, or an authorized representative.
        - (2) County staff who participated in making the decision complained of.
        - (3) The county appeals representative.
        - (4) Any other individual determined by the Administrative Law Judge to be detrimental to the hearing process or having a bias or the appearance of being biased.
  - .62 When the state hearing is held with the assistance of an interpreter the Administrative Law Judge shall assure objective interpretation.
  - .63 A separate oath or affirmation to translate accurately shall be administered to all interpreters.

- .7 The rights of the claimant and the county shall include the right to:
  - .71 Examine parties and witnesses.
  - .72 Conduct such cross-examination as may be required for a full disclosure of the facts.
  - .73 Introduce exhibits.
  - .74 Bring witnesses.
  - .75 Examine all documents prior to and during the hearing.
  - .76 Question opposing witnesses and parties on any matter relevant to the issues even though that matter was not covered in the direct examination.
  - .77 Make oral or written argument.
  - .78 Rebut the evidence.
- .8 The following shall apply to communications concerning the hearing:
  - .81 All documents submitted by either the claimant or the county shall be made available to both parties.
  - .811 Copies of all such documents shall be provided to the claimant free of charge.

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**HANDBOOK BEGINS HERE**

(a) See Section 22-073.25 regarding position statement requirements.

**HANDBOOK ENDS HERE**

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- .82 Merits of a pending state hearing shall not be discussed between the Administrative Law Judge and a party outside the presence of the other party.
- .9 Whenever it is necessary that another county be joined as a party to the action in order to dispose of all issues, the Administrative Law Judge shall so order and shall, subject to Section 22-053.3, postpone the hearing, hold the record of the hearing open, or continue the hearing as necessary.
  - .91 A postponement for this reason shall be deemed a postponement for good cause.

**22-050 EVIDENCE**

- .1 The taking of evidence in a hearing shall be conducted by the Administrative Law Judge in a manner best suited to ascertain the facts and to control the conduct of the hearing.
  - .11 Prior to taking evidence, the Administrative Law Judge shall identify the issues and shall state the order in which evidence shall be received.
- .2 Except as provided below, evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs.
  - .21 The rules of evidence as applicable in judicial proceedings shall not be applicable in state hearings.
  - .22 The Administrative Law Judge shall be permitted to exclude evidence which is irrelevant, cumulative or unduly repetitious.
  - .23 The Administrative Law Judge shall exclude evidence which is privileged under the Evidence Code if the privilege is claimed in accordance with law.
- .3 Although evidence may be admissible under Section 22-050.2, the Administrative Law Judge shall consider the nature of the evidence in assessing its probative value.
- .4 "Official Notice" describes the manner in which an Administrative Law Judge or the Director will recognize the existence and truth of certain facts which have a bearing on the issue in the case, without requiring the actual production of evidence to prove such facts. Official notice may be taken of either a proposition of law or a proposition of fact.
  - .41 The Administrative Law Judge or Director shall take official notice of those matters which must be judicially noticed by a court under Section 451 of the Evidence Code.

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**HANDBOOK BEGINS HERE**

- .411 Generally, Section 451 of the Evidence Code provides that judicial notice must be taken of laws, statutes, regulations, official records, and facts and propositions which are of such universal knowledge that they are not reasonably subject to dispute.

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**HANDBOOK ENDS HERE**

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- .42 The Administrative Law Judge may take official notice of those matters set forth in Section 452 of the Evidence Code.

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**HANDBOOK BEGINS HERE**

- .421 Generally, Section 452 of the Evidence Code provides that official notice may be taken of facts and propositions that are not reasonably subject to dispute and are capable of immediate and accurate determination by resort to sources of reasonably indisputable accuracy.

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**HANDBOOK ENDS HERE**

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- .43 The Administrative Law Judge may take official notice of any generally accepted technical fact relating to the administration of public social service.
- .44 With respect to matters under Subsection .43 above and subdivision (f) of Section 451 and Section 452 of the Evidence Code which are of substantial consequence to the determination of the action, each party shall be given reasonable opportunity, subject to Section 22-053.3, before the decision is submitted, to present information relevant to:
- .441 The propriety of taking official notice, and
- .442 The tenor of the matter to be noticed.

**22-053 POSTPONEMENTS AND CONTINUANCES FOR ADDITIONAL EVIDENCE**

- .1 Postponements shall be granted under limited circumstances.
- .11 A hearing involving the Food Stamp Program shall be postponed upon the initial request of the claimant prior to the hearing for up to 30 days.
- .111 Any aid pending, if appropriate, shall continue at least until the next scheduled hearing. See Section 63-804.64 in the Food Stamp Program.
- .112 In all other programs, a hearing may be postponed upon the request of the claimant only if such request meets the good cause criteria set forth in Section 22-053.16.
- (a) The Department shall have the authority to request verification from the claimant to support the reason why he/she cannot attend the hearing on the scheduled date.
- .12 Upon the request of the county, a hearing shall be permitted to be postponed:
- .121 By the Administrative Law Judge at the hearing.
- .122 Any postponement granted under Section 22-053.12 shall be deemed postponed with good cause.
- .13 The Chief Administrative Law Judge shall have the authority to postpone a hearing prior to the hearing.
- .131 Any postponement granted under Section 22-053.13 shall be deemed postponed with good cause.
- .14 The Administrative Law Judge shall have the authority to postpone a hearing, at the hearing, and continue any applicable aid pending if:
- .141 The claimant establishes good cause as specified in Section 22-053.16.
- .142 The county has failed to furnish adequate notice within the meaning of Sections 22-001.1a.(1) and 22-049.52, and the claimant requests the postponement.
- .15 The Administrative Law Judge shall have the authority to postpone a hearing, for any other reason at his/her discretion.
- .151 The Administrative Law Judge shall order that aid pending be continued only if the postponement is necessary to insure a full and fair hearing and the postponement did not result from any act or omission on the part of the claimant.

- .16 Good cause shall be established if the claimant or authorized representative establishes that the case should be postponed due to:
  - .161 Death in the family.
  - .162 Personal illness or injury.
  - .163 Sudden and unexpected emergencies which prevent the claimant or the authorized representative from appearing.
  - .164 A conflicting court appearance which cannot be postponed.
  - .165 The county, when required, does not make a position statement available to the claimant not less than two working days prior to the date of the scheduled hearing, or the county has modified the position statement (as defined in Section 22-073.252) after providing the statement to the claimant, and the claimant has waived decision deadlines contained in Section 22-060.
- .2 Continuances for additional evidence shall be granted under limited conditions.
  - .21 If the Administrative Law Judge conducting the hearing determines that evidence not available at the hearing is necessary for the proper determination of the case, the Administrative Law Judge shall have the authority to continue the hearing to a later date or close the hearing and hold the record open for a stated period not to exceed 30 days in order to permit the submission of additional documentary evidence.

**22-059 COMMUNICATIONS AFTER HEARING**

- .1 Communications to the Department concerning a case subsequent to the hearing shall be excluded from the record and shall be disregarded prior to the adoption and release of the decision of the Director except that:
  - .11 Oral and written communications after the hearing concerning the status of the decision, or the date of delivery of additional evidence to be submitted under the provisions of Section 22-053.21, or protesting an Administrative Law Judge's determination under Section 22-072.63 with respect to aid pending a hearing or a disqualification request under the provisions of Section 22-055, are not improper; and
  - .12 An Administrative Law Judge shall have authority on his/her own motion or at the request of either party to reopen the record for receipt of additional information, if all parties are notified of the reason for the reopening and the submission of such evidence conforms to the requirements of Sections 22-053.21 and .3.

**22-060 DISPOSITION OF STATE HEARINGS**

- .1 All state hearings shall be decided or dismissed within 90 days from the date of the request for state hearing except in those cases where the claimant waives such requirement or the claimant withdraws or abandons the request for hearing.

**22-061 SUBMISSION OF PROPOSED DECISION/ADOPTION**

- .1 After the hearing has been closed, the Administrative Law Judge shall submit a proposed decision for review by the Chief Administrative Law Judge and submission to the Director, or shall adopt a final decision pursuant to the authority delegated to the Administrative Law Judge by the Director.

**22-069 COUNTY WELFARE RESPONSIBILITY**

- .1 Each county shall furnish to the State Hearings Division the name of an individual who, in coordination with the Chief Administrative Law Judge, is responsible for discharging the requirements of Sections 22-069 through 22-078.

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**HANDBOOK BEGINS HERE**

- .11 Sections 22-069 through 22-078 describe the responsibilities of the county in the state hearing process.

**HANDBOOK ENDS HERE**

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- .12 The county responsibility shall include:

- .121 Investigation of the case and assistance to the claimant prior to the hearing; and
- .122 Presentation of the county's position during the hearing; and
- .123 Compliance with state hearing decisions.

## **22-073 COUNTY WELFARE AGENCY RESPONSIBILITY PRIOR TO THE STATE HEARING**

- .1 Upon receipt of a request for hearing or notice from the Department that a recipient has filed a request for a state hearing, the county shall provide aid pending the state hearing in accordance with Section 22-072, when entitlement exists.
  - .13 Each case for which a state hearing request has been filed shall be assigned to a county representative who shall assume the major responsibility for preparing the case in accordance with the requirements of this Division and/or presenting it at the hearing. The county representative shall not have had immediate prior involvement with the case.
- .2 Prior to the hearing, the county representative shall:
  - .21 Determine the issues raised by the hearing request.
    - .211 If the request for hearing does not clearly set forth the claimant's basis for appeal, the county representative shall immediately contact the claimant for clarification.
  - .22 After determining the issues, the county representative shall review the applicable statutes, regulations and policies in light of the evidence which exists in the case record.
    - .221 In conducting this initial review, the representative shall contact the eligibility worker and other county personnel as appropriate.
    - .222 When assistance of the Department is required to clarify any questions, such assistance shall be sought without delay.
  - .23 After conducting the initial review, the county representative shall make a determination concerning the appropriateness of the county action and the need for and advisability of a hearing. Disagreements and misunderstandings shall be resolved quickly, at the lowest possible administrative level, thereby avoiding unnecessary hearings.
    - .231 If the county representative concludes that the county action was incorrect, the county representative shall contact the claimant and attempt to resolve the case without a hearing.
      - (a) The county representative shall have the authority to make such a decision. The conditional withdrawal procedure described in Section 22-054.21 is usually appropriate in such instances.
    - .232 If the county representative concludes that the county action was correct, the county representative shall contact the claimant and:
      - (a) Inquire if the claimant plans to attend the hearing;
      - (b) Determine if there are any further contentions which the claimant will attempt to raise at the hearing; and
      - (c) Provide any and all information which can be of assistance to the claimant in preparing for the hearing. This shall include revealing to the claimant any and all regulations and evidence including that which might be favorable to the claimant's case. The county representative may explain to the claimant the right to withdraw the request for hearing but shall not be permitted to request such a withdrawal. The claimant shall also be informed of the availability of any free legal representation. If the claimant is not fluent in English and if bilingual services apply as specified in Section 21-115, an explanation of the hearing procedures shall be made in the claimant's language.
  - .24 The county representative shall determine if an interpreter will be necessary at the hearing or if a home hearing will be necessary.
    - .241 The county representative shall notify the State Hearings Division if the claimant has requested an interpreter or home hearing.

- .242 The county representative shall report without delay to the State Hearings Division any changes in the claimant's address or any other circumstances which might affect the necessity for or conduct of the hearing.
  - (a) This responsibility to report changes in the claimant's circumstances continues after the hearing until a decision is rendered.
- .25 Prior to each hearing, the county representative shall prepare a typewritten position statement.
- .251 The position statement shall summarize the facts of the case and set forth the regulatory justification for the county's action.
  - (a) If the issue concerns the amount of aid, grant adjustment, or a demand for repayment, the county representative shall include in the position statement a complete final budget computation, month by month, for the period in issue.
  - (b) The county shall include as attachments to the position statement copies of documentary evidence and a list of witnesses which the county intends to use during the hearing.
    - (1) The documents shall be itemized on the last page of the position statement and attached as exhibits.
- .252 If the county has received a 10-day prior notice of the date and time of the scheduled hearing, a copy of the position statement shall be made available to the claimant at the CWD, not less than two working days prior to the date of the scheduled hearing.

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**HANDBOOK BEGINS HERE**

Example:

The hearing is scheduled for Friday. Absent any intervening holidays, the position statement shall be available by the opening of business the preceding Wednesday.

**HANDBOOK ENDS HERE**

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- .253 If the county, when required, does not make the position statement available not less than two working days prior to the date of the scheduled hearing, or if the county modifies the position statement after providing the statement to the claimant, the hearing shall be postponed upon the request of the claimant conditioned upon the waiver of decision deadlines contained in Section 22-060. A modification is defined as a change which substantively revises the position statement.
- .26 While preparing for the hearing, the county representative shall determine if the presence of the eligibility worker or other county witnesses would be helpful for the resolution of the issue.
- .3 At the hearing, the county representative shall assume full responsibility for presentation of the county's case. Such presentation shall include:
  - .31 Summarizing the written position statement.
  - .32 Examining county witnesses.
  - .33 Cross-examining the claimant and the claimant's witnesses.
  - .34 Responding to any questions from the claimant or Administrative Law Judge concerning the case; and
  - .35 Having the county case record available at the hearing. The county representative shall have authority at the hearing to make binding agreements and stipulations on behalf of the CWD.
  - .36 Having the burden of going forward in the hearing to support its determination.

**22-085 AUTHORIZED REPRESENTATIVE**

- .1 The claimant may authorize a person to represent him/her during all aspects of the hearing process by signing and dating a written statement to that effect or by stating at the hearing that the person is so authorized. If the claimant is not present at the hearing, the written statement authorizing a representative to act on behalf of the claimant for hearing purposes shall be signed and dated by the claimant on or after the date of the action or inaction with which the claimant is dissatisfied.
  - .11 The authorization may be limited in scope or duration by the claimant, and may be revoked by the claimant at any time. The authorization shall be presumed to be a valid authorization. Such presumption is rebuttable.

- .12 If the claimant is not present at the hearing and the written authorization does not meet the requirements set forth in Section 22-085.1, the Administrative Law Judge may proceed with the hearing if the circumstances indicate that the claimant wishes to proceed with the hearing process. In such cases, an amended authorization shall be submitted after the hearing as described in Sections 22-085.22 and .221.

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**HANDBOOK BEGINS HERE**

- .13 The above requirements are for hearing purposes only. For pre-hearing requirements and the release of information to authorized representatives, see Section 19-005.

**HANDBOOK ENDS HERE**

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- .2 If the claimant has not authorized the representative in writing and is not present at the hearing, the person may be recognized as the authorized representative if he/she is an attorney or if, at the hearing, the person swears or affirms under penalty of perjury that the claimant has so authorized him/her to act as the claimant's authorized representative, and the Administrative Law Judge further determines the person is so authorized.
- .21 The Administrative Law Judge may make the determination by contacting a collateral source (e.g., the claimant).
- .22 In all such cases a written authorization shall be submitted within five days from the hearing unless this time period is extended by the Administrative Law Judge.
- .221 If no written authorization is submitted, the case shall be considered abandoned and shall be dismissed by written decision after the hearing. See Section 22-054.
- .23 If, at the hearing, the person cannot swear or affirm under penalty of perjury that the claimant has authorized him/her to act as the claimant's authorized representative because the claimant is incompetent, in a comatose condition, suffering from amnesia or a similar condition, the hearing may proceed at the Administrative Law Judge's discretion if the person is a relative, or a person who has knowledge of the claimant's circumstances and who completed and signed the Statement of Facts on the claimant's behalf.
- .3 Whenever the claimant is represented by an authorized representative, the authorized representative shall be furnished a copy of all notices and decisions concerning the state hearing which are provided to the claimant.
- .4 After a person or organization has been authorized to represent the claimant, the county, after notification of the authorization, shall send copies of any subsequent correspondence that it has with the claimant regarding the state hearing, to the claimant and the authorized representative simultaneously.

## **EVIDENTIARY PRINCIPLES**

Direct evidence is evidence that directly proves a fact, without an inference or presumption, and which in itself, if true, conclusively establishes the fact. (Evidence Code (Ev. C.) §410) Except where additional evidence is required by statute, the direct evidence of one witness who is entitled to full credit is sufficient for proof of any fact. (Ev. C. §411)

The Evidence Code (Evid. Code) deals with general rules as to the determination of credibility of witnesses. The rule provides as follows: "Except as otherwise provided by statute, the court or jury may consider in determining the credibility of a witness any matter that has any tendency in reason to prove or disprove the truthfulness of his testimony at the hearing, including but not limited to any of the following:

- "(a) His demeanor while testifying and the manner in which he testifies.
- "(b) The character of his testimony.

- "(c) The extent of his capacity to perceive, to recollect, or to communicate any matter about which he testifies.
- "(d) The extent of his opportunity to perceive any matter about which he testifies.
- "(e) His character for honesty or veracity or their opposites.
- "(f) The existence or nonexistence of a bias, interest, or other motive.
- "(g) A statement previously made by him that is consistent with his testimony at the hearing.
- "(h) A statement made by him that is inconsistent with any part of his testimony at the hearing.
- "(i) The existence or nonexistence of any fact testified to by him.
- "(j) His attitude toward the action in which he testifies or toward the giving of testimony.
- "(k) His admission of untruthfulness."

(Evid. Code §780)

"Hearsay evidence" is evidence of a statement that was made other than by a witness while testifying at the hearing and that is offered to prove the truth of the matter stated. (Evidence Code §1200(a))

Evidence of a writing made as a record of an act, condition, or event is not made inadmissible by the hearsay rule when offered to prove the act, condition, or event if:

- (a) The writing was made in the regular course of a business;
- (b) The writing was made at or near the time of the act, condition, or event;
- (c) The custodian or other qualified witness testifies to its identity and the mode of its preparation; and
- (d) The sources of information and method and time of preparation were such as to indicate its trustworthiness.

(Evidence Code §1271)

If weaker and less satisfactory evidence is offered when it was within the power of the party to produce stronger and more satisfactory evidence, the evidence offered should be viewed with distrust. (Evidence Code §412)

In administrative tribunals, the party asserting the affirmative of the issue generally has the burden of proof. (*Cornell v. Reilly* (1954) 127 Cal.App.2d 178, 273 P.2d 572; and California Administrative Agency Practice, California Continuing Education of the Bar (1970) p.183)

The burden of producing evidence is the obligation of a party to produce evidence sufficient to avoid a ruling against him on the issue. (Evidence Code (Evid. Code) §110) The burden of producing evidence as to a particular fact is initially on the party with the burden of proof as to that fact. (Evid. Code §550)

The burden of proof is the obligation of a party to establish by evidence a requisite degree of belief concerning a fact in the mind of the trier of fact or the court. Except as otherwise provided by law, the burden of proof requires proof by a preponderance of the evidence. (Evidence Code §115)

The county has the burden of going forward in the state hearing to support its determination. (§22-073.36)

In the June 1995 UCLA Law Review, Professor Michael Asimow discusses review of California administrative agency actions which allow discretion to the agency.

“In exercising discretion, an agency generally must consider and balance various factors established by statute, constitution or common law. A reviewing court decides independently whether the agency considered all of the legally relevant factors and whether it considered factors that it should not have considered.” [Footnotes omitted] “Within the legal limits constraining an agency's discretion, the agency has power to choose between alternatives. A court must not substitute its judgment for the agency's, since the legislature delegated discretionary power to the agency, not to the court. Nevertheless, a court should reverse if an agency's choice was an abuse of discretion. [Footnotes omitted] Review for abuse of discretion consists of two distinct inquiries: the adequacy of the factual underpinning of the discretionary decision and the rationality of the choice.” [Footnotes omitted] (Asimow, Michael, 42 UCLA Law Review 1157, 1228, 1229, June 1995)

The 9th Circuit Court of Appeals has required that the ALJ in a social security case develop the record, even when the claimant is represented. There is a heightened duty when the claimant is mentally ill. As the Court said:

“The ALJ in a social security case has an independent ‘duty to fully and fairly develop the record and to assure that the claimant's interests are considered.’ *Smolen*, 80 F.3d at 1288 (quoting *Brown v. Heckler*, 713 F.2d 441, 443 (9th Cir. 1983)). This duty extends to the represented as well as to the unrepresented claimant. *Id.* When the claimant is unrepresented, however, the AU must be especially diligent in exploring for all the relevant facts. *Cox v. Califano*, 587 F.2d 988, 991 (9th Cir. 1978). In this case, Tonapetyan was represented, but by a lay person rather than an attorney. The ALJ's duty to develop the record fully is also heightened where the claimant may be mentally ill and thus unable to protect her own interests. *Higbee v. Sullivan*, 975 F.2d 558, 562 (9th Cir.1992). Ambiguous evidence, or the ALJ's own finding that the record is inadequate to allow for proper evaluation of the evidence, triggers the ALJ's duty to ‘conduct an appropriate inquiry.’ *Smolen*, 80 F.3d at 1288; *Armstrong v. Commissioner of Soc. Sec. Admin.*, 160 F.3d 587, 590 (9th Cir.1998). The ALJ may discharge this duty in several ways, including: subpoenaing the claimants physicians, submitting questions to the claimants physicians, continuing the hearing, or keeping the record open after the hearing to allow supplementation of the record. *Tidwell v. Apfel*, 161 F.3d 599, 602 (9th Cir. 1998); *Smolen*, 80 F.3d at 1288.” (*Tonapetyan v. Halter* (2001) 242 F. 3d 1144, 1150)

Although a treating physician's opinion is generally afforded the greatest weight in disability cases, it is not binding on an ALJ with respect to the existence of an impairment or the ultimate determination of disability. *Magallanes v. Bowen*, 881 F.2d 747, 751 (9<sup>th</sup> Cir. 1989). When there is a conflict between the opinions of a treating physician and an examining physician, as here, the ALJ may disregard the opinion of the treating physician only if he sets forth "specific and legitimate reasons supported by substantial evidence in the record for doing so." *Lester v. Chater*, 81 F. 3d 821, 830 (9<sup>th</sup> Cir. 1996); see also *Cotton v. Bowen*, 799 F. 2d 1403, 1408 (9<sup>th</sup> Cir. 1986). Although the contrary opinion of a non-examining medical expert does not alone constitute a specific, legitimate reason for rejecting a treating or examining physician's opinion, it may constitute substantial evidence when it is consistent with other independent evidence in the record. *Magallanes*, 881 F.2d at 752. (*Tonapetyan v. Halter* (2001) 242 F. 3d 1144, 1148,49)

A witness does not have to be a doctor to give expert testimony on certain medical issues. (See, e.g., Longuy v. La Cociete Francaise de Bienfaisance Mutelle (1921) 52 CA 370 [dealing with nurses]; Delia S. v. Torres (1982) 134 CA 3d 471 [dealing with licensed clinical social workers])

Medical opinions are statements from acceptable medical sources that reflect judgments about the nature and severity of a claimant's impairment(s), including symptoms, diagnosis and prognosis, what the claimant can still do despite impairment(s), and physical or mental restrictions. Medical opinions may be received from treating sources, nontreating sources who have examined the claimant (e.g., consulting physicians or psychologists), and nonexamining sources (e.g., physicians and psychologists who work for insurance companies, disability determination services) other than those who work for the disability determination services (DDS) or SSA. (For treatment of DDS or SSA physicians, consult POMS DI 24515.007.) In addition to considering medical opinions, evidence from other sources (e.g., chiropractors) may be used to help understand how the claimant's impairment affects his or her ability to work. (Program Operations Manual System (POMS) DI 24515.002A.)

When the case record contains an opinion from a claimant's treating source, it may be given controlling weight or more weight than an opinion from a nontreating source. Give controlling weight to a treating source's medical opinion regarding the nature and severity of the claimant's impairment(s) if the opinion is well supported by medically acceptable clinical and laboratory diagnostic techniques and it is not inconsistent with the other substantial medical or nonmedical evidence in the case record. (POMS DI 24515.003A.2.) Generally, give more weight to:

- (1) Medical opinions from sources who have examined the claimant than from sources which have not examined the claimant.
- (2) Treating source opinions than nontreating source opinions. (POMS DI 24515.005)
- (3) An opinion from a medical source who provides relevant supporting evidence (e.g., medical signs, laboratory findings) and a better explanation for the opinion.
- (4) An opinion consistent with other evidence of record.
- (5) The opinion of a specialist about medical issues related to the source's specialty.

(Program Operations Manual System (POMS) DI 24515.003A.4.)

## **OTHER**

Provisions of law relating to a public assistance program shall be fairly and equitably construed to affect the stated objects and purposes of the program. (Welfare and Institutions Code §11000)

"Regulation" means every rule, regulation, order, or standard of general application or the amendment, supplement or revision of any such rule, regulation, order or standard adopted by any state agency to implement, interpret, or make specific the law enforced or administered by it, or to govern its procedure, except one which is related only to the internal management of the state agency. "Regulation" does not mean or include any form prescribed by a state agency or any instructions relating to the use of the form, but this provision is not a limitation upon any requirement that a regulation be adopted pursuant to this part when one is needed to implement the law under which the form is issued. (Government Code §11342 b.) (Handbook §17-001.1)

"Handbook" material is informational only; it explains and illustrates regulatory sections by example. It is advisory and interpretive in the sense of illustrating appropriate application of a regulation; it may recommend specific processes or methods of implementation of a regulation. However, in order to provide a single source document for departmental clients (county welfare departments, licensees, etc.), appropriate statutes, regulations of other agencies, and court orders will be incorporated verbatim when the result would be helpful to understanding and full compliance with pertinent mandates in any specific program. In addition, it will include published operational standards by which DSS staff evaluate performance within DSS programs, forms, forms' instructions, and other informational materials. (Handbook §17-001.2)

Manual letters are informational. They are used to transmit new or revised DSS Regulations or "handbook" sections. They describe the material transmitted and explain the reasons for adoption; give the effective date, filing instructions plus any relevant information. (Handbook §17-001.3)

All-County Letters are informational and serve to provide explanatory materials for regulations, material of general interest, or interim procedural information (e.g., new reporting dates). They may be used to clarify statewide questions, but do not change previously-Issued regulatory material. They may also be used to trigger required responses by all counties when the basic authority for such is in regulation. (Handbook §17-001.4)

Information notices or unnumbered letters are used to transmit statewide information of short-term interest, booklets, or other materials (including single advance copies of newly adopted regulations). They serve to explain the purpose in sending the attachment; they may include a brief description or summary. (Handbook §17-001.5)

WITHDRAWAL

CONDITIONAL WITHDRAWALS

### OF REQUEST FOR HEARING

Case Name: \_\_\_\_\_  
State Hearing No: \_\_\_\_\_  
County: \_\_\_\_\_

County Case No: \_\_\_\_\_  
Filing Date: \_\_\_\_\_  
Hearing Date: \_\_\_\_\_  
Hearing Time: \_\_\_\_\_

I, \_\_\_\_\_, the undersigned do hereby:

Withdraw my request for a state hearing before the State Department of Social Services. I understand that by withdrawing my request, I lose my right to a hearing on that request. I also understand that by withdrawing my request for hearing, aid which has been paid because of the request will stop without further notice. I may, however, file a new hearing request raising the identical issue provided that the new request is timely per Manual of Policies and Procedures Section 22-009.

Conditionally withdraw my request for a state hearing before the State Department of Social Services. I understand that by conditionally withdrawing my request for hearing, aid which has been paid because of the hearing request will stop without further notice. I understand that the county will issue a redetermination notice within 30 days and that I must request a hearing within **90 DAYS** of the county's notice if I am not satisfied with the county's reconsideration of my case. Upon such renewal, I shall have the same rights I would have had if I had not signed this conditional withdrawal.

**NOTE:** A conditional withdrawal must provide that the actions of both parties will be completed within 30 days.

The reasons for or conditions of this withdrawal are: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signed

Signed

\_\_\_\_\_  
(County Representative) (Date)  
\_\_\_\_\_  
(County Address)  
\_\_\_\_\_  
(City) (Zip Code)  
\_\_\_\_\_  
(Telephone Number)

\_\_\_\_\_  
(Claimant) (Date)  
\_\_\_\_\_  
(Address)  
\_\_\_\_\_  
(City) (Zip Code)  
\_\_\_\_\_  
(Telephone Number)

**NOTE:** A Conditional Withdrawal must also be signed by a County Representative or it is invalid.

## **DECREASING IHSS HOURS – COUNTY RESPONSIBILITY AT STATE HEARINGS**

If the county wishes to decrease IHSS hours and the consumer or his/her authorized representative requests a state hearing, the burden is on the county to establish why it is authorizing fewer hours. If the county fails to meet its burden, it may not reduce the IHSS hours. It is the position of the State Hearings Division that the county can meet this burden in one of the following ways:

- By establishing that there has been a change in law or misapplication of law requiring that a specific IHSS need(s) that was previously authorized no longer be authorized.

*For example: If the county had authorized protective supervision for a recipient with no mental impairment, the county could correct that error at the next assessment.*

- By establishing that there has been a change or misapplication in State policy requiring that a specific IHSS need no longer be authorized.

*For example: If the county had authorized waiting time in the area of medical transportation contrary to State policy, the county could correct that misapplication of policy at the next assessment.*

- By establishing that there has been a change in the claimant's medical condition requiring the reduction of IHSS hours from the prior assessment of IHSS.

*For example: If four hours weekly had been authorized for ambulation at the prior assessment shortly after the claimant had had a stroke, the county could reduce her need for ambulation at the next annual assessment if her condition had improved and she had less need than previously assessed.*

- By establishing that the claimant or provider told the county social worker at the assessment that fewer hours of IHSS are needed than previously assessed in a particular need area or areas. In such case, the judge will make a finding as to the current need based on testimony at the hearing including testimony about the assessment, county records such as the written record of the assessment, and medical records.
- If the first county social worker was incompetent and biased in favor of the claimant and as a result made a completely unreasonable assessment of hours. The burden would be on the county to prove the incompetence and unreasonableness of the first social worker.

(Excerpt from the notes from the SHD CDSS Training Bureau, March 27, 2000, Item No. 00-03-01A)

## **STATE HEARING ROLES DIVISION 22**

### **Administrative Law Judge (ALJ)**

Division 22 – “A person designated by the Director and thereafter assigned by the Chief Administrative Law Judge to conduct state hearings and administrative disqualification hearings. Handbook: The Administrative Law Judge shall prepare fair, impartial and independent decisions.” [MPP Section 22-001 a. (2)]

- Determines order and manner of proof.
- Decides issues of fact and law, asks questions, makes credibility determinations. The ALJ is the only trier of fact, acting as both judge and jury. (Example: Are meals prepared separately for the claimant and his IHSS housemate? This is an issue of fact. If the meals are prepared separately, can the needs assessment for meal preparation be prorated if there is not a health and safety reason for separate meals? This is an issue of law.)
- Ensures each side is given a fair opportunity to be heard. Must act with courtesy and respect but it's not judge's job to make any of the participants happy with the decision.
- After the hearing, reviews exhibits, considers testimony, renders legally complete and correct decision, exercises judicial independence. When in conflict with program or blazing new or controversial areas, writes proposed decisions. Most of the ALJ's case time is spent in this activity.

Division 22 – “The taking of evidence in a hearing shall be conducted by the Administrative Law Judge in a manner best suited to ascertain the facts and to control the conduct of the hearing.” [MPP Section 22-050.1]

- ALJ gives great discretion in determining the manner of proof and the order of proof and to control the hearing.
- Duty to develop the record at the administrative hearing – ALJs are going to be proactive. They are going to participate by asking questions. The judges have a duty to ask questions to follow through with issues that they determine are important to the case.
- Will get variations in style from one judge to another. For example, some may have the SW take the lead during the hearing, while others will want the information filtered through the Appeals Specialist and want the Appeals Specialist to operate more or less as an attorney.
- How does SW navigate? Know your case backwards and forwards, know your role, be flexible and be adaptable.

### **County Representative / Appeals Specialist**

Division 22 – “An employee who is assigned the major responsibility for preparing and/or presenting a hearing case on behalf of the CWD.” [MPP Section 22-001 (c)(7)]

“Each case for which a state hearing request has been filed shall be assigned to a county representative who shall assume the major responsibility for preparing the case in accordance with the requirements of this Division and/or presenting it at the hearing.” [MPP Section 22-073.13]

“At the hearing, the county representative shall assume full responsibility for presentation of the county's case. Such presentation shall include:

- Summarizing the written position statement.
- Examining county witnesses.
- Cross-examining the claimant and the claimant's witnesses.
- Responding to any questions from the claimant or Administrative Law Judge concerning the case; and
- Having the county case record available at the hearing.
- The county representative shall have authority at the hearing to make binding agreements and stipulations on behalf of the CWD.
- Having the burden of going forward in the hearing to support its determination.” [MPP Section 22-073.3]

- Appeals Specialist is responsible for these things, though the information gathering is a shared responsibility.
- The case should not be ‘turned over’ to the SW at hearing.

### **Claimant**

Division 22 – “The person who has requested a state hearing and is or has been either:

(A) An applicant for or recipient of aid, as defined in Section 22-001a.(3).

(B) A foster parent or foster care provider who requests a hearing on behalf of the foster child where the CWD takes action to affect the child's aid and the child resides with or has resided with the foster parent or foster care provider.

(C) A representative of the estate of a deceased applicant or recipient (see Sections 22-004.4 and .5).

(D) The caretaker relative of a child with regard to the child's application for or receipt of aid.

(E) The guardian or conservator of an applicant or recipient.

(F) The sponsor of an alien, see MPP Sections 43-119, 44-353, and 63-804.1. [MPP Section 22-001c.(2)]

- NOTE: For IHSS (B) and (F) are not likely.
- A provider cannot be a claimant – can be a witness or the Authorized Representative.
- ALJs understand that the provider has interest in outcome because the hours are linked to provider income.

### **Authorized Representative**

Division 22 – “An individual or organization that has been authorized by the claimant or designated by the Administrative Law Judge or Department pursuant to Sections 22-085 to act for the claimant in any and all aspects of the state hearing or administrative disqualification hearing.” [MPP Section 22-001a.(5)]

- How do you know there is an AR? Appeals Specialist should know.
- An Authorized Representative may be a professional such as an attorney or paralegal, or may be a non-professional such as a relative, friend or provider.
- ALJs are aware that a provider’s testimony might be influenced by her desire not to have her wages cut, but also realize that the provider is more aware of daily care needs of a consumer than a SW who visits only at assessment time. ALJs evaluate provider’s testimony considering both those aspects.
- The AR can show up at the hearing – he/she just needs to fill out a form before proceedings begin.

## **Social Worker**

**There is no Division 22 language addressing the social worker's role directly – so what is their role?**

- The SW is a very important part of the hearing.
- The SW is a critical witness!
- But, the SW might be asked questions to prove that status. Questions might include how long you've been on the job, whether you've had medical training, etc. Be prepared to answer without defensiveness. And remember to mention the Training Academy training you've attended as well as any other pertinent training you've had by your county or other sources.
- It is your specific knowledge of the case and your specific ability to speak to your assessment that creates the dimensions in the case.
- Preparation is key to success – and preparation for hearing starts at the initial assessment.
- When you go into an assessment, you should bring the possibility that there could be questions about the case in the future. Document and assess thoroughly.
- When judges write decisions, they do so recognizing that the losing party may appeal. You may want to do the same, i.e., when you do an assessment, think whether the claimant has said something that they might say in a hearing should they appeal. Think how you would respond.

## RULES OF EVIDENCE SOME THINGS TO CONSIDER

### Rules of Evidence

- The rules of evidence as applicable in judicial proceedings are not applicable in state hearings.
- Evidence will be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs.
- The ALJ is permitted to exclude evidence which is irrelevant, cumulative or unduly repetitious.
- The ALJ can exclude evidence which is privileged under the Evidence Code if the privilege is claimed in accordance with the law.
- Although evidence may be admissible, the ALJ considers the nature of the evidence in assessing its probative value. [MPP 22-050.2 & .3]
- Note:
  - This is part of claimant friendly process. Set up to be friendly for non-legal (lay) people.
  - It is also friendly to counties in that neither side is expected to be lawyers.
  - Hearsay evidence is admissible.
  - While formal rules of evidence as practiced in court are relaxed, judges still need to control the hearing and may not admit irrelevant or repetitious evidence.
  - ALJs must balance and weigh the probative value (tendency or reason to prove the fact or issue under dispute) of the evidence.

### Weight versus Admissibility

#### **Hearsay –**

- Definition: "Hearsay evidence" is evidence of a statement that was made other than by a witness while testifying at the hearing and that is offered to prove the truth of the matter stated. [Evidence Code §1200(a)]
- In a state hearing, hearsay may / would be admitted but would be given different weight.
- Note:
  - Be aware of the source of your testimony.
  - Generally, the more direct the evidence, the more reliable.
  - Be aware of the extent to which you are relying on the observations and statements made during the home visit and the extent to which you are relying on supporting documentation.

#### **Credibility –**

- ALJ has to assess credibility in all instances and needs to question both sides to make sure he/she understands how each side arrived at their respective time computations.
- ALJ will resort to demonstrations to test the capacity of the claimant to give that sort of testimony.
- Credibility does not necessarily mean one person is telling the truth and the other is lying. It may be that one person misunderstood the other such as in a needs assessment at a home visit.

#### **Opinion –**

- There will be differences in opinion.
- ALJ must consider all of the evidence.
- You don't have to be a doctor to offer an opinion, but be aware, according to some case law in the disability field, ALJs are to give the greatest weight to the opinions of treating physicians.
- SW has burden to show specifically where and how the treating physician decision isn't correct and shouldn't be followed by the ALJ. It is a big hill to climb...but can be done.
- Look at medical opinion, dissect and respond to it. Be specific!
- Not going to make the case just by stating that the MDs don't understand the program.
- With the exception of Paramedical services and in a different sense Protective Supervision, the opinions of a treating physician will go to need, not time per task.



CDSS

JOHN A. WAGNER  
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY  
**DEPARTMENT OF SOCIAL SERVICES**

744 P Street, MS 8-17-12, Sacramento, CA 95814



ARNOLD SCHWARZENEGGER  
GOVERNOR

October 31, 2009

ALL- COUNTY LETTER NO. 09-68

TO: ALL COUNTY WELFARE DIRECTORS  
ALL IHSS PROGRAM MANAGERS

SUBJECT: IHSS PROVIDER APPEALS PROCESS

REFERENCE: WELFARE AND INSTITUTIONS CODE (WIC) SECTION  
12301.6 (E)(2)(b)(ii) AND ALL COUNTY LETTER (ACL) 09-52

REASON FOR THIS TRANSMITTAL

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

Assembly Bill (AB), Fourth Extraordinary Legislative Session (ABX4) 19 (Chapter 17, Statutes of 2009) added a new requirement for the California Department of Social Services (CDSS) to develop a written appeals process for prospective and current providers who are determined ineligible to receive payment for the provision of In-Home Supportive Services (IHSS). This All-County Letter (ACL) provides information to counties regarding the new provider appeals process available to prospective and current IHSS providers whom the county determines are ineligible to serve as IHSS providers. Effective November 1, 2009, counties will be required to:

- Review the findings in the criminal background check and determine if the prospective or current provider is ineligible to be a provider in the IHSS program due to any exclusionary crimes noted on the prospective or current provider's criminal offender record documents.
- Review the Department of Health Care Services Medicaid/Medi-Cal list of ineligible providers resulting from suspension as a licensed health care provider or surrender of his/her license or certificate to provide health care services. The Medi-Cal Suspended and Ineligible Provider List can be found at: [www.Medi-Cal.ca.gov](http://www.Medi-Cal.ca.gov).

If a prospective or current provider disagrees with the county decision which finds him or her ineligible to be paid for providing IHSS services, the provider may appeal to CDSS for review of the county's denial. Any appeal **must be submitted by mail** and received within 60 days from the date of the county's notice that he or she is ineligible to be an IHSS provider.

A prospective or current provider may not appeal the county's decision by telephone. The appeal must be submitted in writing using the attached **APPEAL REQUEST** form (SOC 856) and mailed to:

California Department of Social Services  
Adult Programs Branch  
IHSS Provider Enrollment Appeals Unit, MS 19-04  
P O Box 944243  
Sacramento, CA 94244-2430  
(916) 556-1156

Upon receipt of a valid (timely and complete) request for appeal, the Provider Enrollment Appeals Unit (PEAU) will notify the prospective or current provider and county that the request for appeal has been received and accepted for review. If an appeal is not received timely or complete, the prospective or current provider will be notified by the PEAU (in writing) of the reason the appeal cannot be accepted. The PEAU will request the county forward all information used to support its finding of ineligibility to the PEAU via secured mail within 30 days of receipt of PEAU's request for documents supporting the denial action.

Currently, counties do not have statutory authority to release the Criminal Offender Record Information (CORI) to the PEAU; however, counties will be able to extract information from the provider's criminal record that supports the county's denial action if the provider has been convicted of an exclusionary crime. This information can then be forwarded to the PEAU on a form that is currently being developed for this purpose.

The PEAU may also request additional information from the prospective or current provider or any other pertinent agency. A finding regarding the appeal will be completed by PEAU within 90 days of the receipt of the individual's request for appeal.

The final decision by PEAU will either uphold or overturn the findings of the county. A final notice will be mailed to the applicant and the county social services department advising them of the state's decision. The applicant has the right to request his or her CORI from the Department of Justice (DOJ) and the right to contest the CORI by contacting the DOJ directly.

If the state's decision overturns the findings of the county, the county will be instructed to approve the applicant as a valid provider and make the required necessary changes to his or her records to reflect that decision.

All County Letter No. 09-68  
Page Three

If the county's decision to deny the provider was in error and is overturned by the PEAU, the provider can be paid for services if he or she continued to provide those services during the period in which he or she was deemed ineligible. Should you have any questions regarding this ACL, please contact the PEAU at (916) 556-1156.

Sincerely,

***Original Document Signed By:***

EVA L. LOPEZ  
Deputy Director  
Adult Programs Division

c: CWDA





CDSS

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](http://www.cdss.ca.gov)



ARNOLD SCHWARZENEGGER  
GOVERNOR

September 16, 2010

ALL-COUNTY LETTER (ACL) NO. 10-42

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

SUBJECT: IHSS PROVIDER DISQUALIFICATION APPEAL DECISIONS

REFERENCES: ACL NO. 09-68, DATED OCTOBER 31, 2009; ACL NO. 09-52,  
DATED OCTOBER 1, 2009; ACL NO. 09-70, DATED  
OCTOBER 31, 2009; ACL NO. 09-78, DATED  
NOVEMBER 25, 2009; ACL NO. 10-05, DATED  
FEBRUARY 17, 2010; AND ACL NO. 10-35 DATED JULY 16, 2010

<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 or Settlement Agreement
<input type="checkbox"/>	Clarification Requested by one or More Counties
<input checked="" type="checkbox"/>	Initiated by CDSS

This ACL provides counties with the latest information and instructions regarding the IHSS provider disqualification appeal process. The California Department of Social Services (CDSS) has determined that the time required to complete processing of provider enrollment appeals is taking longer than originally anticipated. As a result, CDSS is advising counties that the timeframe for issuing provider enrollment appeal decisions has been extended to 180 days. Counties are instructed to advise prospective and current providers who file an appeal of the longer processing timeframe for appeal decisions.

**BACKGROUND**

In October 2009, CDSS issued All-County Letter (ACL) No. 09-68, which provided information and instructions to counties regarding the appeal process for prospective and current IHSS providers who were determined ineligible to be enrolled or paid as an IHSS provider. ACL No. 09-68 advised counties that the CDSS Provider Enrollment Appeals Unit (PEAU) would render an appeal decision within 90 days of receipt of the individual's request for appeal. As indicated above, appeal decisions are expected to take up to 180 days to complete. The PEAU will also advise appellants of this extended timeframe for issuing appeal decisions.

All County Letter 10-42  
Page Two

Should you have any questions regarding the information contained in this ACL, please contact the PEAU at (916) 229-4003.

Sincerely,

***Original Document Signed By:***

EILEEN CARROLL  
Deputy Director  
Adult Programs Division



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



EDMUND G. BROWN JR.  
GOVERNOR

March 21, 2013

ALL-COUNTY INFORMATION NOTICE NO.: I-13-13

TO: ALL COUNTY WELFARE DIRECTORS  
ALL IHSS PROGRAM MANAGERS

SUBJECT: RELEASE OF THE UNIFORM STATEWIDE PROTOCOLS FOR  
PROGRAM INTEGRITY ACTIVITIES IN THE IN-HOME SUPPORTIVE  
SERVICES (IHSS) PROGRAM

<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 type="checkbox"/> Clarification Requested by One or More Counties
<input checked="" type="checkbox"/> Initiated by CDSS

This notice accompanies the release of the *Uniform Statewide Protocols for Program Integrity Activities in the IHSS Program*.

On July 24, 2009, ABX4 19 required the California Department of Social Services (CDSS) to establish a state and county stakeholders' workgroup to address the key requirements pertaining to In-Home Supportive Services (IHSS) program integrity. The goal of this workgroup was to develop protocols clarifying state and county roles and responsibilities for developing uniform statewide protocols for the implementation and execution of standardized program integrity measures in the IHSS program. The legislation amended components of the California Welfare and Institutions Code within Sections 12305.7(e)(2), 12305.7(h), 12305.71(c)(3), 12305.71(c)(5), and 12305.82.

In March 2010 CDSS formed the workgroup. The workgroup included representatives from CDSS, the Department of Health Care Services, the California Department of Justice Bureau of Medi-Cal Fraud and Elder Abuse, county program staff and district attorneys' offices. In 2011 IHSS recipients and advocacy groups representing both IHSS recipients and providers, were added to the stakeholder workgroup to ensure sufficient diversity in addressing the protocols. Over a two-year period the full workgroup met seven times. There were numerous subcommittee and focus group meetings and CDSS conducted two public meetings to ensure full stakeholder input. The workgroup engaged in a robust dialogue addressing issues as they pertained to workload, implementation specifics and challenges faced by small counties versus large counties.

The focus of the workgroup was to encourage a coordinated effort between county staff, investigators, prosecutors and the State in order to ensure a statewide consistent approach towards program integrity activities.

The resulting IHSS Uniform Statewide Protocols (enclosed) reflect the workgroup's guiding principles throughout the process, which include:

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

The specific measures addressed in the protocols include Unannounced Home Visits, Directed Mailings to IHSS providers and statewide communication and coordination for IHSS program integrity efforts between state and county offices.

If you have questions or comments regarding these protocols, please contact Mr. Ernie Ruoff, Manager, Quality Assurance Research & Program Integrity Unit at (916) 651-3494 or via e-mail at [IHSS-QA@dss.ca.gov](mailto:IHSS-QA@dss.ca.gov).

Sincerely,

**Original Document Signed By:**

EILEEN CARROLL  
Deputy Director  
Adult Programs Division

Enclosure

2013

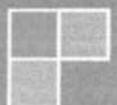
# IN-HOME SUPPORTIVE SERVICES (IHSS)

## Uniform Statewide Protocols



CDSS

California Department of Social Services  
Adult Programs Division



## EXECUTIVE SUMMARY

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

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

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

### Common Themes

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

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

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

### **Unannounced Home Visits**

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

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

### **Statewide Coordination and Communication**

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

## **Directed Mailings**

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

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

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

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**Attachments:**

- Attachment A Unannounced Home Visit Follow-up Letter
- Attachment B IHSS UHV Findings Report (SOC 2247)
- Attachment C Important Program Integrity Information from the In-Home Supportive Services (IHSS) Program
- Attachment D IHSS Complaint of Suspected Fraud Form (SOC 2248)
- Attachment E Department of Health Care Services Memorandum of Understanding (SAMPLE)
- Attachment F Fraud Referral Process
- Attachment G Fraud Referral Process In-Home Supportive Services (IHSS) Fraud Data Reporting Form

# OVERVIEW

## **WIC Section 12305.82(b)**

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

### **PURPOSE**

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

### **APPLICABILITY**

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

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# THE MEASURES

**Unannounced Home Visits**

**Directed Mailings**

**Statewide Coordination and Communication**

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## Unannounced Home Visits

### WIC Section 12305.71(c) (3)

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

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

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

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

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

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

### WIC Section 12305.82

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

### Definition

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

## **Purpose**

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

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

## **Procedures**

### **General**

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

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

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

### **Preparation**

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

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

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

## The UHV

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

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

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

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

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

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

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

### **Follow-up and Reporting**

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

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

### **Roles and Responsibilities**

#### **CDSS shall:**

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

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

**County Agencies shall:**

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

**Law Enforcement:**

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

**Forms and Letters**

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

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## Directed Mailings

### WIC Section 12305.7

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

### WIC Section 12305.71(c)

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

### Definition

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

## **Purpose**

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

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

## **Procedures**

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

### **General**

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

### **Preparation**

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

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

### **Mailing**

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

### **Communication and Coordination**

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

### **Follow-up and Reporting**

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

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

### **Procedural Exceptions**

#### Unforeseeable Circumstances

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

### Zero-Result Data Pulls

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

### Roles and Responsibilities

#### **CDSS shall:**

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

#### **County Agencies shall:**

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

**Forms/Letters**

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

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## Statewide Coordination and Communication

### WIC Section 12305.82

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

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

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

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

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

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

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

## **Definitions**

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

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

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

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

## **Purpose**

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

## **Fraud Referral Procedures**

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

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

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

### **Fraud Complaint**

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

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

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

### **Fraud Referral**

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

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

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

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

### **Fraud Investigation**

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

### **Roles and Responsibilities**

#### **CDSS shall:**

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

**DHCS shall:**

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

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

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

**Counties with MOUs shall:**

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

**Counties without MOUs shall:**

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

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

**All Counties shall:**

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

**Forms/Letters**

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

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**Unannounced Home Visit  
Follow-Up Letter**

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

Dear Mr. Smith:

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

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

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

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

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

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

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

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

<b>General Information</b>			
IHSS recipient name:		County:	
Case no.:		UHV staff name:	
Recipient phone no.:		UHV staff phone no.:	
Alt. phone no.:		Reason for UHV:	
(Attach additional sheets if necessary)			

<b>A. Case File Information</b>			
Primary language:		No. of providers:	
No. in household:		Date of last Face-to-Face(F2F):	
Authorized no. hours:		Who conducted last F2F:	
<input type="checkbox"/> Severely Impaired <input type="checkbox"/> Minor <input type="checkbox"/> Protective Supervision <input type="checkbox"/> FI rank 5 service(s) (specify): _____ <input type="checkbox"/> Case/Narrative notes reviewed			

<b>B. Record of Attempts to Contact the Recipient</b> <i>(Provide details in Section E)</i>			
<b>Visits</b>	<b>Phone calls to recipient</b>	<b>Completed visit</b>	
1st	1st	<input type="checkbox"/> Recipient ID verified <input type="checkbox"/> Provider present <input type="checkbox"/> Provider ID verified Provider name: _____	
2nd	2nd		
3rd	<b>Letter</b>	<b>NOA</b>	
	(date)	(date)	

<b>C. Findings of the UHV</b> <i>(Provide details in Section F)</i>
<input type="checkbox"/> Program Integrity concerns unsubstantiated (check ONLY if ALL statements below are correct) <ul style="list-style-type: none"> <li><input type="checkbox"/> It appears that all authorized services are being provided to the recipient</li> <li><input type="checkbox"/> It appears that all authorized services are provided at an acceptable quality</li> <li><input type="checkbox"/> It appears that the recipient is receiving adequate care</li> </ul> <input type="checkbox"/> Program Integrity concerns appear valid <ul style="list-style-type: none"> <li><input type="checkbox"/> Services appear to be authorized beyond need</li> <li><input type="checkbox"/> Services appear to be authorized below need</li> <li><input type="checkbox"/> Authorized services appear to not be sufficiently provided</li> </ul>



## IHSS UHV FINDINGS REPORT INSTRUCTIONS

### General Information

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

### A. Case File Information

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

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

**B. Record of Attempts to Contact the Recipient**

**Visits**

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

**Phone calls to recipient**

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

**Completed Visit**

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

*Use section E to provide details of section B.*

## **C Findings of the UHV**

### **Program Integrity Concerns Unsubstantiated:**

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

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

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

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

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

### **It appears that the recipient is receiving adequate care:**

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

### **Program integrity concerns appear valid:**

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

### **Services appear to be authorized beyond need:**

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

### **Services appear to be authorized below need:**

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

### **Authorized services appear to not be sufficiently provided:**

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

Use section F to provide details of section C.

**D. Report of Recommendations**

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

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

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

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

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

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

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

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

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

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

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

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

*Use section F to provide details of section D.*

**E. Case File and Visit Summary**

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

Add any other information from case file that seems relevant.

**F. Findings and Recommendations**

Record detailed findings and recommendations from section D.

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

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

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

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

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

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

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

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

## Directed Mailings Letter

### Reasons

**Below are sample reasons for use in the Directed Mailing letter**

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

...who work so many hours.”

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

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

...who submit timesheets inconsistently.”

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

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

...who are also IHSS recipients.”

Please fill in as much Information as possible			
Provider relationship to recipient:		County:	
IHSS recipient name:		IHSS provider name:	
IHSS recipient SSN:		IHSS provider SSN:	
IHSS recipient DOB:		IHSS provider DOB:	
IHSS recipient address:		IHSS provider address:	
<input type="checkbox"/> Complaint against recipient		<input type="checkbox"/> Complaint against provider	
A. Reporting Party			
Name:		Date:	
Email:		Phone no.:	
Relationship to IHSS participant:		No. in household:	
How did you become aware of this information:		Name of person and Agency taking complaint:	
B. Reason for Complaint			
<input type="checkbox"/> Deceased		<input type="checkbox"/> Recipient residing in a care facility or hospital	
<input type="checkbox"/> Recipient	<input type="checkbox"/> Provider	Name of facility:	
Date of death:		Dates of stay:	
<input type="checkbox"/> In Jail		Dates:	
<input type="checkbox"/> Recipient	<input type="checkbox"/> Provider		
Provider Issues			
<input type="checkbox"/> Being paid for services not provided	<input type="checkbox"/> Stealing from recipient	<input type="checkbox"/> Abuse/neglect/maltreatment of recipient	
<input type="checkbox"/> County employee is IHSS provider	<input type="checkbox"/> Other (specify) _____		
Recipient Issues			
<input type="checkbox"/> Does not appear to Need Services			
<input type="checkbox"/> Seen performing strenuous activities (such as yard work, sports, lifting heavy object, etc.)			
<input type="checkbox"/> Seen driving			
<input type="checkbox"/> Seen working	If yes, where:		
<input type="checkbox"/> Other (specify)			
C. Narrative Description (Actions observed, date observed, etc)			

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

IHSS recipient name: _____	Authorized No. hours: _____
Case no.: _____	Date of last F2F: _____
No. in household: _____	Who conducted last F2F: _____
<input type="checkbox"/> Severly Impaired	<input type="checkbox"/> Protective Supervision
<input type="checkbox"/> Married	<input type="checkbox"/> SSN verified
Program service(s) in question: _____	
Rank in service(s): _____	
<input type="checkbox"/> Caseworker contacted for information	
Name of person completing: _____	
Enclosures:	
<input type="checkbox"/> Pay warrants (copy of front and back) <input type="checkbox"/> Other (specify) _____	
<input type="checkbox"/> Timesheets	

**E. Initial Referral (for County use ONLY)**

<input type="checkbox"/> Sent to DHCS	<input type="checkbox"/> Sent to DA/SIU for investigation
<input type="checkbox"/> APS/CPS	<input type="checkbox"/> No action (provide explanation in section G)
<input type="checkbox"/> Sent for administrative action	
Date referred: _____	Aproximate case amount \$: _____
If referred to other than DHCS: <input type="checkbox"/> MOU with DHCS <input type="checkbox"/> Under \$500	

**F. Determination (for County use ONLY)**

<input type="checkbox"/> Administrative action	<input type="checkbox"/> Reassessment	Date: _____
<input type="checkbox"/> Reduced hours	_____ hours reduced	
<input type="checkbox"/> Termination of services	_____ hours saved in termination	
<input type="checkbox"/> Overpayment recovery in the amount of:	\$ _____ -	
<input type="checkbox"/> To DA for prosecution for violation of PC(s):	_____	
<input type="checkbox"/> To DOJ for prosecution for violation of PC(s):	_____	
<input type="checkbox"/> No action – Case not viable (provide explanation in section G)		

**G. Explanation of Non-Viability (Add information obtained that rendered case non-viable)**

Investigator signature: _____	Date: _____
Attach additional case file information. Copy of complaint must be retained in county case file.	

## IHSS COMPLAINT OF SUSPECTED FRAUD FORM INSTRUCTIONS

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

### A. Reporting Party

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

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

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

**B Reason for Complaint**

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

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

**Date of death:** Record the date of death.

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

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

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

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

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

**Provider Issues:**

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

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

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

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

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

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

**Recipient Issues:**

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

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

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

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

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

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

**C Narrative Description**

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

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

Use this section to provide the following information:

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

**Case no.:** Enter the IHSS case number.

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

including the recipient.

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

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

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

Check any of the following applicable boxes:

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

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

**Married:** Check if the recipient is listed as married.

**Minor:** Check if the recipient is a minor.

**SSN Verified:** Check if Social Security Number was verified.

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

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

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

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

**Enclosures:**

Check the applicable boxes for any attached documents.

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

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

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

**E. Initial Referral (for County use ONLY):**

Check the box for the action taken on the case.

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

**Date referred:** Record the date the referral was made.

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

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

#### **F. Determination**

##### **Check the box for the determined outcome of the case**

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

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

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

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

**G. Explanation of Non-Viability**

Record information obtained that rendered the case non-viable.

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

**Date:** Record the date the report was completed.

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

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**I. PURPOSE**

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

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

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

**II. RESPONSIBILITIES**

**County will:**

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

**California Department of Health Care Services will:**

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

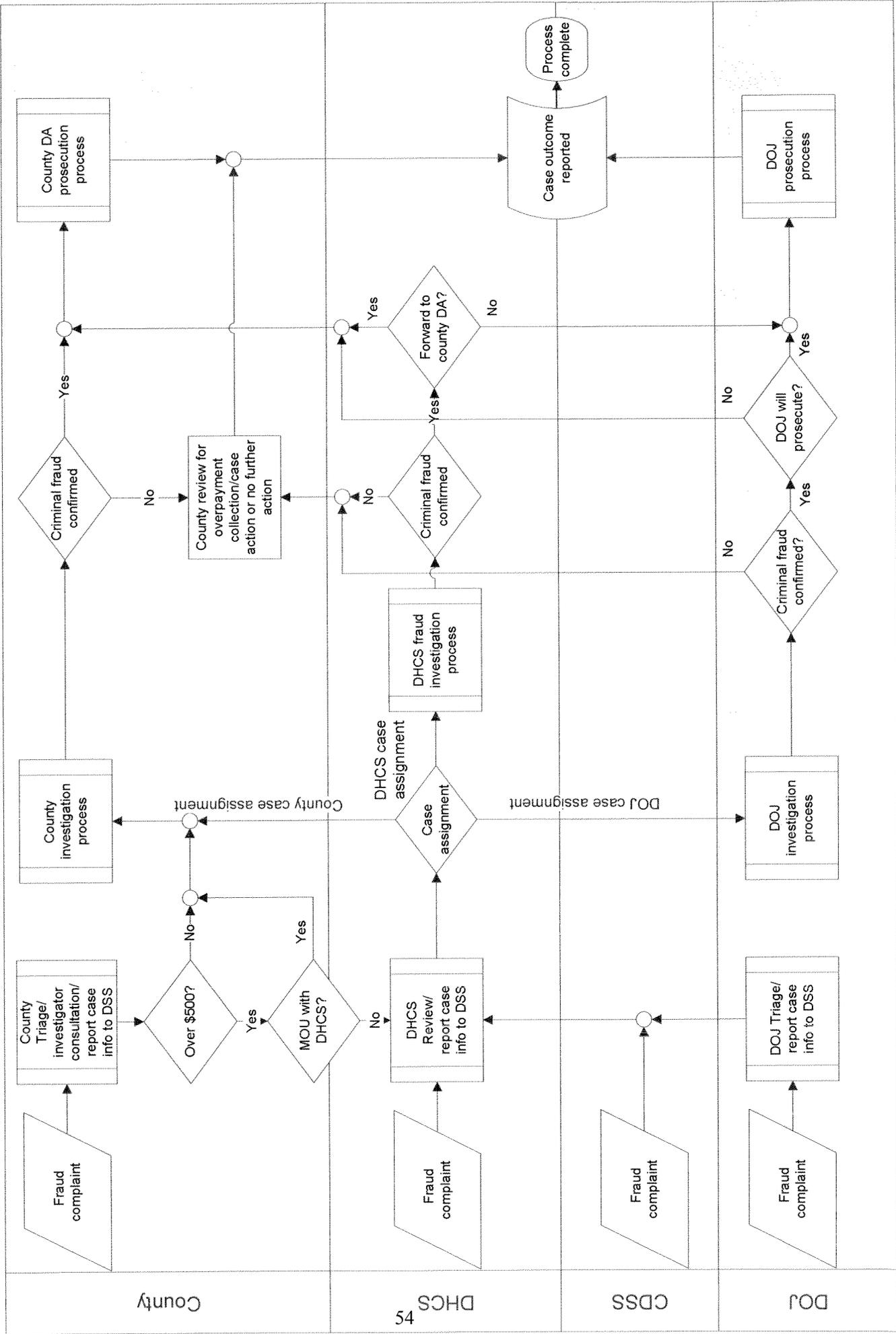
TITLE

Name:

Signature:

Date:

# Fraud Referral Process



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

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

**Section I. Fraud Complaints**

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

**Section II. Early Detection Savings**

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

**Section III. Fraud Investigations - Completed**

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

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

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

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

<b>Section V. Totals (\$)</b>		
<b>A</b>	<b>Loss Identified to IHSS Program</b>	50
<b>B</b>	<b>Total Amount Identified for Collection through Court Ordered Restitution</b>	51
<b>C</b>	<b>Total Amount Identified for Collection through County Overpay Recovery</b>	52

<b>Section VI.1. Comments</b>	
53	

<b>Section VI.2. Comments</b>	
54	

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

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

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

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

### Section I. Fraud Complaints

Definitions:

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

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

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

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

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

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

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

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

## Section II. Early Detection Savings

### Definitions:

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

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

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

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

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

## Section III. Fraud Investigations – Completed

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

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

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

**Section IV. Prosecutions – County**

Definitions:

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

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

**Section V. Totals (\$)**

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

**Section VI. Comments**

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



## IDENTIFYING AND ADDRESSING RED FLAGS

Issue(s) Involved		Observations	Follow-up Questions	Follow-up Actions	Documentation Hints <sup>1</sup>
1.	The consumer or authorized representative may have overstated the need for services.	During a home visit, you observe the consumer safely performing services that were authorized by IHSS.	You told me on my last visit here that you were not able to perform this task (safely or not at all). I am confused about this because I just observed you doing this safely. Can you please clarify this for me?	Contact the physician's office or other individuals or agencies that have knowledge about the consumer's need for services. Discuss inconsistencies.	Document your observation about the inconsistencies. Also document the questions that were asked and the responses. Document reasons for any actions taken as a result of discussions.
2.	The provider signs the timesheets for the consumer.	The consumer states that he never signs a timesheet because the provider takes care of this for him.	How do you keep track of the hours worked? How do you make sure your provider puts the correct hours on the timesheet if you do not sign the timesheet? Do you know that it is your responsibility to make sure that the hours on the timesheet are correct?	Follow county procedures regarding timesheet retrieval and review. Provide the consumer with educational fact sheets, and refer him to the timesheet video, available at the CDSS website.	Document the consumer's statements regarding not signing timesheets, as well as any responses to questions. Complete the IHSS Complaint of Suspected Fraud Form (SOC 2248) as appropriate.
3.	Services were not properly prorated.	On a home visit, you observe that the consumer is not alone in the home.	Earlier today, you indicated that you lived here alone, but I noticed that there was someone sleeping in one of the bedrooms. Can you please tell me who this person is and how long they have been here? How long will they be staying here?	Determine whether there is sufficient information to complete the IHSS Complaint of Suspected Fraud Form (SOC 2248).	Document your observations about other individuals being present in the home. Ask for the names of those present, and include the names and relationships to the consumer. Document all questions asked regarding the inconsistencies and the responses to the questions.

<sup>1</sup> If a fraud referral is indicated, please remember to always document the who, what, when, what happened, and what actions you are taking. Also document any follow-up conversations or consultations you have with others regarding the issue. Follow your county procedures regarding follow up on potential fraud issues. Complete the **IHSS Complaint of Suspected Fraud Form (SOC 2248)** as appropriate.

## IDENTIFYING AND ADDRESSING RED FLAGS

Issue(s) Involved	Observations	Follow-up Questions	Follow-up Actions	Documentation Hints <sup>1</sup>	
4.	Although a family member stated that the consumer needs PS, it appears that she may not meet the requirements for PS.	The consumer admits you into the home and is alone in the home. Although somewhat confused, she is able to answer most questions during the hour that you are there.	I notice that the person who provides services to you is not here right now. Can you tell me where they are and when they will be back? How often do you stay alone in the house/apartment? Have you had any problems when you are left alone such as you getting hurt? Do you worry about something happening when you are left alone? Are there any days when the person caring for you cannot leave you by yourself in the house/apartment?	Determine whether the consumer is safe at home alone. This may be an instance of excess authorization, or it may be an instance of provider neglect because the provider is not providing needed care. It may be necessary to follow up with the provider or schedule another home visit to validate the information provided.	Document the condition of the consumer and his/her functioning. Document the time you were there and that the provider was not there. If the consumer can reliably tell you when the provider is there, document how long she/he has been gone and how often she/he leaves the consumer alone. A referral to APS is probably needed based on neglect if the consumer seems to be at risk.
5.	The provider has been in jail but is still submitting timesheets.	A data match revealed that the provider was in jail during the time that timesheets were submitted.	We have received information that your provider is/was in jail. Can you tell me how long the provider has been in jail and who has been providing services to you during this time? Are you aware that it is against the law for the provider to submit timesheets for hours not worked?	Follow county policy to refer for investigation of potential provider fraud and/or collusion between the provider and consumer.	Include in the IHSS Complaint of Suspected Fraud Form (SOC 2248) all information discovered about the provider being in jail, the source of the information, the date of incarceration, the name of the facility, and all copies of relevant timesheets for the provider during the time of incarceration.

<sup>1</sup> If a fraud referral is indicated, please remember to always document the who, what, when, what happened, and what actions you are taking. Also document any follow-up conversations or consultations you have with others regarding the issue. Follow your county procedures regarding follow up on potential fraud issues. Complete the **IHSS Complaint of Suspected Fraud Form (SOC 2248)** as appropriate.

## IDENTIFYING AND ADDRESSING RED FLAGS

	Issue(s) Involved	Observations	Follow-up Questions	Follow-up Actions	Documentation Hints <sup>1</sup>
6.	A consumer might be the victim of neglect or fraudulent activity.	Attempts have been made to conduct home visits on two occasions. Each time, the person who answered the door said the consumer was sleeping and told you to come back some other time.	Attempt to explain why you must come in and assess the consumer. Ask if they can wake the consumer up. Tell them that you cannot continue to authorize IHSS if you are unable to complete the assessment.	If you still are refused admittance, discuss next steps with your supervisor. It may be necessary to get APS involved.	Document dates and times you attempted to enter the home and the fact that you attempted to explain why you needed to enter. Document the name(s) of the person(s) refusing admittance. Document any discussions with supervisors or others and the next steps that are planned. Complete the IHSS Complaint of Suspected Fraud Form (SOC 2248) as appropriate.
7.	The provider may be submitting timesheets but not performing the services.	An aged consumer resides with her son, who is designated as her IHSS provider. At the home visit, you learn that the neighbor is providing the services authorized by IHSS. The consumer states that her son is rarely there, but she is afraid of what her son would do if she stopped designating him as her provider.	Gather more information about the son and what her son does when he gets angry (assess his potential for violence and her level of vulnerability). If it seems that she is at risk by her son's behavior, tell the consumer that you will be making a referral to APS for them to help her.	Talk to your supervisor, make an APS referral, and complete the Complaint of Suspected Fraud Form (SOC 2248). Depending upon the results of an APS investigation, you may need to discuss alternate providers with the consumer. Provide the consumer with educational fact sheets as appropriate from the CDSS website concerning her duties as an IHSS employer and timesheet management.	Document statements made by the consumer at the time of the visit regarding her son not helping her and the neighbor doing all of the work. Also document what you told the consumer about the APS and fraud referrals and what you told her about not signing timesheets if her son has not worked. Document referrals and any discussions you have with your supervisor or other staff regarding the case.

<sup>1</sup> If a fraud referral is indicated, please remember to always document the who, what, when, what happened, and what actions you are taking. Also document any follow-up conversations or consultations you have with others regarding the issue. Follow your county procedures regarding follow up on potential fraud issues. Complete the **IHSS Complaint of Suspected Fraud Form (SOC 2248)** as appropriate.

## IDENTIFYING AND ADDRESSING RED FLAGS

	Issue(s) Involved	Observations	Follow-up Questions	Follow-up Actions	Documentation Hints <sup>1</sup>
8.	The provider of record has moved too far away from the consumer to reliably provide authorized IHSS services.	A data match or QA activity uncovered that the provider moved far away from the consumer, yet timesheets were still being submitted by the provider.	Do you know where your provider currently lives? When was the last time the provider was here? How many times per week does your provider come here to provide services? If the consumer says, for example, that the provider was there two days earlier and did the laundry, but there are piles of laundry in the residence, the consumer's statements cannot be relied upon as accurate.	If the provider is no longer able to provide services as needed, direct the consumer to the Public Authority to aid him/her in finding an appropriate replacement. Provide the consumer with educational fact sheets available at the CDSS website concerning the program rules and supervising a provider.	Document the questions that were asked and the consumer's responses to each question. Complete the IHSS Complaint of Suspected Fraud Form (SOC 2248) as appropriate.
9.	A consumer is listed as a provider for a different consumer.	A data match revealed that the consumer is listed as a provider of services for another IHSS consumer and is providing similar services to those he/she is authorized to receive.	We recently received information indicating that you not only receive IHSS, but you provide some of the same services that you receive to another IHSS consumer. Can you tell us how long you have been providing services to this person? Has your condition changed so that you no longer need some of the services IHSS has authorized? If so, when did the change occur? Can you explain why you have said in the past that you are unable to (name the services)? How is it that you are able to provide these same services to the other consumer?	Contact the consumer that this person is providing services for to get additional information. Consult with your supervisor about a possible fraud referral.	Document the questions that were asked and the consumers' responses to the questions. Complete the IHSS Complaint of Suspected Fraud Form (SOC 2248) as appropriate.

<sup>1</sup> If a fraud referral is indicated, please remember to always document the who, what, when, what happened, and what actions you are taking. Also document any follow-up conversations or consultations you have with others regarding the issue. Follow your county procedures regarding follow up on potential fraud issues. Complete the **IHSS Complaint of Suspected Fraud Form (SOC 2248)** as appropriate.

## IDENTIFYING AND ADDRESSING RED FLAGS

	Issue(s) Involved	Observations	Follow-up Questions	Follow-up Actions	Documentation Hints <sup>1</sup>
10.	A provider has subcontracted with his wife to provide IHSS for his consumer. She has not been fingerprinted or undergone a criminal background check.	At the home visit, a person who is not the enrolled provider is seen providing services.	How long have you been providing services to Mrs. Smith? Did you know that your husband cannot submit timesheets and be paid for services that he does not provide and that if he does, it is considered fraud? Are you aware that if you provide IHSS to anyone, you must first be fingerprinted and have a criminal background check?		Document all questions asked and the responses. Indicate if the provider understands the questions. Indicate what the provider's spouse states she plans to do and any follow up actions that you plan to take on this case.

<sup>1</sup> If a fraud referral is indicated, please remember to always document the who, what, when, what happened, and what actions you are taking. Also document any follow-up conversations or consultations you have with others regarding the issue. Follow your county procedures regarding follow up on potential fraud issues. Complete the **IHSS Complaint of Suspected Fraud Form (SOC 2248)** as appropriate.

### IHSS COMPLAINT OF SUSPECTED FRAUD FORM

Please fill in as much information as possible

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

Complaint against recipient

Complaint against provider

#### A. REPORTING PARTY

Name: _____	Date: _____
Email: _____	Phone no.: _____
Relationship to IHSS participant: _____	No. in household: _____

How did you become aware of this information: \_\_\_\_\_

Name of person and Agency taking complaint: \_\_\_\_\_

#### B. REASON FOR COMPLAINT

<input type="checkbox"/> Deceased	<input type="checkbox"/> Recipient	<input type="checkbox"/> Provider	<input type="checkbox"/> Recipient residing in a care facility or hospital
Date of death: _____	Name of facility: _____	Dates of stay: _____	
<input type="checkbox"/> In Jail	<input type="checkbox"/> Recipient	<input type="checkbox"/> Provider	Dates: _____

#### Provider Issues

<input type="checkbox"/> Being paid for services not provided	<input type="checkbox"/> Stealing from recipient	<input type="checkbox"/> Abuse/neglect/maltreatment of recipient
<input type="checkbox"/> County employee is IHSS provider	<input type="checkbox"/> Other (specify) _____	

#### Recipient Issues

Does not appear to Need Services

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

Seen driving

Seen working                      If yes, where: \_\_\_\_\_

Other (specify) \_\_\_\_\_

#### C. NARRATIVE DESCRIPTION (Actions observed, date observed, etc)

**D. CASE FILE INFORMATION (for County use ONLY)**

IHSS recipient name: \_\_\_\_\_

Authorized no. hours: \_\_\_\_\_

Case no.: \_\_\_\_\_

Date of last F2F: \_\_\_\_\_

No. in household: \_\_\_\_\_

Who conducted last F2F: \_\_\_\_\_

- Severely Impaired       Protective Supervision       Married       SSN verified

Program service(s) in question: \_\_\_\_\_

Rank in service(s): \_\_\_\_\_

- Caseworker contacted for information

Name of person completing: \_\_\_\_\_

Enclosures:

- Pay warrants (copy of front and back)     Other (specify) \_\_\_\_\_
- Timesheets

**E. INITIAL REFERRAL (for County use ONLY)**

- Sent to DHCS       Sent to DA/SIU for investigation
- APS/CPS       No action (provide explanation in section G)
- Sent for administrative action

Date referred: \_\_\_\_\_      Approximate case amount \$: \_\_\_\_\_

If referred to other than DHCS:     MOU with DHCS     Under \$500

**F. DETERMINATION (for County use ONLY)**

- Administrative action       Reassessment      Date: \_\_\_\_\_
- Reduced hours      \_\_\_\_\_ hours reduced
- Termination of services      \_\_\_\_\_ hours saved in termination
- Overpayment recovery in the amount of:      \$ \_\_\_\_\_ -
- To DA for prosecution for violation of PC(s):
- To DOJ for prosecution for violation of PC(s):
- No action – Case not viable (provide explanation in section G)

**G. EXPLANATION OF NON-VIABILITY (Add information obtained that rendered case non-viable)**

Investigator signature: \_\_\_\_\_      Date: \_\_\_\_\_

Attach additional case file information.  
Copy of complaint must be retained in county case file.

## IHSS COMPLAINT OF SUSPECTED FRAUD FORM INSTRUCTIONS

**Provider relationship to recipient:** Enter the provider's relationship to the recipient if known.

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

**IHSS recipient SSN:** Enter the recipient's social security number (SSN) if known.

**IHSS recipient DOB:** Enter the recipient's date of birth (DOB) if known.

**IHSS recipient address:** Enter the IHSS recipient's address if known.

**County:** Select the county where services are provided.

**IHSS provider name:** Enter the name of the provider. If the complaint is concerning more than one provider, indicate this in section C.

**IHSS provider SSN:** Enter the provider's SSN if known.

**IHSS provider DOB:** Enter the provider's DOB if known.

**IHSS provider address:** Enter the IHSS provider's address if known.

**Check one or both of the following options to indicate whom the complaint is against:** Complaint against recipient and/or complaint against provider.

### A. Reporting Party

**Name:** Enter the name of the person filing the complaint.

**Email:** Enter the email address of the person filing the complaint.

**Relationship to IHSS participant:** Record the relationship of the person filing the complaint to the recipient.

**How did you become aware of this information:** Record how the person filing the complaint knows of the information they are reporting.

**Date:** Enter the date the complaint was taken.

**Phone no.:** Enter the phone number of the person filing the complaint.

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

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

**B Reason for Complaint**

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

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

**Date of death:** Record the date of death.

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

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

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

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

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

**Provider Issues:**

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

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

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

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

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

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

**Recipient Issues:**

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

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

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

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

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

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

**C Narrative Description**

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

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

Use this section to provide the following information:

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

**Case no.:** Enter the IHSS case number.

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

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

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

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

Check any of the following applicable boxes:

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

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

**Married:** Check if the recipient is listed as married.

**Minor:** Check if the recipient is a minor.

**SSN Verified:** Check if Social Security Number was verified.

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

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

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

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

**Enclosures:**

Check the applicable boxes for any attached documents.

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

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

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

**E. Initial Referral** (for County use ONLY):

Check the box for the action taken on the case.

**Sent to DHCS:** Check if the initial referral was sent to DHCS.

**Sent to APS/CPS:** Check if the initial referral was sent to APS/CPS.

**Sent for administrative action:** Check if the initial referral was sent for administrative action.

**Sent to DA/SIU for investigation:** Check if initial referral was sent to DA/SIU for investigation.

**No action:** Check if no action was taken and provide explanation in section G.

**Date referred:** Record the date the referral was made.

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

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

**F. Determination****Check the box for the determined outcome of the case**

**Administrative action:** Check if the case was determined by administrative action.

**Reassessment:** Check if the case was determined by reassessment.

**Date:** Record the date of the reassessment.

**Reduced hours:** Check if the case was determined to reduce hours. Enter the number of hours that were reduced.

**Termination of services:** Check if the case was determined to terminate services. Enter the number of hours saved in termination.

**Overpayment recovery in the amount of:** Check if the case was determined to recover overpayment. Enter the amount of overpayment recovered.

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

code section.

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

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

**G. Explanation of Non-Viability**

Record information obtained that rendered the case non-viable.

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

**Date:** Record the date the report was completed.

## **PROSECUTION 101: AN OVERVIEW OF THE LIFE OF A CRIMINAL CASE**

### **Stages of a Criminal Prosecution:**

1. Investigation by Law Enforcement
  - Local police agencies
  - State agencies
  - Federal agencies
  - Special investigation units
  - Task forces
  - Case review and filing decision by District Attorney (DA)
  
2. Intake/Filing Review
  - Case review conducted by intake unit
  - Prosecutor's ethical standard: Cannot file unless evidence exists to prove the defendant guilty beyond a reasonable doubt
  - Facts of the crime, defendant's record, and local filing guidelines are all considered in determining whether a case is a felony or misdemeanor
    - Felony vs. Misdemeanor:
      - a. Felony – is punishable in state prison and/or probation. Most California felonies have 'triad' of prison sentences (low, middle, and upper terms)
      - b. Misdemeanor – punishable up to a year in county jail
  
3. Arraignment
  - Defendant is formally notified of the type and degree of charges(s) in court
  - May hire their own attorney, have one appointed for them if they are unable to afford one, or represent themselves
  - May enter a plea or continue to plea negotiation process
  
4. Early Settlement / Plea Negotiation
  - County may have special Superior Court Review (SCR) or Early Disposition Courts
  - Settlement offer may be made by DA
  - Defendant may accept, counter, or reject
  - Important to communicate early with DA regarding input on case
  
5. Preliminary Hearing
  - Constitutional right in felony cases
  - Must be held within 10 court days of arraignment or plea, whichever is later (unless waiver or good cause found)
  - Evidentiary hearing – DA must present evidence, defendant has option to present evidence
  - DA's burden to establish "sufficient cause" to believe defendant committed each element of the crime
  - Elements of crime are like ingredients in a recipe
  - Court may issue holding order, dismiss, or reduce charges
  - Defendant may plead following hearing
  - If no plea, case set for jury or court trial

6. Jury or Court Trial
  - Both defendant and The People have the right to trial by jury
  - DA must present evidence, defendant has option
  - Direct and circumstantial evidence may be used to prove elements and intent
  - DA has burden of proof beyond a reasonable doubt
  - Guilty verdict by jury must be unanimous
  - Jury or Court can return verdict of guilty, not guilty, or guilty of a lesser offense
  
7. Judgment and Sentencing
  - Following a plea or verdict, case may be referred to Probation Department for report for Court to consider a sentencing hearing
  - Defendant may make statement, produce letters, testimony for Court's consideration; DA may do the same
  - Victim has right to make impact statement
  - Defendant is sentenced for crime:
    - May be granted term of probation
    - May receive jail time
    - May receive alternative sentence (community service, electronic home monitoring, work project)
    - May be sent to prison
    - Restitution to program should be ordered
  
8. Probation / Parole
  - Grants of probation
    - 3-5 years standard for felonies
    - 1 year for misdemeanors
    - Terms vary
    - Victim restitution should be included
  - Parole
    - Following prison term, inmate released for a period of parole
    - Terms vary

**Notes:**

- *Sufficient Cause / Probable Cause* – State of the facts as would lead a person of ordinary caution or prudence to believe and conscientiously entertain a strong suspicion of the guilt of the accused.
- *Proof Beyond a Reasonable Doubt* – Proof that leaves juror / Court with abiding conviction that the charge is true.

Source: Laura West, Deputy District Attorney, Sacramento County District Attorney's Office, November 2010.

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

<b>County:</b>	<b>Select County Name</b> ▾
<b>Reporting Quarter and State Fiscal Year:</b>	<b>Select Quarter and Year</b> ▾
<b>Date Completed:</b>	

**Section I. Fraud Complaints**

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

**Section II. Early Detection Savings**

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

**Section III. Fraud Investigations - Completed**

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

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

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

<b>Section V. Totals (\$)</b>		
<b>A</b>	<b>Loss Identified to IHSS Program</b>	50
<b>B</b>	<b>Total Amount Identified for Collection through Court Ordered Restitution</b>	51
<b>C</b>	<b>Total Amount Identified for Collection through County Overpay Recovery</b>	52

<b>Section VI.1. Comments</b>	
53	

<b>Section VI.2. Comments</b>	
54	

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

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

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

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

### Section I. Fraud Complaints

Definitions:

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

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

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

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

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

The review is conducted in accordance with your county's process. These are initial outcomes determined this quarter regardless of when the

complaint was received. Record each complaint reviewed during the reporting quarter in every applicable outcome category. If a complaint was referred for county investigation and had an overpay recovery action initiated, mark "referred for county investigation" once and "referred for administrative action" once.

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

## Section II. Early Detection Savings

### Definitions:

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

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

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

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

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

## Section III. Fraud Investigations – Completed

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

A.1. Number of Investigations by Type – The number of complaints investigated during the reporting quarter, grouped by the type of fraud suspected. Record each complaint by the person(s) suspected of committing fraud at the time the

report is being completed. This may or may not be the same person(s) suspected when the original complaint was reported.

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

#### Section IV. Prosecutions – County

Definitions:

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

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

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

#### Section V. Totals (\$)

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

#### Section VI. Comments

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



**IHSS UHV FINDINGS REPORT**

**GENERAL INFORMATION** *(Attach additional sheets if necessary)*

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

**A. CASE FILE INFORMATION**

Primary language: _____	No. of providers: _____
No. in household: _____	Date of last F2F: _____
Authorized no. hours: _____	Who conducted last F2F: _____

- Severely Impaired                       Minor
- Protective Supervision
- FI rank 5 service(s) (specify): \_\_\_\_\_
- Case/Narrative notes reviewed

**B. RECORD OF ATTEMPTS TO CONTACT THE RECIPIENT** *(Provide details in Section E)*

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

**C. FINDINGS OF THE UHV** *(Provide details in Section F)*

- Program Integrity concerns unsubstantiated **(check ONLY if ALL statements below are correct)**
  - It appears that all authorized services are being provided to the recipient
  - It appears that all authorized services are provided at an acceptable quality
  - It appears that the recipient is receiving adequate care
- Program Integrity concerns appear valid
  - Services appear to be authorized beyond need
  - Services appear to be authorized below need
  - Authorized services appear to not be sufficiently provided



**IHSS UHV FINDINGS REPORT INSTRUCTIONS****General Information**

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

**A. Case File Information**

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

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

## **B. Record of Attempts to Contact the Recipient**

### **Visits**

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

### **Phone calls to recipient**

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

### **Completed Visit**

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

*Use section E to provide details of section B.*

**C. Findings of the UHV**

**Program Integrity Concerns Unsubstantiated:**

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

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

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

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

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

**It appears that the recipient is receiving adequate care:**

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

**Program integrity concerns appear valid:**

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

**Services appear to be authorized beyond need:**

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

**Services appear to be authorized below need:**

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

**Authorized services appear to not be sufficiently provided:**

Check if it appears that the recipient is not receiving

the level of services that they are authorized.

*Use section F to provide details of section C.*

**D. Report of Recommendations**

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

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

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

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

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

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

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

**Termination for non-compliance:** Check if the recommendation is the termination of the recipient's case for non-compliance with program requirements. For example, termination is recommended because the UHV was not conducted

due to no contact made or entry denied.

- Other follow-up:** Check if it is necessary to follow-up on the case for any reason not mentioned above. Provide details in Section F.
- No further action:** Check if no further action on the case is necessary.
- UHV staff signature report:** The person who conducted the UHV should sign the report.
- Date of report:** Enter the date the report was completed.

*Use section F to provide details of section D.*

**E. Case File and Visit Summary**

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

Add any other information from case file that seems relevant.

**F. Findings and Recommendations**

Record detailed findings and recommendations from section D.



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

March 23, 2015

ALL-COUNTY INFORMATION NOTICE NO.: I-17-15

TO: ALL COUNTY WELFARE DIRECTORS  
ALL IHSS PROGRAM MANAGERS

**SUBJECT: ENTRY OF FRAUD COMPLAINTS AND APS/CPS/FRAUD  
REFERRALS INTO CASE MANAGEMENT, INFORMATION AND  
PAYROLLING SYSTEM (CMIPS)**

REFERENCES: CMIPS INFORMATIONAL NOTIFICATION, DATED FEBRUARY  
13, 2014; ACL NO. 13-83, IMPLEMENTATION OF THE UNIFORM  
STATEWIDE PROTOCOLS FOR PROGRAM INTEGRITY  
ACTIVITIES IN THE IN-HOME SUPPORTIVE SERVICES (IHSS)  
PROGRAM; SOC 2248, IHSS COMPLAINT OF SUSPECTED  
FRAUD FORM

The purpose of this All-County Information Notice (ACIN) is to provide CMIPS users with clarification to instructions provided in the CMIPS Informational Notification dated February 13, 2014.

**Fraud Complaints**

Information about fraud complaints shall not be entered in CMIPS case notes. Fraud complaints frequently consist of unsubstantiated allegations that may, upon investigation, prove unfounded. As CMIPS case records are visible to a number of county and state employees across California, adhering to this directive will help to protect the due process rights of recipients and providers who may not have committed any wrongdoing.

The proper forum for documenting IHSS fraud complaints is form SOC 2248, *IHSS Complaint of Suspected Fraud Form*.

**Fraud/APS/CPS Referrals**

When a county staff refers a case for internal administrative action or to another agency for investigation, e.g., Department of Health Care Services, district attorney or

REASON FOR THIS  
TRANSMITTAL

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

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Page Two

Adult/Child Protective Services, limited information about the referral should be entered in the CMIPS *Case Investigation Screen*.

This information is limited to the date of the referral and the name of the agency (or internal department/group) to which the case has been referred.

Please note that fraud referrals are different than mere complaints, because the former have been fully triaged and have been determined to be appropriate for investigation. While both are documented on form SOC 2248, initial fraud complaint information is entered in Sections A through D, while triaged complaints that have advanced to the stage of fraud referrals are documented in Sections E and F and noted briefly in the CMIPS Case Investigation Screen. ACL No. 13-83, *Implementation of the Uniform Statewide Protocols for Program Integrity Activities in the In-Home Supportive Services (IHSS) Program* provides details about the proper procedure for handling fraud complaints and the fraud referral process.

For questions regarding the above information, please contact the Adult Programs Division, Adult Programs Policy and Quality Assurance Branch, Quality Assurance and Improvement Bureau, Program Integrity Unit at (916) 651-3494 or [ihss.pi@dss.ca.gov](mailto:ihss.pi@dss.ca.gov).

Sincerely,

***Original Document Signed By:***

HAFIDA HABEK, Chief  
Adult Programs Policy and Quality Assurance Branch  
Adult Programs Division



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



EDMUND G. BROWN JR.  
GOVERNOR

September 27, 2013

ALL-COUNTY LETTER (ACL) NO.: 13-83

TO: ALL COUNTY WELFARE DIRECTORS  
ALL IHSS PROGRAM MANAGERS

SUBJECT: IMPLEMENTATION OF THE UNIFORM STATEWIDE PROTOCOLS  
FOR PROGRAM INTEGRITY ACTIVITIES IN THE IN-HOME  
SUPPORTIVE SERVICES (IHSS) PROGRAM

REFERENCE: ALL-COUNTY INFORMATION NOTICE (ACIN) NO. I-13-13,  
DATED MARCH 21, 2013; ACL NO. 10-39, DATED  
AUGUST 19, 2010; COUNTY FISCAL LETTERS (CFL)  
NO. 09/10-33, DATED OCTOBER 29, 2009; 09/10-37, DATED  
DECEMBER 10, 2009; 10/11-34, DATED NOVEMBER 23,  
2010; 11/12-19, DATED SEPTEMBER 16, 2011; AND 12/13-14,  
DATED SEPTEMBER 27, 2012.

This letter provides implementation guidelines for the *Uniform Statewide Protocols for Program Integrity Activities in the IHSS Program* (hereinafter referred to as “the protocols.”)

**Background**

On July 24, 2009, Assembly Bill 19, fourth extraordinary session (ABX4 19) amended components of the California Welfare and Institutions Code (WIC) Sections 12305.7, 12305.71, and 12305.82, requiring the California Department of Social Services (CDSS) to establish a State and county stakeholders’ workgroup to address key requirements pertaining to IHSS program integrity. The goal of this workgroup was to develop protocols clarifying state and county roles and responsibilities for the implementation and execution of standardized program integrity measures in the IHSS Program.

In March 2010, CDSS established the workgroup which included representatives from CDSS, the Department of Health Care Services (DHCS), the California Department of Justice Bureau of Medi-Cal Fraud and Elder Abuse, county program staff and district attorneys’ offices. In 2011, IHSS recipients and advocacy groups representing both IHSS recipients and providers were added to ensure sufficient

<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 type="checkbox"/> Clarification Requested by One or More Counties
<input checked="" type="checkbox"/> Initiated by CDSS

diversity in addressing the protocols. Over a two-year period, the full workgroup met seven times, there were numerous subcommittee and focus group meetings, and

CDSS conducted two public meetings to ensure public input. The workgroup engaged in a robust dialogue addressing issues as they pertain to workload concerns, implementation specifics and challenges faced by small counties versus large counties.

The focus of the workgroup was to encourage a coordinated effort between all of the involved stakeholders to ensure a consistent approach towards program integrity activities. In March 2013, the workgroup completed the protocols which are available at: <http://www.cdss.ca.gov/agedblinddisabled/PG2170.htm>.

It is essential that each county develop its own policies and procedures clearly addressing how they will implement the components of the protocols.

### **Purpose**

The purpose of the protocols is to establish the basis for State and county policies, procedures, and timelines, and to provide instructions regarding acceptable activities to be performed, and acceptable measures to be taken for the purposes of program integrity and fraud prevention, detection, and coordinated investigation and prosecution in the IHSS Program. The protocols are intended to assist counties in developing and implementing policies and procedures to ensure consistency.

### **Applicability**

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

### **Program Integrity Activities**

The specific measures addressed in the protocols include program integrity training for county IHSS workers, unannounced home visits (UHV), directed mailings to IHSS providers, and statewide communication and coordination for IHSS program integrity efforts between state and county offices.

The delineation between quality assurance and program integrity activities is defined in **ACL No. 10-39**; the appropriation for these program integrity activities is established in **CFL No. 09/10-33** under the heading IHSS Anti-Fraud Initiative County Investigation; claiming instructions first appear in **CFL No. 09/10-37**, and the allocation appears most recently (as of this writing) in **CFL No. 12/13-14** under the heading Program Integrity Administrative Activities – County Investigation.

### **Program Integrity Training**

This training module has been developed and implemented, and is generally available through the IHSS Social Worker Training Academy in various regions throughout the state twice each year. The current training materials can be found at: <http://www.cdss.ca.gov/agedblinddisabled/PG1214.htm>, and each fiscal year's training schedule will be made available to counties as soon as it is finalized. This training is key to successfully conducting the other three program integrity measures of the protocols.

Implementation of the remaining three measures is addressed in this ACL. Specific information concerning these program integrity activities, including staffing, funding, and claiming information, can be found in the ACIN, ACL, and CFLs referenced above.

### **Unannounced Home Visits**

The term "Unannounced Home Visit" refers specifically to program integrity UHVs as established in WIC Section 12305.71(c)(3). Neither the protocols nor this ACL shall preclude counties from conducting, nor dictate county procedures concerning, unscheduled visits to the home of a recipient for the purpose of conducting a needs assessment, reassessment, safety and welfare check, or any purpose other than program integrity UHVs.

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

Implementation of the UHVs will occur over the period of October 1, 2013, through June 30, 2014. CDSS will use this transitional implementation period to evaluate the impact on counties in an effort to establish criteria guiding the acceptable size and frequency of UHV lists from CDSS, as well as the timeframe for counties to complete all UHVs on a list.

Counties are required to assign designated, trained staff responsible for conducting UHVs. Counties will also assign a county Point of Contact (POC) for program integrity issues, and keep CDSS informed as that POC changes. Those designated, trained program integrity staff will participate in all UHVs conducted by the county. As contained in ACL NO. 10-39, CDSS intended that the 78 county program integrity positions would conduct UHVs; however, counties will have flexibility to determine specifically who will be designated and how they will be trained in accordance with county policies and procedures. At a minimum, UHV staff training will include the program integrity training offered by CDSS through the IHSS Social Worker Training Academy; counties may supplement that training with any additional training that they deem appropriate.

CDSS will begin generating lists of recipients who meet UHV criteria, and distributing those lists to the program integrity contacts in counties by October 10, 2013. Typically, a recipient will meet UHV criteria based on some concern about the receipt or the quality of their services, their wellbeing, or other program integrity concerns.

Counties must conduct UHVs on all recipients listed by the end of the implementation period, or provide a clear explanation, based on specific knowledge of a case, why one or more of the identified recipients has not or should not be visited. Counties may add names to the UHV list if they have a clear reason for doing so. Reasons for adding names to the UHV list must be based on concerns about the receipt or the quality of services, recipient wellbeing, program integrity, risk of abuse and/or fraud, or referrals.

Counties will not, under any circumstances, conduct program integrity UHVs at random.

### **Preparation**

Prior to conducting the home visit, county UHV staff shall review the case file and note pertinent information such as specific conditions or needs of the recipient. This may include physical/mental disabilities or documented circumstances that may

place the UHV staff at risk. The UHV staff is encouraged to consult with the IHSS caseworker or supervisor as appropriate. In addition, reviewing the case file and discussing the UHV with the case worker prior to the UHV may provide information about when the recipient is most likely to be home, which may help select the best date and time for the UHV.

To the extent possible, the UHV and all calls and letters to the recipient shall be in the documented primary language of the recipient. If it is not possible to conduct the UHV in the recipient's primary language, an interpreter must be used at no cost to the recipient. Any telephone calls, letters, or UHVs attempted in a language other than the recipient's documented primary language shall not be counted against the three visits, two calls, and letter to which the recipient is entitled.

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

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

#### **The UHV**

**UHV Accomplished:** Counties shall ensure that when entry is granted, the UHV staff informs the recipient of the purpose of the UHV and provides general and/or specific information regarding program requirements and the consequences for failure to adhere to them. The UHV staff shall also ask questions regarding the recipients' services and the quality of those services. Using the IHSS UHV Findings Report (SOC 2247), UHV staff shall observe plain-view areas of the home to help determine whether the recipient is receiving appropriate levels of quality care to remain safely in the home.

**UHV Not Accomplished:** In the event that a county is unable to conduct a UHV based on unavailability of, or lack of cooperation from a recipient, that county shall closely adhere to these UHV follow-up procedures, in order, within 60 calendar days from the date of the initial UHV attempt:

- Mail a UHV Follow-Up Letter (Attachment A to the protocols) to the recipient's home. Alternately, the UHV Follow-Up Letter can be left at the recipient's home in an obvious location, such as in the door or in an area otherwise likely to be seen by the recipient upon their return.
- Call the recipient or authorized representative at the primary phone number in the case file. The telephone call must address:
  - The recipient's current address (confirm whether or not the recipient still resides at the address visited)
  - The recipient's wellbeing
  - The purpose of a UHV and the requirement for recipients to cooperate with the UHV
  - Any recurring commitments in the recipient's schedule that should be considered by the county UHV staff when planning future visits

The telephone call must not be used to schedule a UHV.

- Attempt a second time to conduct a UHV. To the extent possible, the second attempt should be made at a different time and/or day of the week than the first attempt.
- Call the recipient or authorized representative at the primary phone number in the case file.
- Attempt a third time to conduct a UHV. To the extent possible, the third attempt should be made at a different time and/or day of the week than the previous two attempts.

At the end of the 60 calendar day period, after the minimum follow-up procedures have been completed, if the county has been unable to complete the UHV because the recipient has been unavailable or uncooperative, send the recipient a Notice of Action (NOA) indicating termination from the IHSS Program. A NOA Code specific to this circumstance is being developed; appeal rights and aid paid pending remain in full effect.

The follow-up procedures must constitute a good faith effort by the county to complete a UHV.

Counties must use all available resources to ascertain whether the recipient attends school or participates in Community Based Adult Services (CBAS), or otherwise has commitments on certain days, or at certain times of the day. County UHV staff must

then make every reasonable effort to attempt UHVs at times that do not conflict with those commitments. After the UHV Follow-Up Letter is mailed or left at the home, no two contact efforts made on the same day can be counted against the minimum required contacts to which the recipient is entitled. While UHV staff may make two UHV attempts to the same home on the same day, the second attempt will not count as one of the three required UHV attempts unless it results in a completed UHV. Likewise, county UHV staff may attempt multiple calls to the same recipient on the same day, but a call will only count as the second required call *after* a second attempt has been made to complete the UHV.

Counties may, at their discretion, make additional attempts (beyond the required three UHV attempts, two phone calls, and letter) to contact the recipient, the authorized representative, the provider, or other individual named in the case file as an alternate contact up until the end of the 60 calendar days after the initial UHV attempt. Whether or not the county is able to conduct additional efforts to contact the recipient, the requirement is fulfilled upon completion of the minimum follow-up procedures established in the protocols (three UHV attempts, two phone calls, and a letter). Counties are encouraged, but not required, to make additional efforts to contact the recipient prior to sending the termination NOA. Once the NOA is sent, an offer from the recipient to cooperate is not sufficient to stop the termination.

Whether or not the county UHV staff successfully completes a UHV, all efforts and findings must be documented using the SOC 2247. This form must be maintained with the case file, and is available at: <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC2247.pdf>, with instructions for its completion. It is imperative that counties complete the SOC 2247 as thoroughly as possible, carefully documenting each attempted contact with the recipient. Counties must document dates and times of contact attempts, the results of contact attempts, whether or not they left a message, the content of any messages left, and any contact received from the recipient or authorized representative.

As counties conduct the UHVs they will annotate the UHV list with applicable comments, and return the completed UHV list to CDSS upon completion, within the specified timeframe.

Annually, CDSS will validate, compile, and analyze the completed UHV data, and release a report to counties each September.

**CDSS Responsibilities:**

- Provide program integrity training to meet the minimum requirement for training UHV staff.
- Maintain all standard forms and update as necessary.
- Generate lists of recipients identified for UHVs.
- Monitor the size of UHV lists and filter as needed prior to sending to the program integrity POC in each county.
- Receive completed UHV lists from counties, validate, and then aggregate the data for inclusion in the annual report to counties.
- Provide technical assistance to counties as appropriate.

**County Responsibilities:**

- Develop county-specific policies that are consistent with the protocols, and detailed procedures for:
  - training staff,
  - conducting and following up on UHVs, and
  - tracking and reporting UHV data in accordance with the protocols.
- Designate and train staff to begin conducting UHVs.
- Use the CDSS list of recipients identified for UHVs.
- Review case files and note pertinent information prior to conducting UHVs.
- Counties may add names to the list of recipients identified for UHVs if they have a clear reason for doing so.
- Conduct UHVs on all recipients listed, or provide a clear explanation, based on specific knowledge of a case, why one or more of the identified recipients should not be visited.
- Clearly document the completed UHV list to include the reasons why the county has opted *not* to conduct a UHV on an identified recipient.
- Clearly document on the completed UHV list any additional UHVs performed, including the reasons why those additional recipients were selected for UHVs.
- Adhere to follow-up procedures in the event that the UHV is not completed.
- At the end of the 60 calendar day period, after the follow-up procedures have been completed, if the county has been unable to complete the UHV because the recipient has been unavailable or uncooperative, send the recipient a NOA indicating termination from the IHSS Program.
- Thoroughly document UHV efforts and outcomes using the UHV Findings Report (SOC 2247), and follow up as appropriate.
- Counties will conduct the UHVs and electronically return the completed UHV list to the CDSS Quality Assurance and Improvement Bureau, at: [ihss-pi@dss.ca.gov](mailto:ihss-pi@dss.ca.gov) within the specified timeframe.

## Directed Mailings

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

The purpose of directed mailings is to reach out to providers associated with cases which appear to suggest some program integrity concern (whether or not the concern is founded) and proactively educate those providers concerning common program integrity mistakes. The goal is to increase the participants' knowledge and create a better informed provider of IHSS services in an effort to reduce errors, fraud, and abuse in the IHSS program.

Under separate cover, CDSS will disseminate the List of Approved Indicators for directed mailings to identified county program integrity contacts. Counties will select providers to receive directed mailings using the indicators list. If a county attempts to pull data using approved indicators and returns no results (a "Zero Results Data Pull"), the county will adhere to the following guidance:

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

Prior to sending directed mailings to providers, counties will email their list of prospective providers on a spreadsheet to CDSS for review. At a minimum, this list must include the provider identification numbers, associated recipient case numbers, and the specific indicators used to select the providers. CDSS will review these lists against previous lists, and identify and report any duplication to the county. Counties will review the list of duplications and make case by case determinations whether or not to include each case in the mailing. The decision to include or omit any duplicate cases will remain solely with the county; the purpose of the CDSS review is only to ensure that counties are aware of any such duplication.

Counties will send the directed mailing to providers from the list, send copies to each recipient served by those providers, and then notify the CDSS Quality Assurance and Improvement Bureau of which providers were sent mailings, again using a spreadsheet as the reporting format. Counties will conduct at least one directed mailing annually, beginning in Fiscal Year (FY) 2013/14. If, based on some unforeseeable emergency, a county is not able to conduct a data pull or a directed mailing, they will adhere to the "Unforeseeable Circumstances" guidance outlined in the protocols and provided below. Examples of unforeseeable circumstances which prevent a county from conducting the directed mailing include events such as natural disasters that greatly diminish the county's ability to conduct routine business for a prolonged period of time. Upon receipt of directed mailing data, CDSS will validate the data, compile, analyze, and include it in the annual report to counties.

**CDSS Responsibilities:**

- Provide Program Integrity training.
- Maintain the List of Approved Indicators for identifying groups of providers to receive a directed mailing, and update as appropriate.
- Disseminate the current List of Approved Indicators to the program integrity POC in each county.
- Receive counties' pre-mailing list, and compare it against previous mailing lists.
- Receive and validate completed mailing lists, then aggregate the data for inclusion in the annual report to counties.
- Provide technical and practical assistance as appropriate.

**County Responsibilities:**

- Develop county-specific policies that are consistent with the protocols, and detailed procedures for:
  - training staff,
  - conducting directed mailings, and
  - tracking and reporting directed mailings in accordance with the protocols.
- Select indicators from the indicator list provided by CDSS (distributed to county program integrity POC under separate cover), and conduct data pulls to create a directed mailing list of providers who all share the indicator.
- In the event that the county is unable to conduct a data pull or a directed mailing because of some unforeseeable emergency, contact CDSS for assistance.
- In the event that a data pull yields no results, counties will adhere to the "Zero Result Data Pulls" guidance.
- Email their list of prospective providers on a spreadsheet to CDSS for review prior to mailing.

- Customize the letter (*Attachment C to the protocols*) to include a reason for the mailing from the Reasons List and county contact information, and then conduct the mailing.
- Ensure that a copy of the directed mailing is sent to each recipient assisted by those providers.
- Conduct a minimum of one directed mailing per year, beginning in FY 2013/14.
- Mail to providers from the list, and then notify CDSS Quality Assurance and Improvement Bureau of which providers were sent mailings, again using a spreadsheet format for reporting.
- Email CDSS a final list of providers and recipients who were sent directed mailings for tracking and analysis, in order to coordinate and track the mailings and minimize unintentional duplication. At a minimum this list must include the provider numbers, associated recipient case numbers, and the specific indicators used to select the providers.

### **Statewide Communication and Coordination**

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

A complaint is any program integrity concern or allegation identified or received by the state or county.

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

Triage is the process whereby designated county staff reviews a complaint of suspected fraud and determines whether or not the complaint will become a fraud referral.

A fraud referral is a complaint that has been triaged by designated county staff and determined appropriate for referral to a law enforcement agency for fraud investigation.

### **Fraud Referral Procedures**

The intent of the guidelines below is to provide a framework to enable CDSS, DHCS, the DOJ, county welfare departments, county district attorney offices and any

agency that may be involved in the IHSS program and/or fraud detection and prevention related to the program, to work together on fraud referrals and investigations.

This joint/collaborative effort will include implementing uniform statewide protocols in order to avoid duplication of effort, and coordinate fraud detection and prevention activities. These protocols address case referrals, a county's authority to investigate, data sharing, and authority to terminate a provider or recipient's participation in the IHSS program. The county must designate staff that will review the fraud complaint and determine if it is appropriate for investigation. These protocols are designed to assist the counties in developing and implementing individual policies and procedures to ensure consistency.

### **Fraud Complaint**

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

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

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

### **Fraud Referral**

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

Counties without an MOU with DHCS shall send all IHSS fraud referrals over \$500 directly to DHCS for investigation. If a county receives a complaint which appears to be under \$500, refers the complaint for county investigation and it is subsequently determined to involve over \$500 in fraud, the county will confer with DHCS to decide jurisdiction for the continued investigation. Complaints of \$500 or less can also be referred to DHCS, if counties choose not to investigate locally.

Counties who have a MOU with DHCS will abide by the terms of that MOU.

### **Fraud Investigation**

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

### **CDSS Responsibilities:**

- Provide Program Integrity training.
- Maintain all standard forms and update as necessary.
- Define required elements of statistical data reporting.
- Initiate data-sharing agreements with DHCS and DOJ.
- Function as the primary repository for IHSS fraud data.
- Validate fraud data collected from the counties, and then aggregate the data for inclusion in the annual report to counties.
- Provide technical assistance as appropriate.

### **DHCS Responsibilities:**

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

### **DOJ Responsibilities:**

- Assist counties with investigations/prosecutions of provider fraud, at the request of the county or DHCS.
- Provide CDSS statistical data concerning IHSS fraud investigations and prosecutions, including outcome data, within a reasonable timeframe upon request.

**County Responsibilities:**

- Develop county-specific policies that are consistent with the protocols, and detailed procedures for:
  - training staff,
  - receiving, reviewing, and referring fraud complaints, and
  - tracking and reporting fraud data in accordance with the protocols.
- Identify staff to conduct triage on fraud complaints.
- Document suspected fraud using the Complaint of Suspected Fraud Form (SOC 2248) which has replaced the MC 609 for reporting suspected fraud in the IHSS Program. This form must be maintained with the complaint/referral package, and is available at:  
<http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC2248.pdf>.
- Complete the appropriate sections of the Complaint of Suspected Fraud form as completely as possible, and
  - review the form for accuracy and completion;
  - gather any missing information from the Reporting Party;
  - gather any relevant supporting documentation, such as copies of timesheets and pay warrants for the period in question.
- Submit the fraud complaint package to the designated county triage staff.
- The county triage staff shall conduct triage on fraud complaints, complete Section E of the Complaint of Suspected Fraud form, and refer cases to law enforcement when appropriate.
- Refer complaints determined appropriate for investigation along the appropriate path (as outlined below), depending on the amount of overpayment involved, and whether or not the county has an MOU with DHCS.
  - Counties seeking to investigate their own fraud complaints must establish a MOU with DHCS by contacting the Chief of Investigations using the current contact information at:  
[http://www.dhcs.ca.gov/individuals/Pages/AI\\_IB\\_Locations.aspx](http://www.dhcs.ca.gov/individuals/Pages/AI_IB_Locations.aspx).
  - Counties that do not establish an MOU *must* refer all fraud complaints deemed viable to DHCS unless it appears unlikely that the total overpayment will exceed \$500.
  - Counties may investigate complaints of suspected fraud with respect to an overpayment of \$500 or less, or refer them to DHCS.
  - Fraud referrals to DHCS must be made to DHCS Investigations Branch, Policy and Analysis Unit. The preferred method of referral is email at:

[IB.PAU.INTAKE@dhcs.ca.gov](mailto:IB.PAU.INTAKE@dhcs.ca.gov). Counties are reminded that personally identifying information must be password protected when emailing.

- The mailing address for paper documents is:

Department of Health Care Services  
Audits and Investigations  
Investigations Branch – HQ  
1500 Capitol Ave.  
Suite 72.422  
P.O. Box 997413  
Sacramento, CA 95899-7413  
MS 2200

- Complaints deemed not appropriate for investigation (insufficient indication of fraud) that still reveal an overpayment must be evaluated by county staff to determine the most appropriate method of administrative overpayment recovery.
- Counties must track fraud complaints and report to CDSS quarterly using the Fraud Data Reporting Form (SOC 2245) available at: <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC2245.pdf>. CDSS will validate the county fraud data, compile, analyze, and include it in the annual report to counties.

If you have questions or comments regarding this ACL or the protocols, please contact Mr. Ernie Ruoff, Manager of the Quality Assurance & Improvement Bureau's Program Integrity Unit at (916) 651-3494 or via email at: [ihss-pi@dss.ca.gov](mailto:ihss-pi@dss.ca.gov).

Sincerely,

***Original Document Signed By:***

EILEEN CARROLL  
Deputy Director  
Adult Programs Division

c: CWDA



## CMIPS II INFORMATION: POTENTIAL RED FLAGS

Information Addressed	Report	Task (Action Required)	Notification
Providers working 300 or more hours per month.	Provider Hours Over 300 Paid	None	None
Announces that a consumer has been admitted into a hospital or long-term care facility for more than a two-day period.	In-Patient Hospitalization Report	Treatment authorization approval	Treatment Authorization Request approval
Announces that Advance Pay reconciling timesheets have not been received for a 75-day period.	Reconciliation of Advance Payments	Advance Pay timesheets not received in 75 days	Advance reconciling timesheets not received at 45 day
Death of a consumer.	Death Match Response	Recipient death notification	None
Provider has an out of state address.	Out of State Provider Payments	Recipient address changed to out of state	Provider moved out of state
Provider is on the Medi-Cal Suspended and Ineligible Provider list.	None	Sent to the Public Authority – announces that a registry provider has been added to the Medi-Cal Suspended or Ineligible Provider list	Provider is listed on the Medi-Cal Suspended and Ineligible Provider List

## EDUCATING ABOUT ERRORS AND FRAUD AT THE HOME VISIT

Fraud occurs when there is an intentional deception or misrepresentation in order to gain benefits. County social workers should always make a fraud referral when it is suspected that the provider and/or consumer have committed fraud.

Sometimes consumers and providers do things they might not know are considered against the rules. The social worker should use the home visit as an opportunity to educate consumers and providers about questionable things they identify through observation or discussions. This could include a discussion about providing services which are not allowed by IHSS to ensure the consumer and/or provider is not aware that what they are doing is against the rules.

### **Identity**

Providers and consumers must use their own personal information, i.e., name, address, Social Security Number. If they intentionally use someone else's identity, it is fraud. Social workers should always be aware of the consumer's enrolled providers by reviewing the case file prior to the home visit. If the provider is present during the home visit, the social worker should verify the provider's identity. If the person who is providing services is not one of the enrolled providers, further inquiry is required.

### **Overstating Need for IHSS**

The assessment of need is reliant on accurate information given to the social worker by the consumer, their family, and/or provider(s).

- A consumer overstating their needs may be considered fraud. For example, telling the social worker that there is a need for services that the consumer can actually complete independently, or there is a higher level of need for assistance (more time) than actually exists.
- Providers who try to get the consumer to tell the social worker that they need more services than they can do themselves or that it takes more time to do the services than it actually does.. If the provider attempts to have the consumer misstate their needs for their own financial gain, it is fraud.

### **Consumer Reporting Responsibilities**

Consumers must report:

- Names and ages of all members in the household, whether or not they are related.
- If a spouse lives with them, whether they are legally married or common law.
- Changes in living situations, residence, or level of assistance required to perform tasks covered by IHSS. These changes might affect the amount of services available and must be reported.

### **Consumer Out of the Home**

A provider cannot be paid to take care of a consumer who is:

- In the hospital
- In a nursing home
- Incarcerated

When a consumer returns home after being absent for one of the above reasons, a provider cannot make up those hours by adding extra hours to their next timesheet. If a provider reports time worked during the consumer's absence for one of the above reasons, it is a fraudulent claim and a fraud referral should be made per your county procedures.

### **Timesheets**

- Hours claimed on the timesheet must be those that are actually worked.
- Hours cannot be claimed for services that have not been authorized by the consumer, or are not covered by the IHSS program.
- Timesheets cannot be turned in early. The provider must wait until all hours have actually been worked and the end of the pay period before turning in the timesheet.
- If the consumer is not available to sign the timesheet, the provider cannot sign it for them. The consumer is the employer of record and he/she must verify that all of the hours claimed have been worked. If the consumer cannot sign the timesheet, contact the IHSS office.
- If the consumer dies, the provider cannot sign the timesheet for them. The provider may sign their own name and write "deceased" and the date the consumer died or contact the IHSS office.

### **Splitting the Check**

Splitting the check means that an IHSS provider makes an agreement with the consumer or others to share the payment received from IHSS. A consumer should not ask the provider for a part of their IHSS pay, and a provider should not agree to share their pay with consumers.

An enrolled provider may not split the check with a second unenrolled provider. Anyone who provides services and receives payment from IHSS must go through the provider enrollment process which includes fingerprinting and a criminal background check.

### **Missing Paychecks**

If the social worker is aware that an affidavit to receive a replacement check has been completed, they must advise the provider not to cash the original check if it is received and to return the check to the IHSS office. Cashing both checks is fraud. If the social worker determines that both checks have been cashed, a fraud referral should be made per your county procedures.

### **DHCS Medi-Cal IHSS Fraud Hotline**

The hotline number is **(888) 717-8302**. If there is reported IHSS fraud, an investigation will be conducted by the county and/or state fraud investigation unit.

## IN-HOME SUPPORTIVE SERVICES Recipient/Employer Responsibility Checklist

I, \_\_\_\_\_, HAVE BEEN INFORMED BY MY SOCIAL WORKER THAT AS A RECIPIENT/EMPLOYER, I AM RESPONSIBLE FOR THE ACTIVITIES LISTED BELOW.

- 1) Provide required documentation to my Social Worker to determine continued eligibility and need for services. Information to report includes, but is not limited to, changes to my income, household composition, marital status, property ownership, phone number, and time I am away from my home.
- 2) Find, hire, train, supervise, and fire the provider I employ.
- 3) Comply with laws and regulations relating to wages/hours/working conditions and hiring of persons under age 18.

**NOTE:** Refer to Industrial Welfare Commission (IWC) Order Number 15 regarding wages/hours/working conditions obtainable from the State Department of Industrial Relations, Division of Labor Standards and Enforcement listed in the telephone book. Additional information regarding the hiring of minors may be obtained by contacting your local school district.

- 4) Verify that my provider legally resides in the United States. My provider and I will complete Form I-9. I will retain the I-9 for at least three (3) years or one (1) year after employment ends, whichever is longer. I will protect the provider's confidential information, such as his/her social security number, address, and phone number.
- 5) Ensure standards of compensation, work scheduling and working conditions for my provider.
- 6) Inform my Social Worker of any future change in my provider(s), including:
  - \_\_\_ Name
  - \_\_\_ Address
  - \_\_\_ Telephone Number
  - \_\_\_ Relationship to me, if any
  - \_\_\_ Hours to be worked and services to be performed by each provider

- 7) Inform my provider that the gross hourly rate of pay is \$\_\_\_\_\_, and that Social Security and State Disability Insurance taxes are deducted from the provider's wages.
- 8) Inform my provider that he/she may request that Federal and/or State income taxes be deducted from his/her wages. Instruct the provider to submit Form W-4 (for federal income tax withholding) and/or Form DE 4 (for state income tax withholding).
- 9) Inform my provider that he/she is covered by Workers' Compensation, State Unemployment Insurance benefits, and State Disability Insurance benefits.
- 10) Inform my provider that he/she will receive an information sheet that will state my authorized services and the authorized time given to perform those services. Inform the provider that he/she is not paid to perform work when I am away from my home (for example, when in a hospital or away on vacation).
- 11) Pay my share of cost, if any.
- 12) Verify and sign my provider's timesheet for each pay period, showing the correct day(s) and the total number of hours worked. I understand I can be prosecuted under Federal and State laws for reporting false information or concealing information. I understand that when required, it will be necessary for me to place my fingerprint on my provider's timesheet to verify the correct day(s) and hours worked. This will be necessary, so my provider can be paid.
- 13) Ensure my provider signed his/her timesheet.
- 14) Advise my provider to mail his/her signed timesheet to the appropriate address at the end of each pay period.

\_\_\_\_\_  
Recipient' Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

## INSTRUCTIONS FOR USE OF THE RECIPIENT/EMPLOYER RESPONSIBILITY CHECKLIST

1. This form is used for review with recipients receiving service from Individual Providers **only**.
2. Counties shall use this form to assure that recipients have been advised of and understand their basic responsibilities as employers of IHSS providers.
3. Review each item with the recipient and explain how the recipient can comply with each requirement.
4. Leave a copy of the form with the recipient.

## IN-HOME SUPPORTIVE SERVICES (IHSS) PROVIDER ENROLLMENT AGREEMENT

I, \_\_\_\_\_, UNDERSTAND I AM REQUIRED TO ATTEND THE IHSS PROVIDER

(PRINT NAME)

**ORIENTATION TO BE ELIGIBLE TO PROVIDE IHSS. HOWEVER, IF I HAVE BEEN A PROVIDER (ON OR BEFORE OCTOBER 31, 2009), I HAVE THE OPTION TO ATTEND AN IHSS ORIENTATION OR I MAY RECEIVE THE PROVIDER ORIENTATION INFORMATION DIRECTLY FROM THE COUNTY IHSS OFFICE.**

1. During the required orientation for IHSS providers:
  - I was given the requirements to be an eligible IHSS provider and a description of the IHSS program. I was informed of my responsibilities as an IHSS provider.
  - I was informed of the consequences of committing fraud in the IHSS program.
  - I was given the Medi-Cal toll-free telephone fraud hotline number, 1-800-822-6222 and Internet Web site, <http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx> for reporting suspected fraud or abuse in the IHSS program.
2. I received a demonstration of, and understand, how to complete my timesheet. If I have been a provider (on or before October 31, 2009), I received information on the new timesheet and understand how to complete it.
  - I understand the timesheet should indicate only the authorized services I performed for the recipient and the time needed to perform those authorized services. I understand that my signature on my timesheet verifies that the information I reported on it is true and correct.
  - I understand that, if I am convicted of fraudulently reporting information on my timesheet, in addition to any criminal penalties, I may be required to pay civil penalties of at least \$500, and not more than \$1,000, for each violation of fraud.
  - I understand that when required, it will be necessary for me to place my fingerprint on my timesheet in order to be paid.
3. I understand that I am required to complete Form I-9, a form kept on file by the recipient, which states that I have the legal right to work in the United States.
4. I understand I have the option to submit Form W-4 to request federal income tax withholding and/or Form DE 4 to request state income tax withholding from my wages. I understand that if I do not submit Form W-4 and/or DE 4, no withholding will be taken out of my wages.
5. I understand services cannot be performed when the recipient is away from his/her home (for example, when the recipient is in the hospital or away on vacation). I will contact the recipient's social worker for approval of any services that may be performed when the recipient is away from the home.
  - I understand that, in the future, I will receive an information sheet that names the recipient and the services I am authorized to perform for that recipient.
6. I will cooperate with state or county staff to provide requested information related to the evaluation of a recipient's IHSS case.

**I UNDERSTAND THE IHSS PROGRAM RULES EXPLAINED AT THE PROVIDER ORIENTATION OR BY THE PROVIDER ORIENTATION INFORMATION GIVEN TO ME BY THE COUNTY IHSS OFFICE. I ACCEPT THE RESPONSIBILITY TO FOLLOW ANY INFORMATION PROVIDED BY THE COUNTY. I UNDERSTAND THAT FAILURE TO FOLLOW THE REQUIREMENTS PROVIDED TO ME MAY RESULT IN BEING TERMINATED AS AN IHSS PROVIDER.**

Provider's Signature

Date



## INTERVIEW SKILLS

### Establishing Rapport – Warmth, Empathy and Genuineness:

- **Warmth** – conveys a feeling of interest, concern, well-being and affection to another individual. It promotes a sense of comfort and well-being in the other person. Examples: “Hello. It’s good to meet you.” “I’m glad we have the chance to talk about this.” “It’s pleasant talking with you.”
- **Empathy** – being in tune with how a consumer feels, as well as conveying to that consumer that you understand how she/he feels. Does not mean you agree. Helps consumer trust that you are on their side and understand how they feel. It also is a good way to check to see if you are interpreting what you observe correctly. Mirroring non-verbal can send empathetic messages. Example of leading phrases: “My impression is that...” “It appears to me that...” “Is what you’re saying that...” “You seem to be...” “I’m hearing you say that...”
- **Genuineness** – means that you continue to be yourself, despite the fact that you are working to accomplish goals in your professional role. Being yourself and not pretending to be something you are not conveys honesty and makes consumers feel like you are someone they can trust.

### General Interviewing Skills:

- **Before the Interview** – Review the case and think about the possible things you will need to address with this consumer. Are there any cues from the initial information, the case record or CMIPS reports that help you to come up with an approach to the interview? For example: Is the consumer a native English speaker, what are his/her disabilities, does she/he have a mental impairment? Also consider whether there are any red flags which may indicate potential fraud. If so, develop a plan for how you will address the red flags during the interview.
- **Pre-interview Planning – Be Prepared**
  - Review case file and gather cues about consumer.
  - Formulate questions based on cues.
  - Plan interview approach.
  - Contact any other agencies involved such as APS or CPS to get additional information.
  - If there have been fraud referrals in the past, contact fraud investigators or others who may have information. If you believe that there are fraud issues that have not been addressed during prior assessments or contacts, discuss these issues with prior social worker(s) involved in the case, your supervisor or QA staff who may have knowledge about the case. You may also want to discuss concerns with the fraud investigator to get direction about how to proceed during the assessment.
- **Meeting the Consumer – Establish Rapport**
  - Introductions should be formal and cordial.
  - Small talk might get the conversation going, but consider consumer’s reaction and adjust as appropriate.
  - Pay attention to verbal and non-verbal cues.

- **Begin Assessment Interview – Explain Process**
  - Explain purpose of interview.
  - Explain your role to the consumer.
  - Ask the consumer for feedback – do they understand the process and purpose?
  
- **Concluding the Interview**
  - Clarify the next steps.
  - Explain any additional paperwork needed before authorization or reauthorization of services.
  - Discuss the notification process of authorized hours.
  - Answer any questions the consumer may have.
  - Address any concerns you may have regarding potential fraud issues in a non-threatening manner. Examples:
    - Consumer states that he lives alone but there are several people in the home who appear to be living there.
    - Consumer states she has the provider drive her to doctor appointments but consumer has a car that she states she drives to church services.
    - Consumer states that daughter is her provider. Grandson who lives in home appears to be providing services. CMIPS indicates daughter lives in another county.
    - Consumer is authorized many hours and tasks such as Bowel and Bladder Care but the provider is not present when you conduct the home visit.

**It would not be appropriate to address concerns that are more appropriately addressed by fraud investigators or law enforcement, or if you feel addressing the issues would result in a risk to your safety. If you believe that addressing potential fraud issues will result to a threat to your safety or the safety of others, it is appropriate to conclude the interview without addressing the issues. When you return to the office, discuss the issues with your supervisor to determine the best plan to address the issues. Some alternatives may be to get APS, law enforcement agencies or fraud investigators to accompany you on a home visit during which the issues may be addressed.**

## THE INTERVIEW: CHOOSING THE RIGHT QUESTIONS

### Direct or Closed-ended Questions:

- These questions seek a simple “yes” or “no” answer.
- Specifically ask for information with leading questions. For example: “Are you coming tomorrow?” or “Do you eat three times a day?”
- These questions do not encourage or allow for an explanation of why the answer was chosen, or for an elaboration of thought or feeling about the answer.
- They can be leading –they ask a question in narrow terms such that they seem to be “hinting” at the answer.

### Open-ended Questions:

- Cannot be answered by “yes” or “no.”
- These questions begin with ‘who’, ‘what’, ‘where’, ‘when’, ‘why’ or ‘how.’
- They give consumers more choice in how they answer and will encourage them to describe the issue in their own words.
- Open-ended questions seek out the consumer’s thoughts, feelings, ideas, and explanations for answers.
- They encourage elaboration and specifics about a situation. For example: “How do you bathe?”
- Examples:
  - How have you been managing at home since I saw you last/since you got home from the hospital?
  - What do you need in the way of help right now?
  - Let’s talk about things you are able to do and unable to do.
  - Help me understand...
  - Would you tell me more about...?
  - What else can you tell me that might help me understand?
  - Could you tell me more about what you’re thinking?
  - I’d be interested in knowing...
  - Would you explain...?
  - Is there something specific about \_\_\_\_\_that you are asking for?
  - I’m not certain I understand. Can you give me an example?
  - I’m not familiar with\_\_\_\_\_. Can you help me to understand?
  - What examples can you give me?
  - You say that you’re not able to [cook/bathe/...]. How have you been managing [your meals/bathing/...]?
  - When you say \_\_\_\_\_, what do you mean?
  - I’d like to help you get the best possible service. What more can you tell me that will help me understand your need?

**Indirect Questions:**

- Asking questions without seeming to.
- They are not stated as a question.
- The interviewer is asking a question without stating it in question format. For example:  
“You seem like you are in a great deal of stress today.”

## THE INTERVIEW: OTHER ASSESSMENT CUES

### Non-verbal Assessment Cues:

- **Your Body Speaks Your Mind** – Between 60-80% of our message is communicated through our body language; only 7-10% is attributable to the actual words of a conversation. Whenever there is a conflict between verbal and non-verbal, we almost always believe the non-verbal messages without necessarily knowing why.
- **Eye Contact** – It is important to look a consumer directly in the eye. Hold your head straight and face the consumer. This establishes rapport and conveys that you are listening to the consumer. This is not staring, but being attentive. However, be conscious of cultural differences and respect them.
- **Facial Expressions** – These are the strongest non-verbal cues in face-to-face communication. Be aware of your own non-verbal. What are my habits that could be interpreted incorrectly? Make certain that your facial expressions are congruent with your other non-verbal behavior (i.e., frowning, smirking, looking around in a distracted way or focusing on paperwork rather than looking at the consumer, etc.). What do I see in the other person's face? If unclear, ask for interpretation.
- **Body Positioning** – Posture, open arms versus crossed, or hands on hips. When interviewing consumers, look for cues in their body positioning and be aware of your own. Sitting in an attentive manner communicates that you are interested.

### Environmental Cues:

- Discrepancies between the way the environment looks and what consumer reports as service needs.
- Presence of DMEs, diapers, underpads, bedside commode, etc. Location of walker in relationship to consumer.
- Importance of observations (i.e., house condition, cleanliness of consumer, tour the house, etc.).

### Sensory Cues:

- Data obtained by smelling.
- Tactile information – sticky floors, surfaces.

## THE INTERVIEW: CLARIFYING INFORMATION

It is important to probe for details and clarify information in order to get the best outcomes from the interview. Look for:

- **Conflicting Information**

- What is observed is not consistent with information given. For example: Consumer says she can't feed herself but she has been knitting (an activity that demonstrates manual dexterity). Perhaps the consumer's difficulty is in lack of strength. Probing questions would be needed to tease out the basis of the statement that she cannot feed herself. Also, consider good days versus bad days. You may be seeing the consumer whose condition and abilities fluctuate.
- What the consumer says is inconsistent. For example: He says that he has no trouble bathing himself yet he tells you that he is unable to walk without someone's constant assistance because he can't hold onto the handrails of a walker or a cane and he's unsteady on his feet. Perhaps the consumer who is at risk of falling is extremely modest and doesn't want anyone to see his naked body.
- What the consumer says and the family or provider says are in conflict. For example: The consumer says that he needs no help in dressing. The daughter with whom he lives and who is also his primary caretaker says that she dresses him every day. Probing questions are needed to determine whether the daughter is dressing her father because it's faster than to let him do it himself or if he is unable to dress himself. Issues to be considered would include his ability to reach, balance when standing, and perform tasks that require manual dexterity such as buttoning and zipping.

- **Unrealistic Expectations of the Program**

- For example: The consumer had fallen and broken her hip. When she fell, she had laid on the floor for 7 hours until a neighbor heard her calling for help. The consumer just returned home from a rehab facility for therapy following hip replacement. She wants round-the-clock care so that if she falls again, she will get immediate help. Her concerns are understandable, but not within the scope of the IHSS program. An alternative would be to make referrals to organizations that can provide her with a panic button so that she can summon assistance in the event of another fall.

- **Safety Issues**

- For example, a consumer says she is independent in bathing. Though she's unsteady on her feet, she says that she holds onto the towel rack to aid in stability. You look in the bathroom and confirm that what she's using to stabilize herself is not a properly installed grab bar but rather a towel rack that is starting to come loose from the wall behind the bathtub. She needs help getting into and out of the tub and obtaining a grab bar and shower bench. If she discusses this with her physician and obtains a prescription for these items, it is possible that Medi-Cal will pay for these safety devices. Without assistance into and out of the tub, she's at risk of falling.

### **How to Probe to Clarify Information:**

When probing to clarify information, the goal is to check that you have heard the consumer correctly, you are clear on the details of the information, you have a complete picture of the situation, and that the story holds together in a consistent manner. The following are a few methods that can be used to verify information and to decrease the risk of misunderstanding what the consumer has stated.

- **Paraphrasing** – Feed back the consumer’s ideas in your own words. For example, the consumer says that he doesn’t go to church anymore because he can’t be far from a toilet after taking his diuretic. You say, “I see you take a diuretic in the morning and have to be near a toilet. How long does that last? Do you have accidents? If so, how often? What is your provider’s schedule?”
- **Stating Your Observations** – Tell the consumer your observations about his behavior, actions and environment to find out if they are on target. For example, if you see that he can’t get out of the chair without help, say so.
- **Demonstration** – Have the consumer to show you an activity. For example, you wonder how well the consumer transfers. You ask the consumer to show you the apartment which will give you the opportunity to see the consumer transfer without specifically asking the consumer to demonstrate.
- **Asking Clarifying Questions** – These questions get to details. For example:
  - “What do you mean by that? You said that you were tired a lot; tell me what that means to you.” If the consumer doesn’t explain what they mean, it is open to interpretation.
  - “Could you explain that or tell me more about that?”
  - “I’m not sure I understand.” This simply directs the consumer’s comments by letting him know you do not understand.

## THE INTERVIEW: HANDLING DIFFICULT SITUATIONS

Most of the time, the interview will go smoothly; however, there are times when things will come up that will make getting good information more difficult. Here are some hints to help make each situation more successful.

- **The Consumer who is Angry** – It is best to try to handle the anger at the beginning of the interview. This shows the consumer you care and aren't there just to get your agenda accomplished. It never helps to ignore the anger; it will be a constant barrier to getting useful information.
  - Acknowledge the anger by gently confronting the consumer by saying something like, "You seem very upset and I am not sure why. Could we talk about what is upsetting you before we start?"
  - To get an angry person to open up, explain (or re-explain) your purpose and that you need them to help you so you can best understand their needs and how the program can help them.
  
- **The Consumer who is Sad or Grieving** – If the consumer is overcome by sadness and starts to cry:
  - Don't ignore or pretend they are not upset or crying. In some cases, it may not be obvious about the reasons for the sadness/grief, which may not become apparent until you ask a specific question that triggers the sadness/grief. Be direct but polite and sensitive. Let them talk briefly about the reason for their sadness/grief. You may say something like, "I'm sure that is very difficult for you," or "I'm sorry."
  - Try to be reassuring and let them know it is safe to express their feelings. A comment like, "It is okay to cry; we all cry," or "I understand" can be effective.
  - Validate the situation by saying something like, "I have had other consumers who have the same reaction. It is hard." Or "These are difficult issues you're dealing with. It is very normal."
  - If the consumer is too distraught about a recent death or other stressful event to focus on the issues you need to discuss for your assessment, it might be more appropriate to offer to reschedule the interview.
  
- **The Consumer who Rambles without Focus** – These consumers often want to tell long stories and often have a difficult time getting to 'the point.'
  - Remind the consumer of the goal of the interview. "That is very interesting Mrs. Jones. I really need to find out the details of how you get along each day so that I can help you get the services that you need. Can you tell me specifically how you prepare your meals?"
  - Rephrase the question in a more closed-ended question such as "I understand there have been many issues with your personal care. Do you need help with bathing?" If they answer "yes", you can then probe for specifics.

- **The Consumer who Answers with Only a Word or Two** – This can be very difficult because without information it is hard to get an accurate picture of the consumer’s need.
  - Use open-ended questions to try to get the consumer to give you a better picture.
  - Ask the consumer to paint you a picture of their day by saying “Tell me what your day normally looks like.” It is difficult to answer a question like this with one or two words and may get them to open up, or will allow you opportunities to probe for further information.
  
- **The Consumer who is Embarrassed** – Some of the questions asked during the interview may be embarrassing to consumers, especially those related to bowel and bladder care and menstruation.
  - Reassure the consumer and acknowledge that these may be embarrassing questions but that you need the information so they can get the assistance they need. You might say “I know this may be embarrassing for you but I need to find out exactly what your needs are. Now you had said you have problems getting around. I’m wondering if that makes it difficult for you to get to the bathroom in time and causes you to have accidents.”
  
- **Communication Blocks**
  - Hearing difficulties –
    - Ask the consumer if they have a hearing aid. If they do, check to see if it is in and turned on. If the consumer cups his/her hand over the ear, the hearing aid will whistle if it is turned on.
    - Talk slowly without jargon.
    - If the person doesn’t seem to understand, paraphrase yourself.
    - Ask if one ear is better than another and then position yourself on that side.
    - You may need to follow up with a family member to clarify information.
  
  - Language barriers –
    - If they understand and speak some English, make sure speak slowly, give them plenty of time to think of their answers, and do not compound your questions.
    - Follow State regulations [MPP 21-115] and county procedures to arrange for an interpreter if the consumer does not speak English and you do not speak his/her language.

## EXERCISE: RED FLAGS

### **Scenario #1:**

During a home visit or by phone call, the consumer reports that the provider works significantly fewer hours than authorized.

1. What potential red flags could this identify?

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2. How would this be identified?

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3. What follow-up questions are appropriate?

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4. What follow-up actions are appropriate?

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5. Things to consider in documenting this situation?

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## EXERCISE: RED FLAGS

### **Scenario #2:**

Consumer states that he never signs a timesheet because the provider takes care of this for him.

1. What potential red flags could this identify?

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2. How would this be identified?

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3. What follow-up questions are appropriate?

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4. What follow-up actions are appropriate?

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5. Things to consider in documenting this situation?

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## EXERCISE: RED FLAGS

### **Scenario #3:**

Elderly consumer resides with 45-year-old son who is an IHSS provider. At the home visit, you learn that the neighbor is providing services authorized by IHSS. The consumer states her son is hardly ever there and does not help her, but she does not want to have her neighbor be the IHSS provider because her son would get very angry and she is afraid of what he would do.

1. What potential red flags could this identify?

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2. How would this be identified?

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3. What follow-up questions are appropriate?

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4. What follow-up actions are appropriate?

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5. Things to consider in documenting this situation?

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## EXERCISE: RED FLAGS

### **Scenario #4:**

When leaving a reassessment of a couple who both receive IHSS, a neighbor approaches your car and tells you that the people who live next to him are committing fraud. He says that they call their provider the “Maid” and say they brag about not having to do any housework, meal preparation or laundry. He says that they’re always out in the yard working and take several walks in the neighborhood daily. He says they own some rental property down the street and are always doing repairs on the property.

1. What potential red flags could this identify?

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2. How would this be identified?

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3. What follow-up questions are appropriate?

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4. What follow-up actions are appropriate?

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5. Things to consider in documenting this situation?

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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



EDMUND G. BROWN JR.  
GOVERNOR

March 21, 2013

ALL-COUNTY INFORMATION NOTICE NO.: I-13-13

TO: ALL COUNTY WELFARE DIRECTORS  
ALL IHSS PROGRAM MANAGERS

SUBJECT: RELEASE OF THE UNIFORM STATEWIDE PROTOCOLS FOR  
PROGRAM INTEGRITY ACTIVITIES IN THE IN-HOME SUPPORTIVE  
SERVICES (IHSS) PROGRAM

<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 type="checkbox"/> Clarification Requested by One or More Counties
<input checked="" type="checkbox"/> Initiated by CDSS

This notice accompanies the release of the *Uniform Statewide Protocols for Program Integrity Activities in the IHSS Program*.

On July 24, 2009, ABX4 19 required the California Department of Social Services (CDSS) to establish a state and county stakeholders' workgroup to address the key requirements pertaining to In-Home Supportive Services (IHSS) program integrity. The goal of this workgroup was to develop protocols clarifying state and county roles and responsibilities for developing uniform statewide protocols for the implementation and execution of standardized program integrity measures in the IHSS program. The legislation amended components of the California Welfare and Institutions Code within Sections 12305.7(e)(2), 12305.7(h), 12305.71(c)(3), 12305.71(c)(5), and 12305.82.

In March 2010 CDSS formed the workgroup. The workgroup included representatives from CDSS, the Department of Health Care Services, the California Department of Justice Bureau of Medi-Cal Fraud and Elder Abuse, county program staff and district attorneys' offices. In 2011 IHSS recipients and advocacy groups representing both IHSS recipients and providers, were added to the stakeholder workgroup to ensure sufficient diversity in addressing the protocols. Over a two-year period the full workgroup met seven times. There were numerous subcommittee and focus group meetings and CDSS conducted two public meetings to ensure full stakeholder input. The workgroup engaged in a robust dialogue addressing issues as they pertained to workload, implementation specifics and challenges faced by small counties versus large counties.

The focus of the workgroup was to encourage a coordinated effort between county staff, investigators, prosecutors and the State in order to ensure a statewide consistent approach towards program integrity activities.

The resulting IHSS Uniform Statewide Protocols (enclosed) reflect the workgroup's guiding principles throughout the process, which include:

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

The specific measures addressed in the protocols include Unannounced Home Visits, Directed Mailings to IHSS providers and statewide communication and coordination for IHSS program integrity efforts between state and county offices.

If you have questions or comments regarding these protocols, please contact Mr. Ernie Ruoff, Manager, Quality Assurance Research & Program Integrity Unit at (916) 651-3494 or via e-mail at [IHSS-QA@dss.ca.gov](mailto:IHSS-QA@dss.ca.gov).

Sincerely,

***Original Document Signed By:***

EILEEN CARROLL  
Deputy Director  
Adult Programs Division

Enclosure

2013

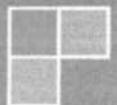
# IN-HOME SUPPORTIVE SERVICES (IHSS)

## Uniform Statewide Protocols



CDSS

California Department of Social Services  
Adult Programs Division



## EXECUTIVE SUMMARY

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

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

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

### Common Themes

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

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

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

### **Unannounced Home Visits**

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

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

### **Statewide Coordination and Communication**

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

## **Directed Mailings**

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

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

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

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**Attachments:**

- Attachment A Unannounced Home Visit Follow-up Letter
- Attachment B IHSS UHV Findings Report (SOC 2247)
- Attachment C Important Program Integrity Information from the In-Home Supportive Services (IHSS) Program
- Attachment D IHSS Complaint of Suspected Fraud Form (SOC 2248)
- Attachment E Department of Health Care Services Memorandum of Understanding (SAMPLE)
- Attachment F Fraud Referral Process
- Attachment G Fraud Referral Process In-Home Supportive Services (IHSS) Fraud Data Reporting Form

# OVERVIEW

## **WIC Section 12305.82(b)**

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

### **PURPOSE**

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

### **APPLICABILITY**

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

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# THE MEASURES

**Unannounced Home Visits**

**Directed Mailings**

**Statewide Coordination and Communication**

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## Unannounced Home Visits

### WIC Section 12305.71(c) (3)

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

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

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

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

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

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

### WIC Section 12305.82

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

### Definition

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

## **Purpose**

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

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

## **Procedures**

### **General**

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

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

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

### **Preparation**

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

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

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

## The UHV

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

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

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

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

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

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

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

### **Follow-up and Reporting**

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

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

### **Roles and Responsibilities**

#### **CDSS shall:**

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

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

**County Agencies shall:**

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

**Law Enforcement:**

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

**Forms and Letters**

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

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## Directed Mailings

### WIC Section 12305.7

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

### WIC Section 12305.71(c)

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

### Definition

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

## **Purpose**

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

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

## **Procedures**

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

### **General**

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

### **Preparation**

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

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

### **Mailing**

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

### **Communication and Coordination**

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

### **Follow-up and Reporting**

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

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

### **Procedural Exceptions**

#### Unforeseeable Circumstances

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

### Zero-Result Data Pulls

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

### Roles and Responsibilities

#### **CDSS shall:**

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

#### **County Agencies shall:**

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

**Forms/Letters**

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

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## Statewide Coordination and Communication

### WIC Section 12305.82

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

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

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

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

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

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

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

### **Definitions**

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

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

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

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

### **Purpose**

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

### **Fraud Referral Procedures**

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

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

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

### **Fraud Complaint**

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

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

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

### **Fraud Referral**

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

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

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

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

### **Fraud Investigation**

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

### **Roles and Responsibilities**

#### **CDSS shall:**

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

**DHCS shall:**

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

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

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

**Counties with MOUs shall:**

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

**Counties without MOUs shall:**

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

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

**All Counties shall:**

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

**Forms/Letters**

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

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**Unannounced Home Visit  
Follow-Up Letter**

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

Dear Mr. Smith:

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

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

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

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

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

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

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

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

<b>General Information</b>			
IHSS recipient name:		County:	
Case no.:		UHV staff name:	
Recipient phone no.:		UHV staff phone no.:	
Alt. phone no.:		Reason for UHV:	
(Attach additional sheets if necessary)			

<b>A. Case File Information</b>			
Primary language:		No. of providers:	
No. in household:		Date of last Face-to-Face(F2F):	
Authorized no. hours:		Who conducted last F2F:	
<input type="checkbox"/> Severely Impaired <input type="checkbox"/> Minor <input type="checkbox"/> Protective Supervision <input type="checkbox"/> FI rank 5 service(s) (specify): _____ <input type="checkbox"/> Case/Narrative notes reviewed			

<b>B. Record of Attempts to Contact the Recipient</b> <i>(Provide details in Section E)</i>			
<b>Visits</b>	<b>Phone calls to recipient</b>	<b>Completed visit</b>	
1st	1st	<input type="checkbox"/> Recipient ID verified <input type="checkbox"/> Provider present <input type="checkbox"/> Provider ID verified	
2nd	2nd	Provider name: _____	
3rd	<b>Letter</b>		
	<b>NOA</b>		
	(date)	(date)	

<b>C. Findings of the UHV</b> <i>(Provide details in Section F)</i>
<input type="checkbox"/> Program Integrity concerns unsubstantiated (check ONLY if ALL statements below are correct) <ul style="list-style-type: none"> <li><input type="checkbox"/> It appears that all authorized services are being provided to the recipient</li> <li><input type="checkbox"/> It appears that all authorized services are provided at an acceptable quality</li> <li><input type="checkbox"/> It appears that the recipient is receiving adequate care</li> </ul>
<input type="checkbox"/> Program Integrity concerns appear valid <ul style="list-style-type: none"> <li><input type="checkbox"/> Services appear to be authorized beyond need</li> <li><input type="checkbox"/> Services appear to be authorized below need</li> <li><input type="checkbox"/> Authorized services appear to not be sufficiently provided</li> </ul>



## **IHSS UHV FINDINGS REPORT INSTRUCTIONS**

### **General Information**

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

### **A. Case File Information**

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

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

**B. Record of Attempts to Contact the Recipient**

**Visits**

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

**Phone calls to recipient**

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

**Completed Visit**

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

*Use section E to provide details of section B.*

**C Findings of the UHV**

**Program Integrity Concerns Unsubstantiated:**

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

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

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

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

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

**It appears that the recipient is receiving adequate care:**

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

**Program integrity concerns appear valid:**

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

**Services appear to be authorized beyond need:**

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

**Services appear to be authorized below need:**

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

**Authorized services appear to not be sufficiently provided:**

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

Use section F to provide details of section C.

**D. Report of Recommendations**

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

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

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

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

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

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

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

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

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

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

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

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

*Use section F to provide details of section D.*

**E. Case File and Visit Summary**

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

Add any other information from case file that seems relevant.

**F. Findings and Recommendations**

Record detailed findings and recommendations from section D.

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

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

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

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

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

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

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

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

## Directed Mailings Letter

### Reasons

**Below are sample reasons for use in the Directed Mailing letter**

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

...who work so many hours.”

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

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

...who submit timesheets inconsistently.”

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

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

...who are also IHSS recipients.”

Please fill in as much Information as possible			
Provider relationship to recipient:		County:	
IHSS recipient name:		IHSS provider name:	
IHSS recipient SSN:		IHSS provider SSN:	
IHSS recipient DOB:		IHSS provider DOB:	
IHSS recipient address:		IHSS provider address:	
<input type="checkbox"/> Complaint against recipient		<input type="checkbox"/> Complaint against provider	
A. Reporting Party			
Name:		Date:	
Email:		Phone no.:	
Relationship to IHSS participant:		No. in household:	
How did you become aware of this information:		Name of person and Agency taking complaint:	
B. Reason for Complaint			
<input type="checkbox"/> Deceased		<input type="checkbox"/> Recipient residing in a care facility or hospital	
<input type="checkbox"/> Recipient	<input type="checkbox"/> Provider	Name of facility:	
Date of death:		Dates of stay:	
<input type="checkbox"/> In Jail		Dates:	
<input type="checkbox"/> Recipient	<input type="checkbox"/> Provider		
Provider Issues			
<input type="checkbox"/> Being paid for services not provided	<input type="checkbox"/> Stealing from recipient	<input type="checkbox"/> Abuse/neglect/maltreatment of recipient	
<input type="checkbox"/> County employee is IHSS provider	<input type="checkbox"/> Other (specify) _____		
Recipient Issues			
<input type="checkbox"/> Does not appear to Need Services			
<input type="checkbox"/>	Seen performing strenuous activities (such as yard work, sports, lifting heavy object, etc.)		
<input type="checkbox"/>	Seen driving		
<input type="checkbox"/>	Seen working	If yes, where:	
<input type="checkbox"/>	Other (specify) _____		
C. Narrative Description (Actions observed, date observed, etc)			

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

IHSS recipient name:		Authorized No. hours:	
Case no.:		Date of last F2F:	
No. in household:		Who conducted last F2F:	
<input type="checkbox"/> Severly Impaired	<input type="checkbox"/> Protective Supervision	<input type="checkbox"/> Married	<input type="checkbox"/> SSN verified
Program service(s) in question:			
Rank in service(s):			
<input type="checkbox"/> Caseworker contacted for information			
Name of person completing:			
Enclosures:			
<input type="checkbox"/> Pay warrants (copy of front and back) <input type="checkbox"/> Other (specify) _____			
<input type="checkbox"/> Timesheets			

**E. Initial Referral (for County use ONLY)**

<input type="checkbox"/> Sent to DHCS	<input type="checkbox"/> Sent to DA/SIU for investigation
<input type="checkbox"/> APS/CPS	<input type="checkbox"/> No action (provide explanation in section G)
<input type="checkbox"/> Sent for administrative action	
Date referred: <input style="width:100px;" type="text"/>	Aproximate case amount \$: _____
If referred to other than DHCS: <input type="checkbox"/> MOU with DHCS <input type="checkbox"/> Under \$500	

**F. Determination (for County use ONLY)**

<input type="checkbox"/> Administrative action	<input type="checkbox"/> Reassessment	Date: <input style="width:100px;" type="text"/>
<input type="checkbox"/> Reduced hours	<input style="width:100px;" type="text"/> hours reduced	
<input type="checkbox"/> Termination of services	<input style="width:100px;" type="text"/> hours saved in termination	
<input type="checkbox"/> Overpayment recovery in the amount of:	\$ <input style="width:100px;" type="text"/> -	
<input type="checkbox"/> To DA for prosecution for violation of PC(s):		
<input type="checkbox"/> To DOJ for prosecution for violation of PC(s):		
<input type="checkbox"/> No action – Case not viable (provide explanation in section G)		

**G. Explanation of Non-Viability (Add information obtained that rendered case non-viable)**

Investigator signature: _____	Date: _____
Attach additional case file information. Copy of complaint must be retained in county case file.	

## IHSS COMPLAINT OF SUSPECTED FRAUD FORM INSTRUCTIONS

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

### A. Reporting Party

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

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

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

**B Reason for Complaint**

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

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

**Date of death:** Record the date of death.

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

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

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

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

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

**Provider Issues:**

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

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

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

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

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

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

**Recipient Issues:**

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

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

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

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

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

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

**C Narrative Description**

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

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

Use this section to provide the following information:

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

**Case no.:** Enter the IHSS case number.

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

including the recipient.

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

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

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

Check any of the following applicable boxes:

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

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

**Married:** Check if the recipient is listed as married.

**Minor:** Check if the recipient is a minor.

**SSN Verified:** Check if Social Security Number was verified.

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

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

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

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

**Enclosures:**

Check the applicable boxes for any attached documents.

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

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

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

**E. Initial Referral (for County use ONLY):**

Check the box for the action taken on the case.

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

**Date referred:** Record the date the referral was made.

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

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

#### **F. Determination**

##### **Check the box for the determined outcome of the case**

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

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

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

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

**G. Explanation of Non-Viability**

Record information obtained that rendered the case non-viable.

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

**Date:** Record the date the report was completed.

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

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**I. PURPOSE**

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

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

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

**II. RESPONSIBILITIES**

**County will:**

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

**California Department of Health Care Services will:**

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

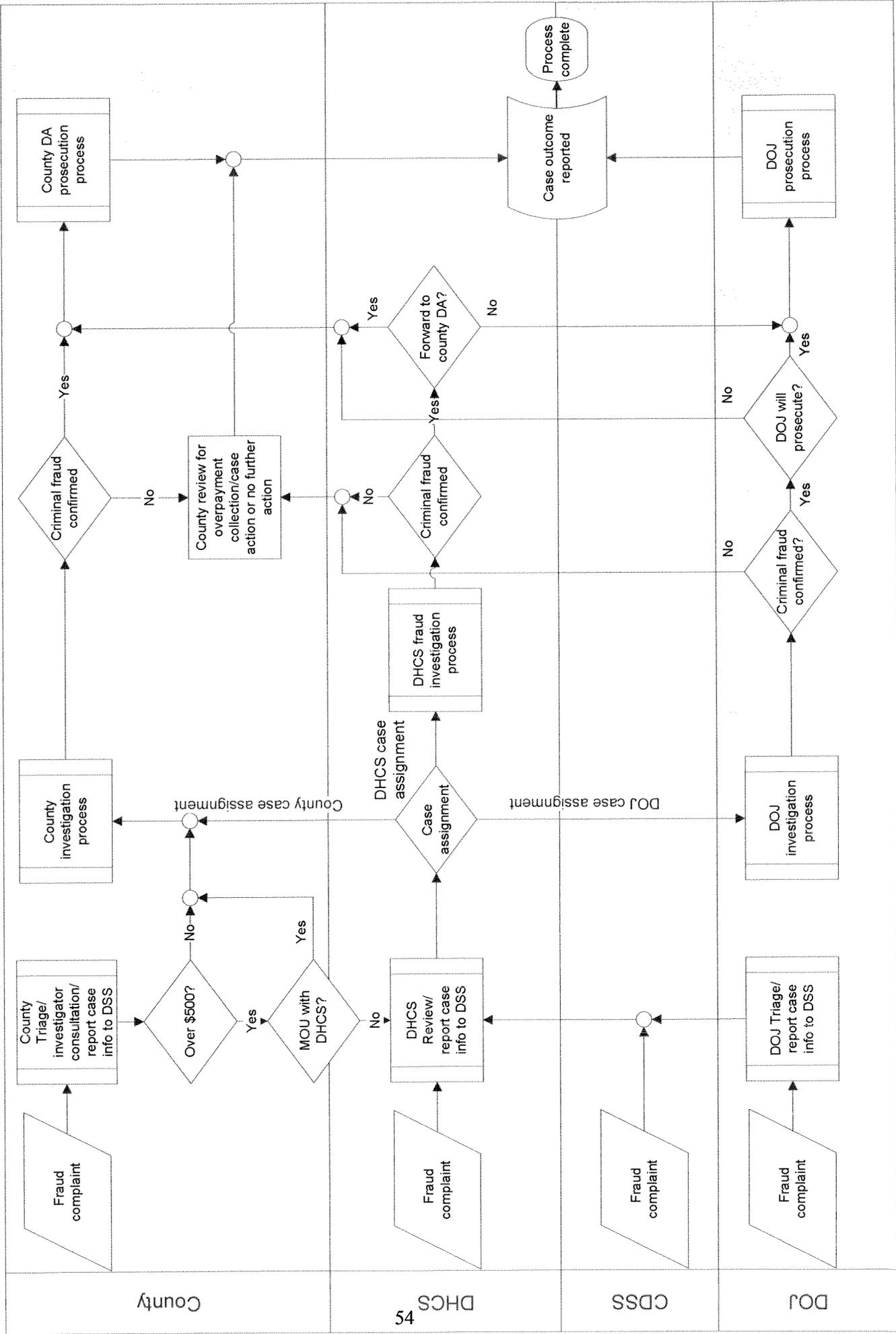
TITLE

Name:

Signature:

Date:

# Fraud Referral Process



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

<b>County:</b>	<b>Select County Name</b> ▼
<b>Reporting Quarter and State Fiscal Year:</b>	<b>Select Quarter and Year</b> ▼
<b>Date Completed:</b>	

**Section I. Fraud Complaints**

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

**Section II. Early Detection Savings**

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

**Section III. Fraud Investigations - Completed**

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

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

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

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

<b>Section V. Totals (\$)</b>		
<b>A</b>	<b>Loss Identified to IHSS Program</b>	50
<b>B</b>	<b>Total Amount Identified for Collection through Court Ordered Restitution</b>	51
<b>C</b>	<b>Total Amount Identified for Collection through County Overpay Recovery</b>	52

<b>Section VI.1. Comments</b>	
53	

<b>Section VI.2. Comments</b>	
54	

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

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

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

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

### Section I. Fraud Complaints

Definitions:

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

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

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

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

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

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

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

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

## Section II. Early Detection Savings

### Definitions:

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

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

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

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

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

## Section III. Fraud Investigations – Completed

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

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

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

**Section IV. Prosecutions – County**

Definitions:

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

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

**Section V. Totals (\$)**

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

**Section VI. Comments**

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





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**DEPARTMENT OF SOCIAL SERVICES**  
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EDMUND G. BROWN JR.  
GOVERNOR

September 27, 2013

ALL-COUNTY LETTER (ACL) NO.: 13-83

TO: ALL COUNTY WELFARE DIRECTORS  
ALL IHSS PROGRAM MANAGERS

SUBJECT: IMPLEMENTATION OF THE UNIFORM STATEWIDE PROTOCOLS  
FOR PROGRAM INTEGRITY ACTIVITIES IN THE IN-HOME  
SUPPORTIVE SERVICES (IHSS) PROGRAM

REFERENCE: ALL-COUNTY INFORMATION NOTICE (ACIN) NO. I-13-13,  
DATED MARCH 21, 2013; ACL NO. 10-39, DATED  
AUGUST 19, 2010; COUNTY FISCAL LETTERS (CFL)  
NO. 09/10-33, DATED OCTOBER 29, 2009; 09/10-37, DATED  
DECEMBER 10, 2009; 10/11-34, DATED NOVEMBER 23,  
2010; 11/12-19, DATED SEPTEMBER 16, 2011; AND 12/13-14,  
DATED SEPTEMBER 27, 2012.

This letter provides implementation guidelines for the *Uniform Statewide Protocols for Program Integrity Activities in the IHSS Program* (hereinafter referred to as “the protocols.”)

**Background**

On July 24, 2009, Assembly Bill 19, fourth extraordinary session (ABX4 19) amended components of the California Welfare and Institutions Code (WIC) Sections 12305.7, 12305.71, and 12305.82, requiring the California Department of Social Services (CDSS) to establish a State and county stakeholders’ workgroup to address key requirements pertaining to IHSS program integrity. The goal of this workgroup was to develop protocols clarifying state and county roles and responsibilities for the implementation and execution of standardized program integrity measures in the IHSS Program.

In March 2010, CDSS established the workgroup which included representatives from CDSS, the Department of Health Care Services (DHCS), the California Department of Justice Bureau of Medi-Cal Fraud and Elder Abuse, county program staff and district attorneys’ offices. In 2011, IHSS recipients and advocacy groups representing both IHSS recipients and providers were added to ensure sufficient

<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 type="checkbox"/> Clarification Requested by One or More Counties
<input checked="" type="checkbox"/> Initiated by CDSS

diversity in addressing the protocols. Over a two-year period, the full workgroup met seven times, there were numerous subcommittee and focus group meetings, and

CDSS conducted two public meetings to ensure public input. The workgroup engaged in a robust dialogue addressing issues as they pertain to workload concerns, implementation specifics and challenges faced by small counties versus large counties.

The focus of the workgroup was to encourage a coordinated effort between all of the involved stakeholders to ensure a consistent approach towards program integrity activities. In March 2013, the workgroup completed the protocols which are available at: <http://www.cdss.ca.gov/agedblinddisabled/PG2170.htm>.

It is essential that each county develop its own policies and procedures clearly addressing how they will implement the components of the protocols.

### **Purpose**

The purpose of the protocols is to establish the basis for State and county policies, procedures, and timelines, and to provide instructions regarding acceptable activities to be performed, and acceptable measures to be taken for the purposes of program integrity and fraud prevention, detection, and coordinated investigation and prosecution in the IHSS Program. The protocols are intended to assist counties in developing and implementing policies and procedures to ensure consistency.

### **Applicability**

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

### **Program Integrity Activities**

The specific measures addressed in the protocols include program integrity training for county IHSS workers, unannounced home visits (UHV's), directed mailings to IHSS providers, and statewide communication and coordination for IHSS program integrity efforts between state and county offices.

The delineation between quality assurance and program integrity activities is defined in **ACL No. 10-39**; the appropriation for these program integrity activities is established in **CFL No. 09/10-33** under the heading IHSS Anti-Fraud Initiative County Investigation; claiming instructions first appear in **CFL No. 09/10-37**, and the allocation appears most recently (as of this writing) in **CFL No. 12/13-14** under the heading Program Integrity Administrative Activities – County Investigation.

### **Program Integrity Training**

This training module has been developed and implemented, and is generally available through the IHSS Social Worker Training Academy in various regions throughout the state twice each year. The current training materials can be found at: <http://www.cdss.ca.gov/agedblinddisabled/PG1214.htm>, and each fiscal year's training schedule will be made available to counties as soon as it is finalized. This training is key to successfully conducting the other three program integrity measures of the protocols.

Implementation of the remaining three measures is addressed in this ACL. Specific information concerning these program integrity activities, including staffing, funding, and claiming information, can be found in the ACIN, ACL, and CFLs referenced above.

### **Unannounced Home Visits**

The term "Unannounced Home Visit" refers specifically to program integrity UHVs as established in WIC Section 12305.71(c)(3). Neither the protocols nor this ACL shall preclude counties from conducting, nor dictate county procedures concerning, unscheduled visits to the home of a recipient for the purpose of conducting a needs assessment, reassessment, safety and welfare check, or any purpose other than program integrity UHVs.

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

Implementation of the UHVs will occur over the period of October 1, 2013, through June 30, 2014. CDSS will use this transitional implementation period to evaluate the impact on counties in an effort to establish criteria guiding the acceptable size and frequency of UHV lists from CDSS, as well as the timeframe for counties to complete all UHVs on a list.

Counties are required to assign designated, trained staff responsible for conducting UHVs. Counties will also assign a county Point of Contact (POC) for program integrity issues, and keep CDSS informed as that POC changes. Those designated, trained program integrity staff will participate in all UHVs conducted by the county. As contained in ACL NO. 10-39, CDSS intended that the 78 county program integrity positions would conduct UHVs; however, counties will have flexibility to determine specifically who will be designated and how they will be trained in accordance with county policies and procedures. At a minimum, UHV staff training will include the program integrity training offered by CDSS through the IHSS Social Worker Training Academy; counties may supplement that training with any additional training that they deem appropriate.

CDSS will begin generating lists of recipients who meet UHV criteria, and distributing those lists to the program integrity contacts in counties by October 10, 2013. Typically, a recipient will meet UHV criteria based on some concern about the receipt or the quality of their services, their wellbeing, or other program integrity concerns.

Counties must conduct UHVs on all recipients listed by the end of the implementation period, or provide a clear explanation, based on specific knowledge of a case, why one or more of the identified recipients has not or should not be visited. Counties may add names to the UHV list if they have a clear reason for doing so. Reasons for adding names to the UHV list must be based on concerns about the receipt or the quality of services, recipient wellbeing, program integrity, risk of abuse and/or fraud, or referrals.

Counties will not, under any circumstances, conduct program integrity UHVs at random.

### **Preparation**

Prior to conducting the home visit, county UHV staff shall review the case file and note pertinent information such as specific conditions or needs of the recipient. This may include physical/mental disabilities or documented circumstances that may

place the UHV staff at risk. The UHV staff is encouraged to consult with the IHSS caseworker or supervisor as appropriate. In addition, reviewing the case file and discussing the UHV with the case worker prior to the UHV may provide information about when the recipient is most likely to be home, which may help select the best date and time for the UHV.

To the extent possible, the UHV and all calls and letters to the recipient shall be in the documented primary language of the recipient. If it is not possible to conduct the UHV in the recipient's primary language, an interpreter must be used at no cost to the recipient. Any telephone calls, letters, or UHVs attempted in a language other than the recipient's documented primary language shall not be counted against the three visits, two calls, and letter to which the recipient is entitled.

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

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

#### **The UHV**

**UHV Accomplished:** Counties shall ensure that when entry is granted, the UHV staff informs the recipient of the purpose of the UHV and provides general and/or specific information regarding program requirements and the consequences for failure to adhere to them. The UHV staff shall also ask questions regarding the recipients' services and the quality of those services. Using the IHSS UHV Findings Report (SOC 2247), UHV staff shall observe plain-view areas of the home to help determine whether the recipient is receiving appropriate levels of quality care to remain safely in the home.

**UHV Not Accomplished:** In the event that a county is unable to conduct a UHV based on unavailability of, or lack of cooperation from a recipient, that county shall closely adhere to these UHV follow-up procedures, in order, within 60 calendar days from the date of the initial UHV attempt:

- Mail a UHV Follow-Up Letter (Attachment A to the protocols) to the recipient's home. Alternately, the UHV Follow-Up Letter can be left at the recipient's home in an obvious location, such as in the door or in an area otherwise likely to be seen by the recipient upon their return.
- Call the recipient or authorized representative at the primary phone number in the case file. The telephone call must address:
  - The recipient's current address (confirm whether or not the recipient still resides at the address visited)
  - The recipient's wellbeing
  - The purpose of a UHV and the requirement for recipients to cooperate with the UHV
  - Any recurring commitments in the recipient's schedule that should be considered by the county UHV staff when planning future visits

The telephone call must not be used to schedule a UHV.

- Attempt a second time to conduct a UHV. To the extent possible, the second attempt should be made at a different time and/or day of the week than the first attempt.
- Call the recipient or authorized representative at the primary phone number in the case file.
- Attempt a third time to conduct a UHV. To the extent possible, the third attempt should be made at a different time and/or day of the week than the previous two attempts.

At the end of the 60 calendar day period, after the minimum follow-up procedures have been completed, if the county has been unable to complete the UHV because the recipient has been unavailable or uncooperative, send the recipient a Notice of Action (NOA) indicating termination from the IHSS Program. A NOA Code specific to this circumstance is being developed; appeal rights and aid paid pending remain in full effect.

The follow-up procedures must constitute a good faith effort by the county to complete a UHV.

Counties must use all available resources to ascertain whether the recipient attends school or participates in Community Based Adult Services (CBAS), or otherwise has commitments on certain days, or at certain times of the day. County UHV staff must

then make every reasonable effort to attempt UHVs at times that do not conflict with those commitments. After the UHV Follow-Up Letter is mailed or left at the home, no two contact efforts made on the same day can be counted against the minimum required contacts to which the recipient is entitled. While UHV staff may make two UHV attempts to the same home on the same day, the second attempt will not count as one of the three required UHV attempts unless it results in a completed UHV. Likewise, county UHV staff may attempt multiple calls to the same recipient on the same day, but a call will only count as the second required call *after* a second attempt has been made to complete the UHV.

Counties may, at their discretion, make additional attempts (beyond the required three UHV attempts, two phone calls, and letter) to contact the recipient, the authorized representative, the provider, or other individual named in the case file as an alternate contact up until the end of the 60 calendar days after the initial UHV attempt. Whether or not the county is able to conduct additional efforts to contact the recipient, the requirement is fulfilled upon completion of the minimum follow-up procedures established in the protocols (three UHV attempts, two phone calls, and a letter). Counties are encouraged, but not required, to make additional efforts to contact the recipient prior to sending the termination NOA. Once the NOA is sent, an offer from the recipient to cooperate is not sufficient to stop the termination.

Whether or not the county UHV staff successfully completes a UHV, all efforts and findings must be documented using the SOC 2247. This form must be maintained with the case file, and is available at: <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC2247.pdf>, with instructions for its completion. It is imperative that counties complete the SOC 2247 as thoroughly as possible, carefully documenting each attempted contact with the recipient. Counties must document dates and times of contact attempts, the results of contact attempts, whether or not they left a message, the content of any messages left, and any contact received from the recipient or authorized representative.

As counties conduct the UHVs they will annotate the UHV list with applicable comments, and return the completed UHV list to CDSS upon completion, within the specified timeframe.

Annually, CDSS will validate, compile, and analyze the completed UHV data, and release a report to counties each September.

**CDSS Responsibilities:**

- Provide program integrity training to meet the minimum requirement for training UHV staff.
- Maintain all standard forms and update as necessary.
- Generate lists of recipients identified for UHVs.
- Monitor the size of UHV lists and filter as needed prior to sending to the program integrity POC in each county.
- Receive completed UHV lists from counties, validate, and then aggregate the data for inclusion in the annual report to counties.
- Provide technical assistance to counties as appropriate.

**County Responsibilities:**

- Develop county-specific policies that are consistent with the protocols, and detailed procedures for:
  - training staff,
  - conducting and following up on UHVs, and
  - tracking and reporting UHV data in accordance with the protocols.
- Designate and train staff to begin conducting UHVs.
- Use the CDSS list of recipients identified for UHVs.
- Review case files and note pertinent information prior to conducting UHVs.
- Counties may add names to the list of recipients identified for UHVs if they have a clear reason for doing so.
- Conduct UHVs on all recipients listed, or provide a clear explanation, based on specific knowledge of a case, why one or more of the identified recipients should not be visited.
- Clearly document the completed UHV list to include the reasons why the county has opted *not* to conduct a UHV on an identified recipient.
- Clearly document on the completed UHV list any additional UHVs performed, including the reasons why those additional recipients were selected for UHVs.
- Adhere to follow-up procedures in the event that the UHV is not completed.
- At the end of the 60 calendar day period, after the follow-up procedures have been completed, if the county has been unable to complete the UHV because the recipient has been unavailable or uncooperative, send the recipient a NOA indicating termination from the IHSS Program.
- Thoroughly document UHV efforts and outcomes using the UHV Findings Report (SOC 2247), and follow up as appropriate.
- Counties will conduct the UHVs and electronically return the completed UHV list to the CDSS Quality Assurance and Improvement Bureau, at: [ihss-pi@dss.ca.gov](mailto:ihss-pi@dss.ca.gov) within the specified timeframe.

## **Directed Mailings**

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

The purpose of directed mailings is to reach out to providers associated with cases which appear to suggest some program integrity concern (whether or not the concern is founded) and proactively educate those providers concerning common program integrity mistakes. The goal is to increase the participants' knowledge and create a better informed provider of IHSS services in an effort to reduce errors, fraud, and abuse in the IHSS program.

Under separate cover, CDSS will disseminate the List of Approved Indicators for directed mailings to identified county program integrity contacts. Counties will select providers to receive directed mailings using the indicators list. If a county attempts to pull data using approved indicators and returns no results (a "Zero Results Data Pull"), the county will adhere to the following guidance:

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

Prior to sending directed mailings to providers, counties will email their list of prospective providers on a spreadsheet to CDSS for review. At a minimum, this list must include the provider identification numbers, associated recipient case numbers, and the specific indicators used to select the providers. CDSS will review these lists against previous lists, and identify and report any duplication to the county. Counties will review the list of duplications and make case by case determinations whether or not to include each case in the mailing. The decision to include or omit any duplicate cases will remain solely with the county; the purpose of the CDSS review is only to ensure that counties are aware of any such duplication.

Counties will send the directed mailing to providers from the list, send copies to each recipient served by those providers, and then notify the CDSS Quality Assurance and Improvement Bureau of which providers were sent mailings, again using a spreadsheet as the reporting format. Counties will conduct at least one directed mailing annually, beginning in Fiscal Year (FY) 2013/14. If, based on some unforeseeable emergency, a county is not able to conduct a data pull or a directed mailing, they will adhere to the "Unforeseeable Circumstances" guidance outlined in the protocols and provided below. Examples of unforeseeable circumstances which prevent a county from conducting the directed mailing include events such as natural disasters that greatly diminish the county's ability to conduct routine business for a prolonged period of time. Upon receipt of directed mailing data, CDSS will validate the data, compile, analyze, and include it in the annual report to counties.

**CDSS Responsibilities:**

- Provide Program Integrity training.
- Maintain the List of Approved Indicators for identifying groups of providers to receive a directed mailing, and update as appropriate.
- Disseminate the current List of Approved Indicators to the program integrity POC in each county.
- Receive counties' pre-mailing list, and compare it against previous mailing lists.
- Receive and validate completed mailing lists, then aggregate the data for inclusion in the annual report to counties.
- Provide technical and practical assistance as appropriate.

**County Responsibilities:**

- Develop county-specific policies that are consistent with the protocols, and detailed procedures for:
  - training staff,
  - conducting directed mailings, and
  - tracking and reporting directed mailings in accordance with the protocols.
- Select indicators from the indicator list provided by CDSS (distributed to county program integrity POC under separate cover), and conduct data pulls to create a directed mailing list of providers who all share the indicator.
- In the event that the county is unable to conduct a data pull or a directed mailing because of some unforeseeable emergency, contact CDSS for assistance.
- In the event that a data pull yields no results, counties will adhere to the "Zero Result Data Pulls" guidance.
- Email their list of prospective providers on a spreadsheet to CDSS for review prior to mailing.

- Customize the letter (*Attachment C to the protocols*) to include a reason for the mailing from the Reasons List and county contact information, and then conduct the mailing.
- Ensure that a copy of the directed mailing is sent to each recipient assisted by those providers.
- Conduct a minimum of one directed mailing per year, beginning in FY 2013/14.
- Mail to providers from the list, and then notify CDSS Quality Assurance and Improvement Bureau of which providers were sent mailings, again using a spreadsheet format for reporting.
- Email CDSS a final list of providers and recipients who were sent directed mailings for tracking and analysis, in order to coordinate and track the mailings and minimize unintentional duplication. At a minimum this list must include the provider numbers, associated recipient case numbers, and the specific indicators used to select the providers.

### **Statewide Communication and Coordination**

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

A complaint is any program integrity concern or allegation identified or received by the state or county.

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

Triage is the process whereby designated county staff reviews a complaint of suspected fraud and determines whether or not the complaint will become a fraud referral.

A fraud referral is a complaint that has been triaged by designated county staff and determined appropriate for referral to a law enforcement agency for fraud investigation.

### **Fraud Referral Procedures**

The intent of the guidelines below is to provide a framework to enable CDSS, DHCS, the DOJ, county welfare departments, county district attorney offices and any

agency that may be involved in the IHSS program and/or fraud detection and prevention related to the program, to work together on fraud referrals and investigations.

This joint/collaborative effort will include implementing uniform statewide protocols in order to avoid duplication of effort, and coordinate fraud detection and prevention activities. These protocols address case referrals, a county's authority to investigate, data sharing, and authority to terminate a provider or recipient's participation in the IHSS program. The county must designate staff that will review the fraud complaint and determine if it is appropriate for investigation. These protocols are designed to assist the counties in developing and implementing individual policies and procedures to ensure consistency.

### **Fraud Complaint**

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

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

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

### **Fraud Referral**

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

Counties without an MOU with DHCS shall send all IHSS fraud referrals over \$500 directly to DHCS for investigation. If a county receives a complaint which appears to be under \$500, refers the complaint for county investigation and it is subsequently determined to involve over \$500 in fraud, the county will confer with DHCS to decide jurisdiction for the continued investigation. Complaints of \$500 or less can also be referred to DHCS, if counties choose not to investigate locally.

Counties who have a MOU with DHCS will abide by the terms of that MOU.

### **Fraud Investigation**

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

### **CDSS Responsibilities:**

- Provide Program Integrity training.
- Maintain all standard forms and update as necessary.
- Define required elements of statistical data reporting.
- Initiate data-sharing agreements with DHCS and DOJ.
- Function as the primary repository for IHSS fraud data.
- Validate fraud data collected from the counties, and then aggregate the data for inclusion in the annual report to counties.
- Provide technical assistance as appropriate.

### **DHCS Responsibilities:**

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

### **DOJ Responsibilities:**

- Assist counties with investigations/prosecutions of provider fraud, at the request of the county or DHCS.
- Provide CDSS statistical data concerning IHSS fraud investigations and prosecutions, including outcome data, within a reasonable timeframe upon request.

**County Responsibilities:**

- Develop county-specific policies that are consistent with the protocols, and detailed procedures for:
    - training staff,
    - receiving, reviewing, and referring fraud complaints, and
    - tracking and reporting fraud data in accordance with the protocols.
  - Identify staff to conduct triage on fraud complaints.
- Document suspected fraud using the Complaint of Suspected Fraud Form (SOC 2248) which has replaced the MC 609 for reporting suspected fraud in the IHSS Program. This form must be maintained with the complaint/referral package, and is available at:  
<http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC2248.pdf>.
- Complete the appropriate sections of the Complaint of Suspected Fraud form as completely as possible, and
    - review the form for accuracy and completion;
    - gather any missing information from the Reporting Party;
    - gather any relevant supporting documentation, such as copies of timesheets and pay warrants for the period in question.
  - Submit the fraud complaint package to the designated county triage staff.
  - The county triage staff shall conduct triage on fraud complaints, complete Section E of the Complaint of Suspected Fraud form, and refer cases to law enforcement when appropriate.
  - Refer complaints determined appropriate for investigation along the appropriate path (as outlined below), depending on the amount of overpayment involved, and whether or not the county has an MOU with DHCS.
    - Counties seeking to investigate their own fraud complaints must establish a MOU with DHCS by contacting the Chief of Investigations using the current contact information at:  
[http://www.dhcs.ca.gov/individuals/Pages/AI\\_IB\\_Locations.aspx](http://www.dhcs.ca.gov/individuals/Pages/AI_IB_Locations.aspx).
- Counties that do not establish an MOU *must* refer all fraud complaints deemed viable to DHCS unless it appears unlikely that the total overpayment will exceed \$500.
- Counties may investigate complaints of suspected fraud with respect to an overpayment of \$500 or less, or refer them to DHCS.
  - Fraud referrals to DHCS must be made to DHCS Investigations Branch, Policy and Analysis Unit. The preferred method of referral is email at:

[IB.PAU.INTAKE@dhcs.ca.gov](mailto:IB.PAU.INTAKE@dhcs.ca.gov). Counties are reminded that personally identifying information must be password protected when emailing.

- The mailing address for paper documents is:

Department of Health Care Services  
Audits and Investigations  
Investigations Branch – HQ  
1500 Capitol Ave.  
Suite 72.422  
P.O. Box 997413  
Sacramento, CA 95899-7413  
MS 2200

- Complaints deemed not appropriate for investigation (insufficient indication of fraud) that still reveal an overpayment must be evaluated by county staff to determine the most appropriate method of administrative overpayment recovery.
- Counties must track fraud complaints and report to CDSS quarterly using the Fraud Data Reporting Form (SOC 2245) available at: <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC2245.pdf>. CDSS will validate the county fraud data, compile, analyze, and include it in the annual report to counties.

If you have questions or comments regarding this ACL or the protocols, please contact Mr. Ernie Ruoff, Manager of the Quality Assurance & Improvement Bureau's Program Integrity Unit at (916) 651-3494 or via email at: [ihss-pi@dss.ca.gov](mailto:ihss-pi@dss.ca.gov).

Sincerely,

***Original Document Signed By:***

EILEEN CARROLL  
Deputy Director  
Adult Programs Division

c: CWDA



## CMIPS II INFORMATION: POTENTIAL RED FLAGS

Information Addressed	Report	Task (Action Required)	Notification
Providers working 300 or more hours per month.	Provider Hours Over 300 Paid	None	None
Announces that a consumer has been admitted into a hospital or long-term care facility for more than a two-day period.	In-Patient Hospitalization Report	Treatment authorization approval	Treatment Authorization Request approval
Announces that Advance Pay reconciling timesheets have not been received for a 75-day period.	Reconciliation of Advance Payments	Advance Pay timesheets not received in 75 days	Advance reconciling timesheets not received at 45 day
Death of a consumer.	Death Match Response	Recipient death notification	None
Provider has an out of state address.	Out of State Provider Payments	Recipient address changed to out of state	Provider moved out of state
Provider is on the Medi-Cal Suspended and Ineligible Provider list.	None	Sent to the Public Authority – announces that a registry provider has been added to the Medi-Cal Suspended or Ineligible Provider list	Provider is listed on the Medi-Cal Suspended and Ineligible Provider List

## EDUCATING ABOUT ERRORS AND FRAUD AT THE HOME VISIT

Fraud occurs when there is an intentional deception or misrepresentation in order to gain benefits. County social workers should always make a fraud referral when it is suspected that the provider and/or consumer have committed fraud.

Sometimes consumers and providers do things they might not know are considered against the rules. The social worker should use the home visit as an opportunity to educate consumers and providers about questionable things they identify through observation or discussions. This could include a discussion about providing services which are not allowed by IHSS to ensure the consumer and/or provider is not aware that what they are doing is against the rules.

### **Identity**

Providers and consumers must use their own personal information, i.e., name, address, Social Security Number. If they intentionally use someone else's identity, it is fraud. Social workers should always be aware of the consumer's enrolled providers by reviewing the case file prior to the home visit. If the provider is present during the home visit, the social worker should verify the provider's identity. If the person who is providing services is not one of the enrolled providers, further inquiry is required.

### **Overstating Need for IHSS**

The assessment of need is reliant on accurate information given to the social worker by the consumer, their family, and/or provider(s).

- A consumer overstating their needs may be considered fraud. For example, telling the social worker that there is a need for services that the consumer can actually complete independently, or there is a higher level of need for assistance (more time) than actually exists.
- Providers who try to get the consumer to tell the social worker that they need more services than they can do themselves or that it takes more time to do the services than it actually does.. If the provider attempts to have the consumer misstate their needs for their own financial gain, it is fraud.

### **Consumer Reporting Responsibilities**

Consumers must report:

- Names and ages of all members in the household, whether or not they are related.
- If a spouse lives with them, whether they are legally married or common law.
- Changes in living situations, residence, or level of assistance required to perform tasks covered by IHSS. These changes might affect the amount of services available and must be reported.

### **Consumer Out of the Home**

A provider cannot be paid to take care of a consumer who is:

- In the hospital
- In a nursing home
- Incarcerated

When a consumer returns home after being absent for one of the above reasons, a provider cannot make up those hours by adding extra hours to their next timesheet. If a provider reports time worked during the consumer's absence for one of the above reasons, it is a fraudulent claim and a fraud referral should be made per your county procedures.

### **Timesheets**

- Hours claimed on the timesheet must be those that are actually worked.
- Hours cannot be claimed for services that have not been authorized by the consumer, or are not covered by the IHSS program.
- Timesheets cannot be turned in early. The provider must wait until all hours have actually been worked and the end of the pay period before turning in the timesheet.
- If the consumer is not available to sign the timesheet, the provider cannot sign it for them. The consumer is the employer of record and he/she must verify that all of the hours claimed have been worked. If the consumer cannot sign the timesheet, contact the IHSS office.
- If the consumer dies, the provider cannot sign the timesheet for them. The provider may sign their own name and write "deceased" and the date the consumer died or contact the IHSS office.

### **Splitting the Check**

Splitting the check means that an IHSS provider makes an agreement with the consumer or others to share the payment received from IHSS. A consumer should not ask the provider for a part of their IHSS pay, and a provider should not agree to share their pay with consumers.

An enrolled provider may not split the check with a second unenrolled provider. Anyone who provides services and receives payment from IHSS must go through the provider enrollment process which includes fingerprinting and a criminal background check.

### **Missing Paychecks**

If the social worker is aware that an affidavit to receive a replacement check has been completed, they must advise the provider not to cash the original check if it is received and to return the check to the IHSS office. Cashing both checks is fraud. If the social worker determines that both checks have been cashed, a fraud referral should be made per your county procedures.

### **DHCS Medi-Cal IHSS Fraud Hotline**

The hotline number is **(888) 717-8302**. If there is reported IHSS fraud, an investigation will be conducted by the county and/or state fraud investigation unit.

## IN-HOME SUPPORTIVE SERVICES Recipient/Employer Responsibility Checklist

I, \_\_\_\_\_, HAVE BEEN INFORMED BY MY SOCIAL WORKER THAT AS A RECIPIENT/EMPLOYER, I AM RESPONSIBLE FOR THE ACTIVITIES LISTED BELOW.

- 1) Provide required documentation to my Social Worker to determine continued eligibility and need for services. Information to report includes, but is not limited to, changes to my income, household composition, marital status, property ownership, phone number, and time I am away from my home.
- 2) Find, hire, train, supervise, and fire the provider I employ.
- 3) Comply with laws and regulations relating to wages/hours/working conditions and hiring of persons under age 18.

**NOTE:** Refer to Industrial Welfare Commission (IWC) Order Number 15 regarding wages/hours/working conditions obtainable from the State Department of Industrial Relations, Division of Labor Standards and Enforcement listed in the telephone book. Additional information regarding the hiring of minors may be obtained by contacting your local school district.

- 4) Verify that my provider legally resides in the United States. My provider and I will complete Form I-9. I will retain the I-9 for at least three (3) years or one (1) year after employment ends, whichever is longer. I will protect the provider's confidential information, such as his/her social security number, address, and phone number.
- 5) Ensure standards of compensation, work scheduling and working conditions for my provider.
- 6) Inform my Social Worker of any future change in my provider(s), including:
  - \_\_\_ Name
  - \_\_\_ Address
  - \_\_\_ Telephone Number
  - \_\_\_ Relationship to me, if any
  - \_\_\_ Hours to be worked and services to be performed by each provider

- 7) Inform my provider that the gross hourly rate of pay is \$\_\_\_\_\_, and that Social Security and State Disability Insurance taxes are deducted from the provider's wages.
- 8) Inform my provider that he/she may request that Federal and/or State income taxes be deducted from his/her wages. Instruct the provider to submit Form W-4 (for federal income tax withholding) and/or Form DE 4 (for state income tax withholding).
- 9) Inform my provider that he/she is covered by Workers' Compensation, State Unemployment Insurance benefits, and State Disability Insurance benefits.
- 10) Inform my provider that he/she will receive an information sheet that will state my authorized services and the authorized time given to perform those services. Inform the provider that he/she is not paid to perform work when I am away from my home (for example, when in a hospital or away on vacation).
- 11) Pay my share of cost, if any.
- 12) Verify and sign my provider's timesheet for each pay period, showing the correct day(s) and the total number of hours worked. I understand I can be prosecuted under Federal and State laws for reporting false information or concealing information. I understand that when required, it will be necessary for me to place my fingerprint on my provider's timesheet to verify the correct day(s) and hours worked. This will be necessary, so my provider can be paid.
- 13) Ensure my provider signed his/her timesheet.
- 14) Advise my provider to mail his/her signed timesheet to the appropriate address at the end of each pay period.

\_\_\_\_\_  
Recipient' Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

## INSTRUCTIONS FOR USE OF THE RECIPIENT/EMPLOYER RESPONSIBILITY CHECKLIST

1. This form is used for review with recipients receiving service from Individual Providers **only**.
2. Counties shall use this form to assure that recipients have been advised of and understand their basic responsibilities as employers of IHSS providers.
3. Review each item with the recipient and explain how the recipient can comply with each requirement.
4. Leave a copy of the form with the recipient.

## IN-HOME SUPPORTIVE SERVICES (IHSS) PROVIDER ENROLLMENT AGREEMENT

I, \_\_\_\_\_, UNDERSTAND I AM REQUIRED TO ATTEND THE IHSS PROVIDER

(PRINT NAME)

**ORIENTATION TO BE ELIGIBLE TO PROVIDE IHSS. HOWEVER, IF I HAVE BEEN A PROVIDER (ON OR BEFORE OCTOBER 31, 2009), I HAVE THE OPTION TO ATTEND AN IHSS ORIENTATION OR I MAY RECEIVE THE PROVIDER ORIENTATION INFORMATION DIRECTLY FROM THE COUNTY IHSS OFFICE.**

1. During the required orientation for IHSS providers:
  - I was given the requirements to be an eligible IHSS provider and a description of the IHSS program. I was informed of my responsibilities as an IHSS provider.
  - I was informed of the consequences of committing fraud in the IHSS program.
  - I was given the Medi-Cal toll-free telephone fraud hotline number, 1-800-822-6222 and Internet Web site, <http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx> for reporting suspected fraud or abuse in the IHSS program.
2. I received a demonstration of, and understand, how to complete my timesheet. If I have been a provider (on or before October 31, 2009), I received information on the new timesheet and understand how to complete it.
  - I understand the timesheet should indicate only the authorized services I performed for the recipient and the time needed to perform those authorized services. I understand that my signature on my timesheet verifies that the information I reported on it is true and correct.
  - I understand that, if I am convicted of fraudulently reporting information on my timesheet, in addition to any criminal penalties, I may be required to pay civil penalties of at least \$500, and not more than \$1,000, for each violation of fraud.
  - I understand that when required, it will be necessary for me to place my fingerprint on my timesheet in order to be paid.
3. I understand that I am required to complete Form I-9, a form kept on file by the recipient, which states that I have the legal right to work in the United States.
4. I understand I have the option to submit Form W-4 to request federal income tax withholding and/or Form DE 4 to request state income tax withholding from my wages. I understand that if I do not submit Form W-4 and/or DE 4, no withholding will be taken out of my wages.
5. I understand services cannot be performed when the recipient is away from his/her home (for example, when the recipient is in the hospital or away on vacation). I will contact the recipient's social worker for approval of any services that may be performed when the recipient is away from the home.
  - I understand that, in the future, I will receive an information sheet that names the recipient and the services I am authorized to perform for that recipient.
6. I will cooperate with state or county staff to provide requested information related to the evaluation of a recipient's IHSS case.

**I UNDERSTAND THE IHSS PROGRAM RULES EXPLAINED AT THE PROVIDER ORIENTATION OR BY THE PROVIDER ORIENTATION INFORMATION GIVEN TO ME BY THE COUNTY IHSS OFFICE. I ACCEPT THE RESPONSIBILITY TO FOLLOW ANY INFORMATION PROVIDED BY THE COUNTY. I UNDERSTAND THAT FAILURE TO FOLLOW THE REQUIREMENTS PROVIDED TO ME MAY RESULT IN BEING TERMINATED AS AN IHSS PROVIDER.**

Provider's Signature

Date



## INTERVIEW SKILLS

### Establishing Rapport – Warmth, Empathy and Genuineness:

- **Warmth** – conveys a feeling of interest, concern, well-being and affection to another individual. It promotes a sense of comfort and well-being in the other person. Examples: “Hello. It’s good to meet you.” “I’m glad we have the chance to talk about this.” “It’s pleasant talking with you.”
- **Empathy** – being in tune with how a consumer feels, as well as conveying to that consumer that you understand how she/he feels. Does not mean you agree. Helps consumer trust that you are on their side and understand how they feel. It also is a good way to check to see if you are interpreting what you observe correctly. Mirroring non-verbal can send empathetic messages. Example of leading phrases: “My impression is that...” “It appears to me that...” “Is what you’re saying that...” “You seem to be...” “I’m hearing you say that...”
- **Genuineness** – means that you continue to be yourself, despite the fact that you are working to accomplish goals in your professional role. Being yourself and not pretending to be something you are not conveys honesty and makes consumers feel like you are someone they can trust.

### General Interviewing Skills:

- **Before the Interview** – Review the case and think about the possible things you will need to address with this consumer. Are there any cues from the initial information, the case record or CMIPS reports that help you to come up with an approach to the interview? For example: Is the consumer a native English speaker, what are his/her disabilities, does she/he have a mental impairment? Also consider whether there are any red flags which may indicate potential fraud. If so, develop a plan for how you will address the red flags during the interview.
- **Pre-interview Planning – Be Prepared**
  - Review case file and gather cues about consumer.
  - Formulate questions based on cues.
  - Plan interview approach.
  - Contact any other agencies involved such as APS or CPS to get additional information.
  - If there have been fraud referrals in the past, contact fraud investigators or others who may have information. If you believe that there are fraud issues that have not been addressed during prior assessments or contacts, discuss these issues with prior social worker(s) involved in the case, your supervisor or QA staff who may have knowledge about the case. You may also want to discuss concerns with the fraud investigator to get direction about how to proceed during the assessment.
- **Meeting the Consumer – Establish Rapport**
  - Introductions should be formal and cordial.
  - Small talk might get the conversation going, but consider consumer’s reaction and adjust as appropriate.
  - Pay attention to verbal and non-verbal cues.

- **Begin Assessment Interview – Explain Process**
  - Explain purpose of interview.
  - Explain your role to the consumer.
  - Ask the consumer for feedback – do they understand the process and purpose?
  
- **Concluding the Interview**
  - Clarify the next steps.
  - Explain any additional paperwork needed before authorization or reauthorization of services.
  - Discuss the notification process of authorized hours.
  - Answer any questions the consumer may have.
  - Address any concerns you may have regarding potential fraud issues in a non-threatening manner. Examples:
    - Consumer states that he lives alone but there are several people in the home who appear to be living there.
    - Consumer states she has the provider drive her to doctor appointments but consumer has a car that she states she drives to church services.
    - Consumer states that daughter is her provider. Grandson who lives in home appears to be providing services. CMIPS indicates daughter lives in another county.
    - Consumer is authorized many hours and tasks such as Bowel and Bladder Care but the provider is not present when you conduct the home visit.

**It would not be appropriate to address concerns that are more appropriately addressed by fraud investigators or law enforcement, or if you feel addressing the issues would result in a risk to your safety. If you believe that addressing potential fraud issues will result to a threat to your safety or the safety of others, it is appropriate to conclude the interview without addressing the issues. When you return to the office, discuss the issues with your supervisor to determine the best plan to address the issues. Some alternatives may be to get APS, law enforcement agencies or fraud investigators to accompany you on a home visit during which the issues may be addressed.**

## THE INTERVIEW: CHOOSING THE RIGHT QUESTIONS

### Direct or Closed-ended Questions:

- These questions seek a simple “yes” or “no” answer.
- Specifically ask for information with leading questions. For example: “Are you coming tomorrow?” or “Do you eat three times a day?”
- These questions do not encourage or allow for an explanation of why the answer was chosen, or for an elaboration of thought or feeling about the answer.
- They can be leading –they ask a question in narrow terms such that they seem to be “hinting” at the answer.

### Open-ended Questions:

- Cannot be answered by “yes” or “no.”
- These questions begin with ‘who’, ‘what’, ‘where’, ‘when’, ‘why’ or ‘how.’
- They give consumers more choice in how they answer and will encourage them to describe the issue in their own words.
- Open-ended questions seek out the consumer’s thoughts, feelings, ideas, and explanations for answers.
- They encourage elaboration and specifics about a situation. For example: “How do you bathe?”
- Examples:
  - How have you been managing at home since I saw you last/since you got home from the hospital?
  - What do you need in the way of help right now?
  - Let’s talk about things you are able to do and unable to do.
  - Help me understand...
  - Would you tell me more about...?
  - What else can you tell me that might help me understand?
  - Could you tell me more about what you’re thinking?
  - I’d be interested in knowing...
  - Would you explain...?
  - Is there something specific about \_\_\_\_\_that you are asking for?
  - I’m not certain I understand. Can you give me an example?
  - I’m not familiar with\_\_\_\_\_. Can you help me to understand?
  - What examples can you give me?
  - You say that you’re not able to [cook/bathe/...]. How have you been managing [your meals/bathing/...]?
  - When you say \_\_\_\_\_, what do you mean?
  - I’d like to help you get the best possible service. What more can you tell me that will help me understand your need?

**Indirect Questions:**

- Asking questions without seeming to.
- They are not stated as a question.
- The interviewer is asking a question without stating it in question format. For example:  
“You seem like you are in a great deal of stress today.”

## THE INTERVIEW: OTHER ASSESSMENT CUES

### Non-verbal Assessment Cues:

- **Your Body Speaks Your Mind** – Between 60-80% of our message is communicated through our body language; only 7-10% is attributable to the actual words of a conversation. Whenever there is a conflict between verbal and non-verbal, we almost always believe the non-verbal messages without necessarily knowing why.
- **Eye Contact** – It is important to look a consumer directly in the eye. Hold your head straight and face the consumer. This establishes rapport and conveys that you are listening to the consumer. This is not staring, but being attentive. However, be conscious of cultural differences and respect them.
- **Facial Expressions** – These are the strongest non-verbal cues in face-to-face communication. Be aware of your own non-verbal. What are my habits that could be interpreted incorrectly? Make certain that your facial expressions are congruent with your other non-verbal behavior (i.e., frowning, smirking, looking around in a distracted way or focusing on paperwork rather than looking at the consumer, etc.). What do I see in the other person's face? If unclear, ask for interpretation.
- **Body Positioning** – Posture, open arms versus crossed, or hands on hips. When interviewing consumers, look for cues in their body positioning and be aware of your own. Sitting in an attentive manner communicates that you are interested.

### Environmental Cues:

- Discrepancies between the way the environment looks and what consumer reports as service needs.
- Presence of DMEs, diapers, underpads, bedside commode, etc. Location of walker in relationship to consumer.
- Importance of observations (i.e., house condition, cleanliness of consumer, tour the house, etc.).

### Sensory Cues:

- Data obtained by smelling.
- Tactile information – sticky floors, surfaces.

## THE INTERVIEW: CLARIFYING INFORMATION

It is important to probe for details and clarify information in order to get the best outcomes from the interview. Look for:

- **Conflicting Information**

- What is observed is not consistent with information given. For example: Consumer says she can't feed herself but she has been knitting (an activity that demonstrates manual dexterity). Perhaps the consumer's difficulty is in lack of strength. Probing questions would be needed to tease out the basis of the statement that she cannot feed herself. Also, consider good days versus bad days. You may be seeing the consumer whose condition and abilities fluctuate.
- What the consumer says is inconsistent. For example: He says that he has no trouble bathing himself yet he tells you that he is unable to walk without someone's constant assistance because he can't hold onto the handrails of a walker or a cane and he's unsteady on his feet. Perhaps the consumer who is at risk of falling is extremely modest and doesn't want anyone to see his naked body.
- What the consumer says and the family or provider says are in conflict. For example: The consumer says that he needs no help in dressing. The daughter with whom he lives and who is also his primary caretaker says that she dresses him every day. Probing questions are needed to determine whether the daughter is dressing her father because it's faster than to let him do it himself or if he is unable to dress himself. Issues to be considered would include his ability to reach, balance when standing, and perform tasks that require manual dexterity such as buttoning and zipping.

- **Unrealistic Expectations of the Program**

- For example: The consumer had fallen and broken her hip. When she fell, she had laid on the floor for 7 hours until a neighbor heard her calling for help. The consumer just returned home from a rehab facility for therapy following hip replacement. She wants round-the-clock care so that if she falls again, she will get immediate help. Her concerns are understandable, but not within the scope of the IHSS program. An alternative would be to make referrals to organizations that can provide her with a panic button so that she can summon assistance in the event of another fall.

- **Safety Issues**

- For example, a consumer says she is independent in bathing. Though she's unsteady on her feet, she says that she holds onto the towel rack to aid in stability. You look in the bathroom and confirm that what she's using to stabilize herself is not a properly installed grab bar but rather a towel rack that is starting to come loose from the wall behind the bathtub. She needs help getting into and out of the tub and obtaining a grab bar and shower bench. If she discusses this with her physician and obtains a prescription for these items, it is possible that Medi-Cal will pay for these safety devices. Without assistance into and out of the tub, she's at risk of falling.

### **How to Probe to Clarify Information:**

When probing to clarify information, the goal is to check that you have heard the consumer correctly, you are clear on the details of the information, you have a complete picture of the situation, and that the story holds together in a consistent manner. The following are a few methods that can be used to verify information and to decrease the risk of misunderstanding what the consumer has stated.

- **Paraphrasing** – Feed back the consumer’s ideas in your own words. For example, the consumer says that he doesn’t go to church anymore because he can’t be far from a toilet after taking his diuretic. You say, “I see you take a diuretic in the morning and have to be near a toilet. How long does that last? Do you have accidents? If so, how often? What is your provider’s schedule?”
- **Stating Your Observations** – Tell the consumer your observations about his behavior, actions and environment to find out if they are on target. For example, if you see that he can’t get out of the chair without help, say so.
- **Demonstration** – Have the consumer to show you an activity. For example, you wonder how well the consumer transfers. You ask the consumer to show you the apartment which will give you the opportunity to see the consumer transfer without specifically asking the consumer to demonstrate.
- **Asking Clarifying Questions** – These questions get to details. For example:
  - “What do you mean by that? You said that you were tired a lot; tell me what that means to you.” If the consumer doesn’t explain what they mean, it is open to interpretation.
  - “Could you explain that or tell me more about that?”
  - “I’m not sure I understand.” This simply directs the consumer’s comments by letting him know you do not understand.

## THE INTERVIEW: HANDLING DIFFICULT SITUATIONS

Most of the time, the interview will go smoothly; however, there are times when things will come up that will make getting good information more difficult. Here are some hints to help make each situation more successful.

- **The Consumer who is Angry** – It is best to try to handle the anger at the beginning of the interview. This shows the consumer you care and aren't there just to get your agenda accomplished. It never helps to ignore the anger; it will be a constant barrier to getting useful information.
  - Acknowledge the anger by gently confronting the consumer by saying something like, "You seem very upset and I am not sure why. Could we talk about what is upsetting you before we start?"
  - To get an angry person to open up, explain (or re-explain) your purpose and that you need them to help you so you can best understand their needs and how the program can help them.
  
- **The Consumer who is Sad or Grieving** – If the consumer is overcome by sadness and starts to cry:
  - Don't ignore or pretend they are not upset or crying. In some cases, it may not be obvious about the reasons for the sadness/grief, which may not become apparent until you ask a specific question that triggers the sadness/grief. Be direct but polite and sensitive. Let them talk briefly about the reason for their sadness/grief. You may say something like, "I'm sure that is very difficult for you," or "I'm sorry."
  - Try to be reassuring and let them know it is safe to express their feelings. A comment like, "It is okay to cry; we all cry," or "I understand" can be effective.
  - Validate the situation by saying something like, "I have had other consumers who have the same reaction. It is hard." Or "These are difficult issues you're dealing with. It is very normal."
  - If the consumer is too distraught about a recent death or other stressful event to focus on the issues you need to discuss for your assessment, it might be more appropriate to offer to reschedule the interview.
  
- **The Consumer who Rambles without Focus** – These consumers often want to tell long stories and often have a difficult time getting to 'the point.'
  - Remind the consumer of the goal of the interview. "That is very interesting Mrs. Jones. I really need to find out the details of how you get along each day so that I can help you get the services that you need. Can you tell me specifically how you prepare your meals?"
  - Rephrase the question in a more closed-ended question such as "I understand there have been many issues with your personal care. Do you need help with bathing?" If they answer "yes", you can then probe for specifics.

- **The Consumer who Answers with Only a Word or Two** – This can be very difficult because without information it is hard to get an accurate picture of the consumer’s need.
  - Use open-ended questions to try to get the consumer to give you a better picture.
  - Ask the consumer to paint you a picture of their day by saying “Tell me what your day normally looks like.” It is difficult to answer a question like this with one or two words and may get them to open up, or will allow you opportunities to probe for further information.
  
- **The Consumer who is Embarrassed** – Some of the questions asked during the interview may be embarrassing to consumers, especially those related to bowel and bladder care and menstruation.
  - Reassure the consumer and acknowledge that these may be embarrassing questions but that you need the information so they can get the assistance they need. You might say “I know this may be embarrassing for you but I need to find out exactly what your needs are. Now you had said you have problems getting around. I’m wondering if that makes it difficult for you to get to the bathroom in time and causes you to have accidents.”
  
- **Communication Blocks**
  - Hearing difficulties –
    - Ask the consumer if they have a hearing aid. If they do, check to see if it is in and turned on. If the consumer cups his/her hand over the ear, the hearing aid will whistle if it is turned on.
    - Talk slowly without jargon.
    - If the person doesn’t seem to understand, paraphrase yourself.
    - Ask if one ear is better than another and then position yourself on that side.
    - You may need to follow up with a family member to clarify information.
  
  - Language barriers –
    - If they understand and speak some English, make sure speak slowly, give them plenty of time to think of their answers, and do not compound your questions.
    - Follow State regulations [MPP 21-115] and county procedures to arrange for an interpreter if the consumer does not speak English and you do not speak his/her language.

## EXERCISE: RED FLAGS

### **Scenario #1:**

During a home visit or by phone call, the consumer reports that the provider works significantly fewer hours than authorized.

1. What potential red flags could this identify?

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2. How would this be identified?

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3. What follow-up questions are appropriate?

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4. What follow-up actions are appropriate?

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5. Things to consider in documenting this situation?

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## EXERCISE: RED FLAGS

### **Scenario #2:**

Consumer states that he never signs a timesheet because the provider takes care of this for him.

1. What potential red flags could this identify?

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2. How would this be identified?

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3. What follow-up questions are appropriate?

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4. What follow-up actions are appropriate?

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5. Things to consider in documenting this situation?

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## EXERCISE: RED FLAGS

### **Scenario #3:**

Elderly consumer resides with 45-year-old son who is an IHSS provider. At the home visit, you learn that the neighbor is providing services authorized by IHSS. The consumer states her son is hardly ever there and does not help her, but she does not want to have her neighbor be the IHSS provider because her son would get very angry and she is afraid of what he would do.

1. What potential red flags could this identify?

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2. How would this be identified?

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3. What follow-up questions are appropriate?

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4. What follow-up actions are appropriate?

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5. Things to consider in documenting this situation?

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## EXERCISE: RED FLAGS

### **Scenario #4:**

When leaving a reassessment of a couple who both receive IHSS, a neighbor approaches your car and tells you that the people who live next to him are committing fraud. He says that they call their provider the “Maid” and say they brag about not having to do any housework, meal preparation or laundry. He says that they’re always out in the yard working and take several walks in the neighborhood daily. He says they own some rental property down the street and are always doing repairs on the property.

1. What potential red flags could this identify?

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2. How would this be identified?

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3. What follow-up questions are appropriate?

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4. What follow-up actions are appropriate?

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5. Things to consider in documenting this situation?

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## IDENTIFYING AND ADDRESSING RED FLAGS

Issue(s) Involved		Observations	Follow-up Questions	Follow-up Actions	Documentation Hints <sup>1</sup>
1.	The consumer or authorized representative may have overstated the need for services.	During a home visit, you observe the consumer safely performing services that were authorized by IHSS.	You told me on my last visit here that you were not able to perform this task (safely or not at all). I am confused about this because I just observed you doing this safely. Can you please clarify this for me?	Contact the physician's office or other individuals or agencies that have knowledge about the consumer's need for services. Discuss inconsistencies.	Document your observation about the inconsistencies. Also document the questions that were asked and the responses. Document reasons for any actions taken as a result of discussions.
2.	The provider signs the timesheets for the consumer.	The consumer states that he never signs a timesheet because the provider takes care of this for him.	How do you keep track of the hours worked? How do you make sure your provider puts the correct hours on the timesheet if you do not sign the timesheet? Do you know that it is your responsibility to make sure that the hours on the timesheet are correct?	Follow county procedures regarding timesheet retrieval and review. Provide the consumer with educational fact sheets, and refer him to the timesheet video, available at the CDSS website.	Document the consumer's statements regarding not signing timesheets, as well as any responses to questions. Complete the IHSS Complaint of Suspected Fraud Form (SOC 2248) as appropriate.
3.	Services were not properly prorated.	On a home visit, you observe that the consumer is not alone in the home.	Earlier today, you indicated that you lived here alone, but I noticed that there was someone sleeping in one of the bedrooms. Can you please tell me who this person is and how long they have been here? How long will they be staying here?	Determine whether there is sufficient information to complete the IHSS Complaint of Suspected Fraud Form (SOC 2248).	Document your observations about other individuals being present in the home. Ask for the names of those present, and include the names and relationships to the consumer. Document all questions asked regarding the inconsistencies and the responses to the questions.

<sup>1</sup> If a fraud referral is indicated, please remember to always document the who, what, when, what happened, and what actions you are taking. Also document any follow-up conversations or consultations you have with others regarding the issue. Follow your county procedures regarding follow up on potential fraud issues. Complete the **IHSS Complaint of Suspected Fraud Form (SOC 2248)** as appropriate.

## IDENTIFYING AND ADDRESSING RED FLAGS

Issue(s) Involved	Observations	Follow-up Questions	Follow-up Actions	Documentation Hints <sup>1</sup>	
4.	Although a family member stated that the consumer needs PS, it appears that she may not meet the requirements for PS.	The consumer admits you into the home and is alone in the home. Although somewhat confused, she is able to answer most questions during the hour that you are there.	I notice that the person who provides services to you is not here right now. Can you tell me where they are and when they will be back? How often do you stay alone in the house/apartment? Have you had any problems when you are left alone such as you getting hurt? Do you worry about something happening when you are left alone? Are there any days when the person caring for you cannot leave you by yourself in the house/apartment?	Determine whether the consumer is safe at home alone. This may be an instance of excess authorization, or it may be an instance of provider neglect because the provider is not providing needed care. It may be necessary to follow up with the provider or schedule another home visit to validate the information provided.	Document the condition of the consumer and his/her functioning. Document the time you were there and that the provider was not there. If the consumer can reliably tell you when the provider is there, document how long she/he has been gone and how often she/he leaves the consumer alone. A referral to APS is probably needed based on neglect if the consumer seems to be at risk.
5.	The provider has been in jail but is still submitting timesheets.	A data match revealed that the provider was in jail during the time that timesheets were submitted.	We have received information that your provider is/was in jail. Can you tell me how long the provider has been in jail and who has been providing services to you during this time? Are you aware that it is against the law for the provider to submit timesheets for hours not worked?	Follow county policy to refer for investigation of potential provider fraud and/or collusion between the provider and consumer.	Include in the IHSS Complaint of Suspected Fraud Form (SOC 2248) all information discovered about the provider being in jail, the source of the information, the date of incarceration, the name of the facility, and all copies of relevant timesheets for the provider during the time of incarceration.

<sup>1</sup> If a fraud referral is indicated, please remember to always document the who, what, when, what happened, and what actions you are taking. Also document any follow-up conversations or consultations you have with others regarding the issue. Follow your county procedures regarding follow up on potential fraud issues. Complete the **IHSS Complaint of Suspected Fraud Form (SOC 2248)** as appropriate.

## IDENTIFYING AND ADDRESSING RED FLAGS

	Issue(s) Involved	Observations	Follow-up Questions	Follow-up Actions	Documentation Hints <sup>1</sup>
6.	A consumer might be the victim of neglect or fraudulent activity.	Attempts have been made to conduct home visits on two occasions. Each time, the person who answered the door said the consumer was sleeping and told you to come back some other time.	Attempt to explain why you must come in and assess the consumer. Ask if they can wake the consumer up. Tell them that you cannot continue to authorize IHSS if you are unable to complete the assessment.	If you still are refused admittance, discuss next steps with your supervisor. It may be necessary to get APS involved.	Document dates and times you attempted to enter the home and the fact that you attempted to explain why you needed to enter. Document the name(s) of the person(s) refusing admittance. Document any discussions with supervisors or others and the next steps that are planned. Complete the IHSS Complaint of Suspected Fraud Form (SOC 2248) as appropriate.
7.	The provider may be submitting timesheets but not performing the services.	An aged consumer resides with her son, who is designated as her IHSS provider. At the home visit, you learn that the neighbor is providing the services authorized by IHSS. The consumer states that her son is rarely there, but she is afraid of what her son would do if she stopped designating him as her provider.	Gather more information about the son and what her son does when he gets angry (assess his potential for violence and her level of vulnerability). If it seems that she is at risk by her son's behavior, tell the consumer that you will be making a referral to APS for them to help her.	Talk to your supervisor, make an APS referral, and complete the Complaint of Suspected Fraud Form (SOC 2248). Depending upon the results of an APS investigation, you may need to discuss alternate providers with the consumer. Provide the consumer with educational fact sheets as appropriate from the CDSS website concerning her duties as an IHSS employer and timesheet management.	Document statements made by the consumer at the time of the visit regarding her son not helping her and the neighbor doing all of the work. Also document what you told the consumer about the APS and fraud referrals and what you told her about not signing timesheets if her son has not worked. Document referrals and any discussions you have with your supervisor or other staff regarding the case.

<sup>1</sup> If a fraud referral is indicated, please remember to always document the who, what, when, what happened, and what actions you are taking. Also document any follow-up conversations or consultations you have with others regarding the issue. Follow your county procedures regarding follow up on potential fraud issues. Complete the **IHSS Complaint of Suspected Fraud Form (SOC 2248)** as appropriate.

## IDENTIFYING AND ADDRESSING RED FLAGS

	Issue(s) Involved	Observations	Follow-up Questions	Follow-up Actions	Documentation Hints <sup>1</sup>
8.	The provider of record has moved too far away from the consumer to reliably provide authorized IHSS services.	A data match or QA activity uncovered that the provider moved far away from the consumer, yet timesheets were still being submitted by the provider.	Do you know where your provider currently lives? When was the last time the provider was here? How many times per week does your provider come here to provide services? If the consumer says, for example, that the provider was there two days earlier and did the laundry, but there are piles of laundry in the residence, the consumer's statements cannot be relied upon as accurate.	If the provider is no longer able to provide services as needed, direct the consumer to the Public Authority to aid him/her in finding an appropriate replacement. Provide the consumer with educational fact sheets available at the CDSS website concerning the program rules and supervising a provider.	Document the questions that were asked and the consumer's responses to each question. Complete the IHSS Complaint of Suspected Fraud Form (SOC 2248) as appropriate.
9.	A consumer is listed as a provider for a different consumer.	A data match revealed that the consumer is listed as a provider of services for another IHSS consumer and is providing similar services to those he/she is authorized to receive.	We recently received information indicating that you not only receive IHSS, but you provide some of the same services that you receive to another IHSS consumer. Can you tell us how long you have been providing services to this person? Has your condition changed so that you no longer need some of the services IHSS has authorized? If so, when did the change occur? Can you explain why you have said in the past that you are unable to (name the services)? How is it that you are able to provide these same services to the other consumer?	Contact the consumer that this person is providing services for to get additional information. Consult with your supervisor about a possible fraud referral.	Document the questions that were asked and the consumers' responses to the questions. Complete the IHSS Complaint of Suspected Fraud Form (SOC 2248) as appropriate.

<sup>1</sup> If a fraud referral is indicated, please remember to always document the who, what, when, what happened, and what actions you are taking. Also document any follow-up conversations or consultations you have with others regarding the issue. Follow your county procedures regarding follow up on potential fraud issues. Complete the **IHSS Complaint of Suspected Fraud Form (SOC 2248)** as appropriate.

## IDENTIFYING AND ADDRESSING RED FLAGS

	Issue(s) Involved	Observations	Follow-up Questions	Follow-up Actions	Documentation Hints <sup>1</sup>
10.	A provider has subcontracted with his wife to provide IHSS for his consumer. She has not been fingerprinted or undergone a criminal background check.	At the home visit, a person who is not the enrolled provider is seen providing services.	How long have you been providing services to Mrs. Smith? Did you know that your husband cannot submit timesheets and be paid for services that he does not provide and that if he does, it is considered fraud? Are you aware that if you provide IHSS to anyone, you must first be fingerprinted and have a criminal background check?		Document all questions asked and the responses. Indicate if the provider understands the questions. Indicate what the provider's spouse states she plans to do and any follow up actions that you plan to take on this case.

<sup>1</sup> If a fraud referral is indicated, please remember to always document the who, what, when, what happened, and what actions you are taking. Also document any follow-up conversations or consultations you have with others regarding the issue. Follow your county procedures regarding follow up on potential fraud issues. Complete the **IHSS Complaint of Suspected Fraud Form (SOC 2248)** as appropriate.



### IHSS COMPLAINT OF SUSPECTED FRAUD FORM

Please fill in as much information as possible

Provider relationship to recipient: \_\_\_\_\_ County: \_\_\_\_\_

IHSS recipient name: \_\_\_\_\_ IHSS provider name: \_\_\_\_\_

IHSS recipient SSN: \_\_\_\_\_ IHSS provider SSN: \_\_\_\_\_

IHSS recipient DOB: \_\_\_\_\_ IHSS provider DOB: \_\_\_\_\_

IHSS recipient address: \_\_\_\_\_ IHSS provider address: \_\_\_\_\_

Complaint against recipient

Complaint against provider

#### A. REPORTING PARTY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Email: \_\_\_\_\_ Phone no.: \_\_\_\_\_

Relationship to IHSS participant: \_\_\_\_\_ No. in household: \_\_\_\_\_

How did you become aware of this information: \_\_\_\_\_

Name of person and Agency taking complaint: \_\_\_\_\_

#### B. REASON FOR COMPLAINT

Deceased  Recipient  Provider  Recipient residing in a care facility or hospital

Date of death: \_\_\_\_\_ Name of facility: \_\_\_\_\_

In Jail  Recipient  Provider  Abuse/neglect/maltreatment of recipient

Dates: \_\_\_\_\_ Dates of stay: \_\_\_\_\_

#### Provider Issues

- Being paid for services not provided
- Stealing from recipient
- Abuse/neglect/maltreatment of recipient
- County employee is IHSS provider
- Other (specify) \_\_\_\_\_

#### Recipient Issues

- Does not appear to Need Services
- Seen performing strenuous activities (such as yard work, sports, lifting heavy object, etc.)
- Seen driving
- Seen working If yes, where: \_\_\_\_\_
- Other (specify) \_\_\_\_\_

#### C. NARRATIVE DESCRIPTION (Actions observed, date observed, etc)

**D. CASE FILE INFORMATION (for County use ONLY)**

IHSS recipient name: \_\_\_\_\_

Authorized no. hours: \_\_\_\_\_

Case no.: \_\_\_\_\_

Date of last F2F: \_\_\_\_\_

No. in household: \_\_\_\_\_

Who conducted last F2F: \_\_\_\_\_

- Severely Impaired       Protective Supervision       Married       SSN verified

Program service(s) in question: \_\_\_\_\_

Rank in service(s): \_\_\_\_\_

- Caseworker contacted for information

Name of person completing: \_\_\_\_\_

Enclosures:

- Pay warrants (copy of front and back)     Other (specify) \_\_\_\_\_
- Timesheets

**E. INITIAL REFERRAL (for County use ONLY)**

- Sent to DHCS       Sent to DA/SIU for investigation
- APS/CPS       No action (provide explanation in section G)
- Sent for administrative action

Date referred: \_\_\_\_\_      Approximate case amount \$: \_\_\_\_\_

If referred to other than DHCS:     MOU with DHCS     Under \$500

**F. DETERMINATION (for County use ONLY)**

- Administrative action       Reassessment      Date: \_\_\_\_\_
- Reduced hours      \_\_\_\_\_ hours reduced
- Termination of services      \_\_\_\_\_ hours saved in termination
- Overpayment recovery in the amount of:      \$ \_\_\_\_\_ -
- To DA for prosecution for violation of PC(s):
- To DOJ for prosecution for violation of PC(s):
- No action – Case not viable (provide explanation in section G)

**G. EXPLANATION OF NON-VIABILITY (Add information obtained that rendered case non-viable)**

Investigator signature: \_\_\_\_\_      Date: \_\_\_\_\_

Attach additional case file information.  
Copy of complaint must be retained in county case file.

## IHSS COMPLAINT OF SUSPECTED FRAUD FORM INSTRUCTIONS

**Provider relationship to recipient:** Enter the provider's relationship to the recipient if known.

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

**IHSS recipient SSN:** Enter the recipient's social security number (SSN) if known.

**IHSS recipient DOB:** Enter the recipient's date of birth (DOB) if known.

**IHSS recipient address:** Enter the IHSS recipient's address if known.

**County:** Select the county where services are provided.

**IHSS provider name:** Enter the name of the provider. If the complaint is concerning more than one provider, indicate this in section C.

**IHSS provider SSN:** Enter the provider's SSN if known.

**IHSS provider DOB:** Enter the provider's DOB if known.

**IHSS provider address:** Enter the IHSS provider's address if known.

**Check one or both of the following options to indicate whom the complaint is against:** Complaint against recipient and/or complaint against provider.

### A. Reporting Party

**Name:** Enter the name of the person filing the complaint.

**Email:** Enter the email address of the person filing the complaint.

**Relationship to IHSS participant:** Record the relationship of the person filing the complaint to the recipient.

**How did you become aware of this information:** Record how the person filing the complaint knows of the information they are reporting.

**Date:** Enter the date the complaint was taken.

**Phone no.:** Enter the phone number of the person filing the complaint.

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

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

## **B** Reason for Complaint

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

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

**Date of death:** Record the date of death.

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

**Name of facility:** Enter the name of the facility, if known.

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

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

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

### **Provider Issues:**

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

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

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

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

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

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

**Recipient Issues:**

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

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

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

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

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

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

**C Narrative Description**

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

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

Use this section to provide the following information:

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

**Case no.:** Enter the IHSS case number.

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

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

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

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

Check any of the following applicable boxes:

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

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

**Married:** Check if the recipient is listed as married.

**Minor:** Check if the recipient is a minor.

**SSN Verified:** Check if Social Security Number was verified.

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

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

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

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

**Enclosures:**

Check the applicable boxes for any attached documents.

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

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

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

**E. Initial Referral** (for County use ONLY):

Check the box for the action taken on the case.

**Sent to DHCS:** Check if the initial referral was sent to DHCS.

**Sent to APS/CPS:** Check if the initial referral was sent to APS/CPS.

**Sent for administrative action:** Check if the initial referral was sent for administrative action.

**Sent to DA/SIU for investigation:** Check if initial referral was sent to DA/SIU for investigation.

**No action:** Check if no action was taken and provide explanation in section G.

**Date referred:** Record the date the referral was made.

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

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

**F. Determination****Check the box for the determined outcome of the case**

**Administrative action:** Check if the case was determined by administrative action.

**Reassessment:** Check if the case was determined by reassessment.

**Date:** Record the date of the reassessment.

**Reduced hours:** Check if the case was determined to reduce hours. Enter the number of hours that were reduced.

**Termination of services:** Check if the case was determined to terminate services. Enter the number of hours saved in termination.

**Overpayment recovery in the amount of:** Check if the case was determined to recover overpayment. Enter the amount of overpayment recovered.

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

code section.

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

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

**G. Explanation of Non-Viability**

Record information obtained that rendered the case non-viable.

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

**Date:** Record the date the report was completed.

## **PROSECUTION 101: AN OVERVIEW OF THE LIFE OF A CRIMINAL CASE**

### **Stages of a Criminal Prosecution:**

1. Investigation by Law Enforcement
  - Local police agencies
  - State agencies
  - Federal agencies
  - Special investigation units
  - Task forces
  - Case review and filing decision by District Attorney (DA)
  
2. Intake/Filing Review
  - Case review conducted by intake unit
  - Prosecutor's ethical standard: Cannot file unless evidence exists to prove the defendant guilty beyond a reasonable doubt
  - Facts of the crime, defendant's record, and local filing guidelines are all considered in determining whether a case is a felony or misdemeanor
    - Felony vs. Misdemeanor:
      - a. Felony – is punishable in state prison and/or probation. Most California felonies have 'triad' of prison sentences (low, middle, and upper terms)
      - b. Misdemeanor – punishable up to a year in county jail
  
3. Arraignment
  - Defendant is formally notified of the type and degree of charges(s) in court
  - May hire their own attorney, have one appointed for them if they are unable to afford one, or represent themselves
  - May enter a plea or continue to plea negotiation process
  
4. Early Settlement / Plea Negotiation
  - County may have special Superior Court Review (SCR) or Early Disposition Courts
  - Settlement offer may be made by DA
  - Defendant may accept, counter, or reject
  - Important to communicate early with DA regarding input on case
  
5. Preliminary Hearing
  - Constitutional right in felony cases
  - Must be held within 10 court days of arraignment or plea, whichever is later (unless waiver or good cause found)
  - Evidentiary hearing – DA must present evidence, defendant has option to present evidence
  - DA's burden to establish "sufficient cause" to believe defendant committed each element of the crime
  - Elements of crime are like ingredients in a recipe
  - Court may issue holding order, dismiss, or reduce charges
  - Defendant may plead following hearing
  - If no plea, case set for jury or court trial

6. Jury or Court Trial
  - Both defendant and The People have the right to trial by jury
  - DA must present evidence, defendant has option
  - Direct and circumstantial evidence may be used to prove elements and intent
  - DA has burden of proof beyond a reasonable doubt
  - Guilty verdict by jury must be unanimous
  - Jury or Court can return verdict of guilty, not guilty, or guilty of a lesser offense
  
7. Judgment and Sentencing
  - Following a plea or verdict, case may be referred to Probation Department for report for Court to consider a sentencing hearing
  - Defendant may make statement, produce letters, testimony for Court's consideration; DA may do the same
  - Victim has right to make impact statement
  - Defendant is sentenced for crime:
    - May be granted term of probation
    - May receive jail time
    - May receive alternative sentence (community service, electronic home monitoring, work project)
    - May be sent to prison
    - Restitution to program should be ordered
  
8. Probation / Parole
  - Grants of probation
    - 3-5 years standard for felonies
    - 1 year for misdemeanors
    - Terms vary
    - Victim restitution should be included
  - Parole
    - Following prison term, inmate released for a period of parole
    - Terms vary

**Notes:**

- *Sufficient Cause / Probable Cause* – State of the facts as would lead a person of ordinary caution or prudence to believe and conscientiously entertain a strong suspicion of the guilt of the accused.
- *Proof Beyond a Reasonable Doubt* – Proof that leaves juror / Court with abiding conviction that the charge is true.

Source: Laura West, Deputy District Attorney, Sacramento County District Attorney's Office, November 2010.

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

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

**Section I. Fraud Complaints**

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

**Section II. Early Detection Savings**

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

**Section III. Fraud Investigations - Completed**

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

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

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

<b>Section V. Totals (\$)</b>		
<b>A</b>	<b>Loss Identified to IHSS Program</b>	50
<b>B</b>	<b>Total Amount Identified for Collection through Court Ordered Restitution</b>	51
<b>C</b>	<b>Total Amount Identified for Collection through County Overpay Recovery</b>	52

<b>Section VI.1. Comments</b>	
53	

<b>Section VI.2. Comments</b>	
54	

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

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

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

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

### Section I. Fraud Complaints

Definitions:

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

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

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

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

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

The review is conducted in accordance with your county's process. These are initial outcomes determined this quarter regardless of when the

complaint was received. Record each complaint reviewed during the reporting quarter in every applicable outcome category. If a complaint was referred for county investigation and had an overpay recovery action initiated, mark "referred for county investigation" once and "referred for administrative action" once.

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

## Section II. Early Detection Savings

### Definitions:

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

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

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

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

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

## Section III. Fraud Investigations – Completed

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

A.1. Number of Investigations by Type – The number of complaints investigated during the reporting quarter, grouped by the type of fraud suspected. Record each complaint by the person(s) suspected of committing fraud at the time the

report is being completed. This may or may not be the same person(s) suspected when the original complaint was reported.

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

#### Section IV. Prosecutions – County

##### Definitions:

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

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

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

#### Section V. Totals (\$)

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

#### Section VI. Comments

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



**IHSS UHV FINDINGS REPORT**

**GENERAL INFORMATION** *(Attach additional sheets if necessary)*

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

**A. CASE FILE INFORMATION**

Primary language: _____	No. of providers: _____
No. in household: _____	Date of last F2F: _____
Authorized no. hours: _____	Who conducted last F2F: _____

Severely Impaired                       Minor  
 Protective Supervision  
 FI rank 5 service(s) (specify): \_\_\_\_\_  
 Case/Narrative notes reviewed

**B. RECORD OF ATTEMPTS TO CONTACT THE RECIPIENT** *(Provide details in Section E)*

Visits		Phone calls to recipient		Completed visit
1st	(date)   (time)	1st	(date)   (time)	
2nd	(date)   (time)	2nd	(date)   (time)	
3rd	(date)   (time)		Letter                      NOA (date)                      (date)	

**C. FINDINGS OF THE UHV** *(Provide details in Section F)*

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

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

Program Integrity concerns appear valid

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



**IHSS UHV FINDINGS REPORT INSTRUCTIONS****General Information**

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

**A. Case File Information**

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

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

## **B. Record of Attempts to Contact the Recipient**

### **Visits**

**1<sup>st</sup> home visit:** Record the date and time the first UHV was attempted, whether or not it was completed.

**2<sup>nd</sup> home visit:** Record the date and time the second UHV was attempted, whether or not it was completed.

**3<sup>rd</sup> home visit:** Record the date and time the third UHV was attempted, whether or not it was completed.

### **Phone calls to recipient**

**1<sup>st</sup> Recipient Phone Call:** Record the date and time the first phone call was made to the recipient.

**2<sup>nd</sup> Recipient Phone Call:** Record the date and time the second phone call was made to the recipient.

**UHV Follow-up Letter:** Record the date the UHV Follow-up letter was sent.

**NOA:** Record the date the Notice of Action was sent.

### **Completed Visit**

**Recipient ID Verified:** Check if the recipient ID was verified during the UHV.

**Provider Present:** Check if the provider was present during the UHV.

**Provider ID Verified:** Check if the provider ID was verified. Document the provider's name.

*Use section E to provide details of section B.*

**C. Findings of the UHV**

**Program Integrity Concerns Unsubstantiated:**

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

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

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

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

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

**It appears that the recipient is receiving adequate care:**

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

**Program integrity concerns appear valid:**

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

**Services appear to be authorized beyond need:**

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

**Services appear to be authorized below need:**

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

**Authorized services appear to not be sufficiently provided:**

Check if it appears that the recipient is not receiving

the level of services that they are authorized.

*Use section F to provide details of section C.*

**D. Report of Recommendations**

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

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

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

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

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

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

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

**Termination for non-compliance:** Check if the recommendation is the termination of the recipient's case for non-compliance with program requirements. For example, termination is recommended because the UHV was not conducted

due to no contact made or entry denied.

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

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

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

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

*Use section F to provide details of section D.*

**E. Case File and Visit Summary**

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

Add any other information from case file that seems relevant.

**F. Findings and Recommendations**

Record detailed findings and recommendations from section D.



CDSS

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



EDMUND G. BROWN JR.  
GOVERNOR

March 23, 2015

ALL-COUNTY INFORMATION NOTICE NO.: I-17-15

TO: ALL COUNTY WELFARE DIRECTORS  
ALL IHSS PROGRAM MANAGERS

**SUBJECT: ENTRY OF FRAUD COMPLAINTS AND APS/CPS/FRAUD  
REFERRALS INTO CASE MANAGEMENT, INFORMATION AND  
PAYROLLING SYSTEM (CMIPS)**

REFERENCES: CMIPS INFORMATIONAL NOTIFICATION, DATED FEBRUARY  
13, 2014; ACL NO. 13-83, IMPLEMENTATION OF THE UNIFORM  
STATEWIDE PROTOCOLS FOR PROGRAM INTEGRITY  
ACTIVITIES IN THE IN-HOME SUPPORTIVE SERVICES (IHSS)  
PROGRAM; SOC 2248, IHSS COMPLAINT OF SUSPECTED  
FRAUD FORM

The purpose of this All-County Information Notice (ACIN) is to provide CMIPS users with clarification to instructions provided in the CMIPS Informational Notification dated February 13, 2014.

**Fraud Complaints**

Information about fraud complaints shall not be entered in CMIPS case notes. Fraud complaints frequently consist of unsubstantiated allegations that may, upon investigation, prove unfounded. As CMIPS case records are visible to a number of county and state employees across California, adhering to this directive will help to protect the due process rights of recipients and providers who may not have committed any wrongdoing.

The proper forum for documenting IHSS fraud complaints is form SOC 2248, *IHSS Complaint of Suspected Fraud Form*.

**Fraud/APS/CPS Referrals**

When a county staff refers a case for internal administrative action or to another agency for investigation, e.g., Department of Health Care Services, district attorney or

REASON FOR THIS  
TRANSMITTAL

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

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Adult/Child Protective Services, limited information about the referral should be entered in the CMIPS *Case Investigation Screen*.

This information is limited to the date of the referral and the name of the agency (or internal department/group) to which the case has been referred.

Please note that fraud referrals are different than mere complaints, because the former have been fully triaged and have been determined to be appropriate for investigation. While both are documented on form SOC 2248, initial fraud complaint information is entered in Sections A through D, while triaged complaints that have advanced to the stage of fraud referrals are documented in Sections E and F and noted briefly in the CMIPS Case Investigation Screen. ACL No. 13-83, *Implementation of the Uniform Statewide Protocols for Program Integrity Activities in the In-Home Supportive Services (IHSS) Program* provides details about the proper procedure for handling fraud complaints and the fraud referral process.

For questions regarding the above information, please contact the Adult Programs Division, Adult Programs Policy and Quality Assurance Branch, Quality Assurance and Improvement Bureau, Program Integrity Unit at (916) 651-3494 or [ihss.pi@dss.ca.gov](mailto:ihss.pi@dss.ca.gov).

Sincerely,

***Original Document Signed By:***

HAFIDA HABEK, Chief  
Adult Programs Policy and Quality Assurance Branch  
Adult Programs Division



## ACTIVITY: THE YOUNG WOMAN AND THE SAILOR

### The Dilemma

A ship sank in a storm. Five survivors scrambled aboard two lifeboats. In one lifeboat were a sailor, a young woman, and a seriously ill old man. In the other boat were the young woman's fiancé and his best friend. Each lifeboat was equipped with two day's ration of water.

That evening the storm continued, and the two boats separated. The one with the sailor, the young woman, and the sick old man washed ashore on an island and was wrecked. The young woman searched all night in vain for the other boat or any sign of her fiancé.

The next day, the weather cleared, and still the young woman could not locate her fiancé. In the distance she saw another island. Hoping to find her fiancé, she begged the sailor to repair their boat and row her to the other island. The sailor agreed, on the condition that she take the sick old man's ration of water and give it to the sailor.

Distraught, she went to the old man and blurted out through tears, "I am facing a difficult decision and don't know what to do." He immediately responded, "I can't tell you what's right or wrong for you. Look into your heart and follow it." Confused by desperation, she agreed to the sailor's condition.

The next morning, the sailor fixed the boat and rowed her to the other island. Jumping out of the boat, she ran up the beach into the arms of her fiancé. Then she decided to tell him about the sailor's condition. In a rage he pushed her aside and said, "Get away from me! I don't want to see you again!" Weeping, she started to walk slowly down the beach.

Her fiancé's best friend saw her and went to her, put his arm around her, and said, "I can tell that you two have had a fight. I'll try to patch it up, but in the meantime, I'll take care of you."

## CASE SCENARIO – MARJORIE

### Part 1 – Making the Case

Marjorie is a 67-year-old woman who lives with her daughter, Betty, in a large three-bedroom house. Marjorie has been receiving IHSS for five years. She lived independently until two years ago when she moved in with her daughter because Betty was concerned about the decline in Marjorie's mental status. (Note: For this exercise, assume that Marjorie moved in with her daughter to receive IHSS.)

Marjorie's diagnoses include arthritis, hypertension and dementia. During Marjorie's last assessment, she was assessed for 283 hours of service which included 35.58 hours per week of Protective Supervision. A need for Protective Supervision was approved based on information from her doctor and daughter. This information indicated that Marjorie had, on several occasions, left the house and on two occasions had to be brought home by the police.

You have recently been assigned to Marjorie's case and performed a reassessment because Betty called and said that Marjorie had just returned from the hospital because she had a major stroke which left her pretty much confined to bed. During the reassessment, you discuss the need for Protective Supervision with Betty. You indicate to her that you believe Marjorie will no longer be eligible for Protective Supervision. You explain that the reason Marjorie previously qualified for this service was that she placed herself at risk for injury, hazard or accident because of her wandering and other behaviors. Betty appears to understand, but states that since her mother needs more help because she is confined to bed, she doesn't think the hours should change. After reviewing all of the services with Betty, you return to the office and prepare the necessary paperwork to complete the assessment. You also discuss the case with your supervisor and the RN who reviews all Protective Supervision cases. The RN contacts Marjorie's long-time physician who indicates verbally that because of the impacts of her stroke, Marjorie is no longer able to place herself at risk for injury, hazard, or accident. Although Betty feels like her mother needs more care and that the hours should not change, the actual total hours assessed were decreased to 116.87 hours per month and you've determined that Marjorie no longer qualifies for Protective Supervision. The assessed need for some other services was also changed because of the change in Marjorie's functioning and due to recent policy/program changes.

After receiving the NOA, Betty calls. She is in tears and states that she wants to have her mother reassessed. She states that nothing has changed since you were there, but she feels that you missed something during the assessment because Marjorie now requires more care than she did before. You tell her that unless something has changed, you will not be able to do a reassessment. She states that she cannot survive without the income and wants to know what she can do. You direct her to the information on the back of the NOA regarding her right to a hearing and provide her with the toll-free number.

You have received information indicating that Betty has requested a fair hearing. You have been asked by the county Appeals Worker to prepare information which substantiates the reasons for the decrease in hours. The Appeals Worker states that she has contacted Betty and she wishes to appeal all of the hours that were decreased.

### **Group Tasks**

#### **Group 1:**

1. Review the prior assessment and reassessment (Documentation Worksheet) for:
  - Domestic,
  - Meal Preparation,
  - Meal Cleanup, and
  - Routine Laundry.
2. Review service authorization specifics, and if your group does not agree with the assessment of any of the service categories, be prepared to state why and identify actions you would take prior to the hearing.
3. Be prepared to present your findings as if you are a witness in the fair hearing.

#### **Group 2:**

1. Review the prior assessment and reassessment (Documentation Worksheet) for:
  - Shopping for Food,
  - Other Shopping and Errands,
  - Ambulation, and
  - Moving In/Out of Bed (Transfer).
2. Review service authorization specifics, and if your group does not agree with the assessment of any of the service categories, be prepared to state why and identify actions you would take prior to the hearing.
3. Be prepared to present your findings as if you are a witness in the fair hearing.

**Group 3:**

1. Review the prior assessment and reassessment (Documentation Worksheet) the following services:
  - Bathing and Grooming,
  - Routine Bed Baths,
  - Dressing, and
  - Bowel and Bladder Care.
2. Review service authorization specifics, and if your group does not agree with the assessment of any of the service categories, be prepared to state why and identify actions you would take prior to the hearing.
3. Be prepared to present your findings as if you are a witness in the fair hearing.

**Group 4:**

1. Review the prior assessment and reassessment (Documentation Worksheet) the following services:
  - Feeding,
  - Repositioning/Rubbing Skin,
  - Care and Assistance with Prosthetic Devices,
  - Accompaniment to Medical Appointments, and
  - Protective Supervision.
2. Review service authorization specifics, and if your group does not agree with the assessment of any of the service categories, be prepared to state why and identify actions you would take prior to the hearing.
3. Be prepared to present your findings as if you are a witness in the fair hearing.

Service Category	Times Per Day	Times Per Week	Time per Occurrence	Auth Hours	Comments
Domestic				3:00	Guideline prorated by 2
Meal Prep				3:30	They eat together. 7.00 hours ÷ 2
Meal Cleanup				1:45	Clean up at same time 3.50 ÷ 2
Routine Laundry				:30	State guideline ÷ 2
Food Shopping				:30	State guideline ÷ 2
Other Shopping				:30	No proration per policy.
Respiration					
Bowel/Bladder	6	42	5 min.	3:30	Help on and off toilet
Feeding	3	21	10 min.	3:30	Needs help with all meals
Bed Baths					
Dressing	2	14	10 min.	2:20	Needs help putting on and taking off clothes
Menstrual Care					
Ambulation	10	70	5 min.	5:50	Stand by assistance needed
In/Out Bed	4	28	2 min.	:56	Gets in and out of bed 2 x day
Bathing/Oral Hygiene/Grooming	1	7	30 min	3:30	Cannot bathe or do other grooming
Rubbing Skin/ Repositioning					
Care/Assistance w/Prosthesis	3	21	5 min	1:45	Takes 5 medications
Accomp. To Med. Appts.				1:00	Goes to dr. 1 x month
Accomp. To Alt. Resources					
Paramedical					
Protective Sup.				35:35	PCSP SI – Eligible for 283 hours total IHSS.

## MARGORIE EXERCISE: HTG DOCUMENTATION WORKSHEET

Category	Documentation of Hours																		
	<p><b>Important: This Worksheet Should Be Used in Conjunction with Time Per Task Tools</b></p> <p><b><u>For all Tasks Include Time for Clean Techniques/Universal Precautions When Required</u></b></p>																		
<p><b>Domestic (Housework)</b></p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width: 20%;">FI Rank (Enter)</td> <td style="text-align: center;">5</td> </tr> <tr> <td>Guideline</td> <td>6.00 hours per month per household</td> </tr> </table>	FI Rank (Enter)	5	Guideline	6.00 hours per month per household	<table border="1" style="width: 100%; border-collapse: collapse; margin-bottom: 10px;"> <thead> <tr> <th style="width: 30%;">Task</th> <th style="width: 20%;">Total Need</th> <th style="width: 20%;">Adjustments</th> <th style="width: 30%;">Authorized</th> </tr> </thead> <tbody> <tr> <td>Routine housework per MPP</td> <td style="text-align: center;">1 hr 5 min</td> <td></td> <td style="text-align: center;">1 hr 5 min</td> </tr> <tr> <td>Additional time</td> <td style="text-align: center;">1 hr</td> <td style="background-color: #cccccc;"></td> <td style="text-align: center;">1 hr</td> </tr> </tbody> </table> <p>Reason for assistance:</p> <p style="text-align: right;"><b>TOTAL 2:05 HRS</b></p> <p><b>Confined to bed. Cannot do any housework.</b></p> <p>Additional information to document Need and Adjustments (include shared living factors and other factors such as size of dwelling, Alt. Resources, etc.):</p> <p><b>Moved in with daughter to receive IHSS. Uses 1 room exclusively. Allow 1:05 hours per room. In addition, allow 1.00 hour per month for frequent bed changes due to incontinence.</b></p> <p>Reason for more or less time than guideline (extra bedding changes, etc.):</p>	Task	Total Need	Adjustments	Authorized	Routine housework per MPP	1 hr 5 min		1 hr 5 min	Additional time	1 hr		1 hr		
FI Rank (Enter)	5																		
Guideline	6.00 hours per month per household																		
Task	Total Need	Adjustments	Authorized																
Routine housework per MPP	1 hr 5 min		1 hr 5 min																
Additional time	1 hr		1 hr																
<p><b>Laundry</b></p> <p>In home <input type="checkbox"/> Out-of-home <input type="checkbox"/></p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width: 20%;">FI Rank (Enter)</td> <td style="text-align: center;">5</td> </tr> <tr> <td>Guideline In-Home</td> <td>1.00 hour per week</td> </tr> <tr> <td>Guideline Out-of-Home</td> <td>1.50 hours per week</td> </tr> </table> <p><i>Note: Laundry facilities on premises of apartment complex, mobile home park, etc. considered in-home (DSS Policy)</i></p>	FI Rank (Enter)	5	Guideline In-Home	1.00 hour per week	Guideline Out-of-Home	1.50 hours per week	<table border="1" style="width: 100%; border-collapse: collapse; margin-bottom: 10px;"> <thead> <tr> <th style="width: 30%;">Task</th> <th style="width: 20%;">Total Need</th> <th style="width: 20%;">Adjustments</th> <th style="width: 30%;">Authorized</th> </tr> </thead> <tbody> <tr> <td>Routine laundry</td> <td style="text-align: center;">1 hr 30 min</td> <td></td> <td style="text-align: center;">1 hr 30 min</td> </tr> <tr> <td>Additional time</td> <td></td> <td style="background-color: #cccccc;"></td> <td></td> </tr> </tbody> </table> <p>Reason for assistance:</p> <p style="text-align: right;"><b>TOTAL 1 hr 30 min</b></p> <p><b>Confined to bed. Cannot do any laundry.</b></p> <p>Additional information to document Need and Adjustments (include laundry done separately, etc.):</p> <p><b>Laundry done separately and extra laundry due to incontinence.</b></p> <p>Reason for more or less time than guideline (extra laundry due to incontinence, etc.):</p>	Task	Total Need	Adjustments	Authorized	Routine laundry	1 hr 30 min		1 hr 30 min	Additional time			
FI Rank (Enter)	5																		
Guideline In-Home	1.00 hour per week																		
Guideline Out-of-Home	1.50 hours per week																		
Task	Total Need	Adjustments	Authorized																
Routine laundry	1 hr 30 min		1 hr 30 min																
Additional time																			

### Shopping and Errands

FI Rank (Enter)	5
Guideline Food Shopping	1.00 hour per week
Guideline Other Shopping/Errands	0.50 hours per week

Task	Total Need	Adjustments	Authorized
Food shopping	1 hr	30 min	30 min
Other shopping/errands	30 min	15 min	15 min

Reason for assistance:

**Unable to do any shopping.** **TOTAL FOOD SHOPPING 30 min**  
**TOTAL OTHER SHOPPING 15 min**

Additional information to document Need and Adjustments (include distance to nearest store consistent with needs and economy, need for shopping to be done separately, etc.):

Reason for more or less time than guideline:

**Other shopping not prorated during prior assessment – error.**

### Meal Preparation

FI Rank (Enter)	5	
	Low	High
Rank 2	3.02	7.00
Rank 3	3.50	7.00
Rank 4	5.25	7.00
Rank 5	7.00	7.00

	Low	High
Rank 2	03:01	07:00
Rank 3	03:30	07:00
Rank 4	05:15	07:00
Rank 5	07:00	07:00

Needs help with  Breakfast  Lunch  Dinner

Meal	Example of Typical Meal	Need Per Meal	Times Per Week	Total Need
Breakfast	Tea/Toast/Poached Egg	5 min	7	35 min
Lunch	Soup/Sandwich	10 min	7	1 hr 10 min ÷ 2
Dinner	Meat/Veg/Potato	30 min	7	3 hr 30 min ÷ 2
Snacks	None per daughter.			

Reason for assistance:

**Needs total assistance.** **TOTAL 2 hours 55 mins**

Shared living exceptions (required when services not prorated):

Breakfast not prorated. **Per daughter. she does not eat breakfast. Brkfst prepared only for mom. Other meals are shared.**

Additional information to document exceptions to guidelines and identification of Alt. Resources such as MOW:

**Current assessment based on actual time for meals as stated by daughter.**

### Meal Cleanup

FI Rank (Enter)	<b>5</b>	
	<b>Low</b>	<b>High</b>
Rank 2	<b>1.17</b>	<b>3.50</b>
Rank 3	<b>1.75</b>	<b>3.50</b>
Rank 4	<b>1.75</b>	<b>3.50</b>
Rank 5	<b>2.33</b>	<b>3.50</b>

	<b>Low</b>	<b>High</b>
Rank 2	<b>01:10</b>	<b>03:30</b>
Rank 3	<b>01:45</b>	<b>03:30</b>
Rank 4	<b>01:45</b>	<b>03:30</b>
Rank 5	<b>02:20</b>	<b>03:30</b>

Note: Assessed time should reflect actual schedule/frequency with which provider performs meal cleanup. Example: Consumer rinses all dishes and provider washes three times per week.

	Frequency (Daily, 3 x week, etc.)	Assessed Time Per Occurrence	Total Need
Breakfast			
Lunch	<b>Daily</b>	<b>10 min</b>	<b>1 hr 10 min ÷ 2</b>
Dinner	<b>Daily</b>	<b>15 min</b>	<b>1 hr 45 min ÷ 2</b>

Reason for assistance: **TOTAL 1 hr 28 mins**

**Confined to bed.**

Shared living exceptions:

Additional information to document exceptions to guidelines and identification of Alt. Resources:

**Breakfast and lunch dishes are done at same time. Takes 10 min. per dau.**

### Ambulation

FI Rank (Enter)	<b>5</b>	
	<b>Low</b>	<b>High</b>
Rank 2	<b>0.58</b>	<b>1.75</b>
Rank 3	<b>1.00</b>	<b>2.50</b>
Rank 4	<b>1.75</b>	<b>3.50</b>
Rank 5	<b>1.75</b>	<b>3.50</b>

	<b>Low</b>	<b>High</b>
Rank 2	<b>00:35</b>	<b>01:45</b>
Rank 3	<b>01:00</b>	<b>02:06</b>
Rank 4	<b>01:45</b>	<b>03:30</b>
Rank 5	<b>01:45</b>	<b>03:30</b>

Task	Need Per Occurrence	Times Per Day	Times Per Week	Total Need
Walking inside home				
Retrieving assistive devices				
Assistance from house to car & in/out of car for medical appt. and to Alt. Resource				

Reason for assistance:

**No time allowed as consumer confined to bed.**

Additional information to document exceptions to guidelines and identification of Alt. Resources:

**Bathing, Oral Hygiene, and Grooming**

FI Rank (Enter)	<b>5</b>	
	Low	High
Rank 2	0.50	1.92
Rank 3	1.27	3.15
Rank 4	2.35	4.08
Rank 5	3.00	5.10

	Low	High
Rank 2	00:30	01:55
Rank 3	01:16	03:09
Rank 4	02:21	04:05
Rank 5	03:00	05:06

Task	Need Per Occurrence	Times Per Day	Times Per Week	Total Need
Assistance with getting in/out of tub/shower				
Oral hygiene	10 min	2	7	2 hrs 20 min
Grooming	5 min	1	7	35 min
Shampoo hair	30 min		1	30 min

Reason for assistance: **TOTAL 3 hr 25 min – 30 min = 2 hr 55 min**

**Cannot remember to groom self or how to brush teeth. Time includes getting and putting supplies away.**

Additional information to document exceptions to guidelines and identification of Alt. Resources:

**VNA helps her daughter shampoo hair 1 x per week in bed. Reduce auth. hrs by 30 min as this is an Alternative Resource. Does not get in tub or shower. Daughter gives bed baths.**

**Routine Bed Baths**

FI Rank (Enter)	<b>5</b>	
	Low	High
Rank 2	0.50	1.75
Rank 3	1.00	2.33
Rank 4	1.17	3.50
Rank 5	1.75	3.50

	Low	High
Rank 2	00:30	01:45
Rank 3	01:00	02:20
Rank 4	01:10	03:30
Rank 5	01:45	03:30

Task	Need Per Occurrence	Times Per Day	Times Per Week	Total Need
Bed baths	20 min	1	7	2 hr 20 min

Reason for assistance: **TOTAL 2:20 HRS**

**Cannot get into bathroom for shower or bath. Time based on dau. statement that it takes total of 20 minutes for bed bath including getting and putting away supplies.**

Additional information to document exceptions to guidelines and identification of Alt. Resources:

**Auth. hours reduced due to VNA coming to provide bed bath 3 times per week. 2 hr 20 min – 1.00 = 1 hr 20 min Auth.**

### Dressing

FI Rank (Enter)	5	
	Low	High
Rank 2	0.56	1.20
Rank 3	1.00	1.86
Rank 4	1.50	2.33
Rank 5	1.90	3.50

	Low	High
Rank 2	00:34	01:12
Rank 3	01:00	01:52
Rank 4	01:30	02:20
Rank 5	01:54	03:30

Task	Need Per Occurrence	Times Per Day	Times Per Week	Total Need
Assistance with clothing, shoes, socks/stockings	5	2	7	1 hr 10 min
Assistance with putting on/taking off corsets, elastic stockings, braces, etc.				
Bringing tools to consumer				
Reason for assistance:				TOTAL 1 hr 10 min
<p><b>Is not able to assist with dressing. Decrease from last year because she only wears nightgowns.</b></p> <p>Additional information to document exceptions to guidelines and identification of Alt. Resources:</p>				

### Bowel and Bladder Care

FI Rank (Enter)	5	
	Low	High
Rank 2	0.58	2.00
Rank 3	1.17	3.33
Rank 4	2.91	5.83
Rank 5	4.08	8.00

	Low	High
Rank 2	00:35	02:00
Rank 3	01:10	03:20
Rank 4	02:55	05:50
Rank 5	04:05	08:00

Task	Need Per Occurrence	Times Per Day	Times Per Week	Total Need
Assistance with getting on/off toilet/commode				
Wiping/cleaning consumer	2 min 5 min	5 2	35 14	1 hr 10 min 1 hr 10 min
Assist with using, emptying, cleaning bedpans/commodes, urinals, etc.				
Application of diapers	2 min	7	49	1 hr 38 min
Changing barrier pads	2 min	2	14	28 min
Reason for assistance:				TOTAL 4 hr 26 min
<p><b>Incontinent of B/B. Cannot get into bathroom.</b></p> <p>Additional information to document exceptions to guidelines and identification of Alt. Resources:</p> <p><b>Daughter states that takes about 1 hour per day to assist with bowel and bladder care. Could not provide details, therefore I used my best guess.</b></p>				

**Menstrual Care**

**Note: Functional Index Rank does not apply**

	<b>Low</b>	<b>High</b>
	<b>0.28</b>	<b>0.80</b>

	<b>Low</b>	<b>High</b>
	<b>00:17</b>	<b>00:48</b>

Task	Need Per Occurrence	Times Per Day	Times Per Week	Total Need
External application of sanitary napkins				
Using/disposing barrier pads				
Reason for assistance: <b>N/A</b>				
Additional information to document exceptions to guidelines and identification of Alt. Resources:				
<b>Note: Remember that hours on SOC 293 are weekly. For menstrual care, in most cases, divide weekly need by 4.33 to authorize correct need.</b>				

**Transfer**

<b>FI Rank (Enter)</b>	<b>5</b>	
	<b>Low</b>	<b>High</b>
<b>Rank 2</b>	<b>0.50</b>	<b>1.17</b>
<b>Rank 3</b>	<b>0.58</b>	<b>1.40</b>
<b>Rank 4</b>	<b>1.10</b>	<b>2.33</b>
<b>Rank 5</b>	<b>1.17</b>	<b>3.50</b>

	<b>Low</b>	<b>High</b>
<b>Rank 2</b>	<b>00:30</b>	<b>01:10</b>
<b>Rank 3</b>	<b>00:35</b>	<b>01:24</b>
<b>Rank 4</b>	<b>01:06</b>	<b>02:20</b>
<b>Rank 5</b>	<b>01:10</b>	<b>03:30</b>

Task	Need Per Occurrence	Times Per Day	Times Per Week	Total Need
Assistance from standing, sitting, or prone position to another, or transfer from one piece of equipment or furniture to another				
Reason for assistance: <b>Does not need to be transferred. Confined to bed.</b>				
Additional information to document exceptions to guidelines and identification of Alt. Resources:				

**Feeding**

FI Rank (Enter)	3	
	Low	High
Rank 2	0.70	2.30
Rank 3	1.17	3.50
Rank 4	3.50	7.00
Rank 5	5.25	9.33

	Low	High
Rank 2	00:42	02:18
Rank 3	01:10	03:30
Rank 4	03:30	07:00
Rank 5	05:15	09:20

Task	Need Per Occurrence	Times Per Day	Times Per Week	Total Need
Feeding or related assistance with consumption of food and fluid intake	5 min	3	21	1 hr 45 min

Reason for assistance: **TOTAL 1 hr 45 min**

Additional information to document exceptions to guidelines and identification of Alt. Resources:

**I observed her drinking from a water bottle during the assessment, so I think she needs minimal help with eating. Above time should be sufficient.**

**Repositioning / Rubbing Skin**

*Note: Functional Index Rank does not apply*

	Low	High
	0.75	2.80

	Low	High
	00:45	02:48

Task	Need Per Occurrence	Times Per Day	Times Per Week	Total Need
Rubbing skin to promote circulation	5 min	2	14	1 hr 10 min
Turning in bed and other repositioning	5 min	5	35	2 hr 55 min
Range of motion exercises				

Reason for assistance: **TOTAL 4 hr 5 min**

**Daughter rubs skin in the a.m. and at night time. Per daughter is turned 5 times per day.**

Additional information to document exceptions to guidelines and identification of Alt. Resources:

**Care and Assistance with Prosthetic Devices and Assistance with Self-Administration of Medications**

**Note: Functional Index Rank does not apply**

	<b>Low</b>	<b>High</b>
	<b>0.47</b>	<b>1.12</b>

	<b>Low</b>	<b>High</b>
	<b>00:28</b>	<b>01:07</b>

Task	Need Per Occurrence	Times Per Day	Times Per Week	Total Need
Assistance with taking off/putting on and maintaining/cleaning prosthetic devices and vision and hearing aids				
Assistance with the self-administration of medications	<b>5 min</b>	<b>3</b>	<b>21</b>	<b>1 hr 45 min</b>
Reason for assistance:			<b>TOTAL 1 hr 45 min</b>	
Additional information to document exceptions to guidelines and identification of Alt. Resources:				

**Accompaniment to Medical Appts.**

Appt Type (Specify doctor, dentist, etc.)	Frequency of Visits	Travel Time Each Way	Total Monthly Need	Average Weekly Need*
<b>Doctor</b>	<b>1 x mo</b>	<b>1 hr</b>	<b>2 hr</b>	<b>28 min</b>
Reason for assistance:			<b>TOTAL 28 min</b>	
<b>Requires total assistance. Daughter must accompany. Must wait at doctor's but time not allowed per policy.</b>				
*Note: Remember that SOC 293 hours reflect weekly need, so monthly need must be divided by 4.33 to arrive at weekly need. (Example: 1.00 hour each way 1 time per month would be a monthly need of 2.00 hours ÷ 4.33 = .46 weekly)				

**Accompaniment to Alt. Resources**

*(Note: Assessed only when transport is to/from site where Alt. Resources provide IHSS-type services in lieu of IHSS. Example: Transport to Senior Center where consumer receives meal.)*

Name of Alt. Resource	Frequency of Visits	Travel Time Each Way	Total Monthly Need	Average Weekly Need*
Reason for assistance:				
*Note: Remember that SOC 293 hours reflect weekly need, so monthly need must be divided by 4.33 to arrive at weekly need. (Example: 1.00 hour each way 1 time per month would be a monthly need of 2.00 hours ÷ 4.33 = .46 weekly)				

<b>Heavy Cleaning</b>	<table border="1"> <tr> <td>Tasks to be performed:</td> <td>Hours Assessed</td> </tr> <tr> <td></td> <td></td> </tr> <tr> <td></td> <td></td> </tr> <tr> <td></td> <td></td> </tr> </table>	Tasks to be performed:	Hours Assessed							
Tasks to be performed:	Hours Assessed									
Reason for assistance:										
<b>Remove Ice, Snow</b>  <i>Note: Limited to removal of snow, or other hazardous substances from entrances and essential walkways when access to the home is hazardous.</i>	<table border="1"> <tr> <td>Tasks to be performed:</td> <td>Hours Assessed</td> </tr> <tr> <td></td> <td></td> </tr> <tr> <td></td> <td></td> </tr> </table>	Tasks to be performed:	Hours Assessed							
Tasks to be performed:	Hours Assessed									
Reason for assistance:  <i>Note: Remember that this service is seasonal and should not be authorized on a yearly basis.</i>										
<b>Yard Hazard Abatement</b>  <i>Note: Limited to light work in the yard for removal of high grass or weeds and rubbish when constituting a fire hazard.</i>	<table border="1"> <tr> <td>Tasks to be performed:</td> <td>Hours Assessed</td> </tr> <tr> <td></td> <td></td> </tr> <tr> <td></td> <td></td> </tr> </table>	Tasks to be performed:	Hours Assessed							
Tasks to be performed:	Hours Assessed									
Reason for assistance:  <i>Note: Remember that this service should not be routinely authorized on an ongoing basis.</i>										

## ADDENDUM TO CASE SCENARIO – MARJORIE

### Strengthening Your Case / Establishing Credibility

The following are some of the ways the social worker can establish credibility during the hearing:

1. The social worker should be prepared to describe her experience in the IHSS program, if asked about this by the ALJ. S/he should include the number of years s/he has been performing assessments, and any specific training that they have had that is job related or helps them in their job.
2. Provide general information about their caseload that is related to the case being appealed. In this scenario, this would include assessing Protective Supervision, cases involving the elderly, and cases involving people who have had strokes and are confined to bed.
3. If you performed any research which supports your needs assessment, present any written evidence for inclusion in the record. (Examples: Copies of Internet articles or informational material that has been provided to Training Academy participants regarding diseases, mental illness, etc.)
4. Information should be provided about the actual assessment. Also include information regarding others that you discussed the assessment with including any county nursing staff, doctors, or their staff. If possible, have statements signed by the individuals involved that can be admitted to the hearing record.
5. The social worker should be prepared to show that they did a thorough investigation and considered all of the tasks that are included within each category of service. This would include amount of time spent performing the assessment.
6. If there were telephone discussions or a reassessment was done prior to the hearing, this information should also be presented along with a description of what was discussed and the outcome of these conversations or re-evaluations. Copies of documents from the case file including narrative notes which document conversations or reassessments and any follow-up letters should be presented for inclusion into the record. If agreements were made to change the assessment on any of the services prior to the hearing, also include this information.

### Possible Issues that May Arise at the Hearing – Questions and Answers

1. The consumer appears with a representative from an advocacy group to represent her. You did not know prior to the hearing that she had an Authorized Representative (A/R).

**Response: The consumer is not required to notify the county that they will have a representative at the hearing. There is no response required.**

2. The county begins by presenting the reasons for the reduction in services. When it is time for the consumer and A/R to make statements, the ALJ indicates to them that he has a 90-year-old mother with similar medical problems and he understands how family members end up giving 24-hour care.

**Response:** This information, in itself, would not be an indication that the ALJ should be recused. If this type of situation does occur, SWs should be diligent in presenting all of the facts in the case. If the SW does not provide full and clear facts, a greater possibility for bias and assumptions exists.

If the county feels that the hearing decision does not reflect the actual facts and documentation that were presented in the case, the county should ask for a re-hearing and indicate that they feel that the ALJ may have been biased based on his/her own experience with a relative with similar needs.

3. The A/R begins by stating that she has the entire record from the most recent hospital stay that she would like to have admitted to the record. She states the hospital record shows much care is required and supports the argument that hours should not be reduced.

**Response:** The county may request that the hearing record be left open so that they can have an opportunity to review the information to see if it would change the assessment. In all cases where new information is presented, the ALJ will give the county an opportunity to review the material at the hearing. Because there is a large amount of material that is being asked to be included in the record, the ALJ may ask the A/R to narrow down what is being submitted to what is pertinent in this case. For example, the hospital discharge summary and any discharge planner's notes and doctor's discharge orders should give a clear indication of the condition of the consumer at the time of discharge. In this case, because there is a significant amount of material being submitted, it is reasonable to ask that the record be left open.

4. The A/R states that in addition to the services that were reduced or eliminated, it is clear that there are other services where there are not enough hours assessed, and there are services needed where no time was given. For example, she states that the consumer now has a decubitus which requires dressing changes two times per day.

**Response:** The ALJs will try to address all issues that existed at the time of the assessment in the current hearing with the goal of avoiding an additional hearing in the future, which is beneficial to all involved. If new services are requested, the ALJ will probably ask if the need for those services existed at the time of the assessment. If they did, they will be included in the hearing even if the need for the service was not identified in the assessment. In the case of the decubitus, if the decubitus existed at the time of the assessment, the ALJ would probably indicate that the matter will be included in the hearing decision and would leave the record open to allow the county to obtain a SOC 321 and assess the need. *(Hopefully, in cases where a consumer is confined to bed, the SW will address the issue of skin condition/existence of decubiti during the assessment process.)*

5. The A/R states that some services were reduced due to the availability of an alternative resource, Visiting Nurses Association (VNA). She states that VNA has recently indicated they are no longer able to provide those services.

**Response:** This is new information for the county. Although, the county cannot be expected to act on information that has not been made available, it would be reasonable for the county to agree to increase the hours based on the VNA services no longer being available. (The county already knows how much additional time should be assessed because this time was deducted from the individual need identified on the SOC 293 when determining the hours to be authorized for purchase.)

6. The A/R presents a letter from the consumer's new doctor and a Protective Supervision form (SOC 821) stating that she needs Protective Supervision. The county has not reviewed the letter or the form. The letter states that because Marjorie is confined to bed, she is not able to get out of the house in case of an emergency. There is no indication of any behavior which places her at risk for injury, hazard, or accident.

**Response: The county should respond that the information received from the new doctor is new and that the new doctor may not be familiar with IHSS Protective Supervision and what the criteria is, and that there is no indication in the doctor's statement that indicates that the consumer places herself at risk. The county should indicate that they based their assessment on the information received from Marjorie's long-time doctor. The county should also reference court cases which apply in Protective Supervision which are applicable (*Calderon v. Anderson*).**

## **CASE SCENARIO – SOC 2248 COMPLETION**

You receive a call from Michelle, the daughter of an IHSS consumer. She reports that her sister, Elena, who is enrolled as the IHSS provider for their mother, Doris, has become unreliable and is not providing the authorized services consistently. Michelle suspects that Elena is claiming wages for hours not worked.

Michelle says that she has talked with her mother about her concerns, but Doris has always protected Elena, who has had problems throughout her life. Her mother does not want to make waves or fire Elena.

Michelle also has witnessed that Elena sometimes sends one of her teenage children to make meals for Doris or complete household chores while claiming the hours for herself.