IN-HOME SUPPORTIVE SERVICES
QUALITY ASSURANCE INITIATIVE

FORMS WORKGROUP

FRIDAY, AUGUST 12, 2005

10:00 A.M. – 12:30 P.M.

LOCATION:

HEALTH & HUMAN SERVICES TRAINING CENTER
9323 Tech Center Drive, Conference Room 3
Sacramento, California

Attached for your review: Meeting agenda, June 7th meeting summary, Provider Enrollment form-Draft C1; and Final Drafts of Protective Supervision and 24-Hour-A-Day care Plan forms

Note: If reasonable accommodations are needed to attend this meeting, or if you need the meeting materials provided to you in an alternate format including Braille, large print, computer disk or tape cassette, please contact Andrea Allgood at 916-229-3494 before 4PM on Friday, August 5, 2005.

AGENDA

FORMS WORKGROUP

IN-HOME SUPPORT SERVICES
QUALITY ASSURANCE INITIATIVE

August 12, 2005

10:00 A.M. – 12:30 P.M.

LOCATION: Health and Human Services Data Center
9323 Tech Center Dr., Conf. Room 3, Sacramento

CALL IN CONFERENCE LINE NUMBER: 1-888-935-0258
PASS CODE: 54970

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- **Introductions/Housekeeping and Outcomes for today** — **10:00 am**
- **Review of 7/7 Forms Workgroup and 7/22 Provider Enrollment Sub-Group** — **10:15 am**
- **Provider Enrollment Form Group Discussion** — **10:30 am**

Break - - - - - - - - - - - - 11:15 am

- **Review finalized and/or additional forms** — **11:30 am**
- **Next Steps / Assignments** — **12:15 pm**
- **Adjourn** — **12:30 pm**

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◇ NEXT MEETING: ***Tentatively scheduled for THURSDAY, SEPT. 1, 2005*** **◇**

SUMMARY OF THE FORMS WORKGROUP

Organizer: CDSS Adult Programs, Quality Assurance Bureau

Location: Health & Human Services Data Training Center
9323 Tech Center Drive
Conference Room 2, Sacramento, California

Date / Time: July 7, 2005, 10:00am -- 12:30 pm

Meeting Objectives:

1) Clarify and complete the Protective Supervision form and 24-Hours-A-Day-Care Plan;
2) Further develop the Provider Enrollment form and clarify requirements needed to complete and finalize;
3) Review any other forms that may need to be reviewed by the Workgroup.

Meeting Summary:

The meeting began shortly after 10:00am, with introductions by all attendees and co-chairs Pam Borrelli and Jeannie Smalley. Two attendees connected by conference call.

Protective Supervision Form -- The Workgroup reviewed the draft "D" of the Protective Supervision form. It was decided that the form would move forward with current Regulations as the guide. When the Regulations change the form will then be revised to incorporate any updates.

Protection and Advocacy, Inc. submitted concerns regarding two court decisions, Calderon v. Anderson and Marshall v. McMahon, as they both involved Protective Supervision. In reviewing the decisions, participants did not see where the two decisions broadened the scope of Protective Supervision. The Workgroup responded to the concerns and approved the form as drafted.

Draft "D" of the Protective Supervision form was reviewed and approved by the Workgroup as the final draft, with two minor changes being: 1) to add in the closing sentence, top paragraph, "Thank you for your assistance in determining eligibility for Protective Supervision"; and 2) on the physician's signature line, add area to list the professional specialty. (See "Final Draft" attached.)

The Workgroup decided not to add at the bottom or elsewhere on the form that the physician needs to be aware that the form may be used in an Administrative Hearing. It was felt that this could dissuade a physician from completing and returning the form, and that physicians are aware of program compliance issues and hearing issues. However, the Workgroup did acknowledge that adding "Thank you for your assistance in determining eligibility for Protective Supervision" would help indicate that this a document that was being used to determine needs for their patient.

The Workgroup also agreed that it is important that the forms remain as "clean" as possible, making it easier to understand and capture information.

SUMMARY OF THE FORMS WORKGROUP

The 24-Hour-A-Day Care Plan form was reviewed and minor suggestions made to finalize the form. This is an optional form that will be available for counties to use in determining Protective Supervision care plans. (See "Final Draft" attached.)

The Provider Enrollment form received much detailed scrutiny and a number of valid suggestions were made. It was determined that a sub-group be formed to review specific requirements on the Provider Enrollment form. This sub-group will meet on July 22nd, prior to the next Workgroup meeting scheduled for August 12, 2005, to draft a more complete Provider Enrollment form. Jeannie asked for volunteers to contact her if interested in participating on the sub-group.

The Workgroup discussed the need to incorporate "child abuse" along with "adult abuse" in the heading when declaring that providers are mandated reporters.

It was also discussed if a synopsis of Penal Code 273(a) and 368, needs to be noted on the form, since they are to be attached to the Provider Enrollment form as stated in SB1104. It was stated that if a person was convicted of either of those laws, he/ she would be aware of the penal code. And if he/she had not been convicted of that crime or other crimes they would be aware, and able to state "No" to questions regarding if they had committed these crimes. It was also discussed that in CalWORKS, if a person was convicted of a drug related felony, they are excluded from the aid program, and there is no need to explain the regulation or provide a synopsis of that Penal Code.

In further review of the Provider Enrollment form Draft B, if the provider checks the "Yes" box that he/she has been convicted of a crime against a state or federal program, there is no need to explain when, etc., in the other space provided – this space can be eliminated.

It was discussed that the Provider Enrollment form and attachments will need to be translated into many languages. The form needs to incorporate the necessary information that is currently on the Personal Care Services Program Provider/ Enrollment Agreement form (SOC 426), so that form can be eliminated. The form is not exactly a replacement for the SOC 426, but is required by SB1104 and to meet federal funding requirements. The form also needs to have the client's name and case number on it for identification purposes and appropriate filing at the county level.

Other questions that will need to be reviewed are: 1) Does the client (employer) get a copy of this form? 2) Does the client (employer) need to know the IP's social security card number and his/ her driver's license or CAL ID number and other personal identifying information? Advance pay clients already have the identifying information from providers. However, these questions brought up trust issues and if the provider knows the client's information is it fair that the client knows the provider's?

Additional questions that were brought up for further discussion were: 1) there needs to be a way to cross reference employee fraud; and 2) if we need to have the client's signature also on the form?

SUMMARY OF THE FORMS WORKGROUP

Parking Lot Issues

- Are we concerned with other penal code violations?
- It's frustrating to not be able to ask about other felony convictions. There are currently regulations in affect that allow the provider to be fingerprinted.
- Different counties and Public Authorities have different levels of clearances provided at the county level. How will the forms all fit?

Meeting adjourned at 12:30 pm

Meeting Attendees:

Name	Organization
1. Pam Borrelli, Co-Chair	San Mateo County IHSS
2. Jeannie Smalley, Co-Chair	CDSS – QA Monitoring Unit
3. Bill Weidinger	Contra Costa Co EHSD
4. Brian Koepp	CDSS. QA Bureau
5. Maher Dimachkle	Dept. of Health Services
6. Betty Goertzen	IHSS AC Fresno
7. Stan Kubochi	Sacramento County District Attorney
8. Jim Newton	Sacramento County IHSS Fraud Investigations.
9. Damon Nelson	Sacramento Public Authority
10. Sharon Rehm	Sacramento County QI/QA
11. Toua Thao	Sacramento County IHSS
12. Susan Schwendimann	Sacramento County IHSS
13. Judy Leavell	Sacramento County IHSS
14. Kathleen Schwartz	Sacramento County, IHSS
15. Melody McInturf	Sacramento County, IHSS
16. Cyndee Forbes	Sacramento County, IHSS
17. Jan Dancy	Sacramento County, IHSS
18. Guy Howard Klopp	Sacramento County QI/QA
19. Fay Mikiska	IHSS Advisory Committee
20. Gregg Gibelot	CDAA
21. Rosa Hildago	Public Authority, San Bernardino
22. Ken Field	Shasta Co. Public Authority
23. Stormaliza Powmacinicalord	Consumer
24. Ann Coller	PAI
25. Julia Pascencia	SEIU 434B Los Angeles
26. Laurie Silva	CDSS - QA
27. Karan Spencer	CDSS - QA
28. Debbie Wender	CDSS - QA
29. Jennifer Posehn	CDSS
30. Sharleen Lock	DSS – via conference call
31. Dennis Dishaw	CDCAS – Via conference call

1In-Home Supportive Services Program
Provider Enrollment Statement

Persons who provide In-Home Supportive Services are Mandated Reporters.
Report any suspected child, elder or dependent-adult abuse to your local authorities immediately.

Instructions:

- This form must be completed prior to enrollment for each provider/recipient relationship.
- Part I is to be completed by the provider.
- Part II is to be completed by the recipient or authorized representative as long as the authorized representative is NOT the provider.
- Part III is to be completed by the county.
- The original form is to be maintained by the county and a copy given to the provider and the recipient.

PART I – PROVIDER INFORMATION

Provider Name:	Date of Birth	Sex: M F
Home Address:		
Mailing Address (If Different):		
Telephone Number:	Social Security #:	
Drivers License # or Government issued ID #:	Expiration Date:	
Ethnic Origin:		

PROVIDER CERTIFICATION STATEMENT

- I certify that all claims I submit for services to In-Home Supportive Services Program (IHSS) recipients, will be provided as authorized through this program for the recipient.
- I certify that all claims submitted will be for IHSS services provided to the recipient only while the recipient is residing in their own home.
- I certify that all information submitted to the county will be accurate and complete to the best of my knowledge.

Within ten years of the date of this statement, have you been convicted or incarcerated following conviction for a crime involving fraud against a government health care or supportive services program? *An individual who, in the past ten years, has been convicted for, or incarcerated following a conviction for, fraud against a government health care or supportive services program is ineligible to be enrolled as a provider or to receive payment for providing supportive services.*	**Check one:** ☐ Yes ☐ No
Within ten years of the date of this statement, have you been convicted for, or incarcerated following conviction for, a violation of subdivision (a) of Section 273a of the Penal Code or Section 368 of the Penal Code, or similar violations in another jurisdiction? See attached. *An individual who, in the past ten years, has been convicted for, or incarcerated following a conviction for, a violation of subdivision (a) of Section 273a of the Penal Code or Section 368 of the Penal Code is ineligible to be enrolled as a provider or to receive payment for providing supportive services.*	**Check one:** ☐ Yes ☐ No

In-Home Supportive Services Program
Provider Enrollment Statement

PART I -- PROVIDER INFORMATION - CERTIFICATION STATEMENT, Continued

Fraud is a crime – It is an illegal act involving deception, intentional misrepresentation, or omission of facts and disclosures deliberately practiced to unlawfully gain or unfairly secure something of value.

If you commit fraud you can be prosecuted, convicted, go to jail, pay a fine, and be disqualified from providing services in the IHSS program for ten years.

By signing this form I understand that payment of these claims will be from federal and/or state funds and that any false statement, claim, or concealment of information may be prosecuted under federal and/or state laws. I agree to reimburse the state for any overpayments paid to me as determined in accordance with Welfare and Institutions Code Section 12305.83, and that the amount of any overpayment, individually or in the aggregate, may be deducted from any future warrant to me for services provided to any recipient of supportive services, as authorized in Welfare and Institutions Code Section 12305.83.

I, THE UNDERSIGNED, DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING STATEMENTS ARE TRUE AND CORRECT.

Provider Signature: _____ Date: _____

Print Provider's Full Name: _____

PART II – RECIPIENT INFORMATION

Recipient Name:	Identification / County Number:
Relationship to Recipient (if any):	Start Date (mm / dd / yyyy): Of Service:

I certify that the provider named above is my choice to provide services for me as authorized by the county:

Recipient's signature or Authorized Representative: _____ Date: _____

PART III – FOR COUNTY USE ONLY

SUMMARY OF IDENTIFICATION FROM DOCUMENTS VIEWED

Driver's License # or Government-Issued ID#: _____ *(Attach current and legible copy)*

California ☐ or Issuing State: _____ Expiration Date: _____

Social Security Number: _____-_____-_____

Name on Social Security card: _____
(Attach legible copy)

This is to certify that the above evidence was viewed on:_____
(Date)

By: _____
(County worker name and contact number)

Penal Code 273a.

(a) Any person who, under circumstances or conditions likely to produce great bodily harm or death, willfully causes or permits any child to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any child, willfully causes or permits the person or health of that child to be injured, or willfully causes or permits that child to be placed in a situation where his or her person or health is endangered, shall be punished by imprisonment in a county jail not exceeding one year, or in the state prison for two, four, or six years.

(b) Any person who, under circumstances or conditions other than those likely to produce great bodily harm or death, willfully causes or permits any child to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any child, willfully causes or permits the person or health of that child to be injured, or willfully causes or permits that child to be placed in a situation where his or her person or health may be endangered, is guilty of a misdemeanor.

(c) If a person is convicted of violating this section and probation is granted, the court shall require the following minimum conditions of probation:

(1) A mandatory minimum period of probation of 48 months.

(2) A criminal court protective order protecting the victim from further acts of violence or threats, and if appropriate, residence exclusion or stay-away conditions.

(3) (A) Successful completion of no less than one year of a child abuser's treatment counseling program approved by the probation department. The defendant shall be ordered to begin participation in the program immediately upon the grant of probation. The counseling program shall meet the criteria specified in Section 273.1. The defendant shall produce documentation of program enrollment to the court within 30 days of enrollment, along with quarterly progress reports.

(B) The terms of probation for offenders shall not be lifted until all reasonable fees due to the counseling program have been paid in full, but in no case shall probation be extended beyond the term provided in subdivision (a) of Section 1203.1. If the court finds that the defendant does not have the ability to pay the fees based on the defendant's changed circumstances, the court may reduce or waive the fees.

(4) If the offense was committed while the defendant was under the influence of drugs or alcohol, the defendant shall abstain from the use of drugs or alcohol during the period of probation and shall be subject to random drug testing by his or her probation officer.

(5) The court may waive any of the above minimum conditions of probation upon a finding that the condition would not be in the best interests of justice. The court shall state on the record its reasons for any waiver.

Penal Code 368.

(a) The Legislature finds and declares that crimes against elders and dependent adults are deserving of special consideration and protection, not unlike the special protections provided for minor children, because elders and dependent adults may be confused, on various medications, mentally or physically impaired, or incompetent, and therefore less able to protect themselves, to understand or report criminal conduct, or to testify in court proceedings on their own behalf.

(b) (1) Any person who knows or reasonably should know that a person is an elder or dependent adult and who, under circumstances or conditions likely to produce great bodily harm or death, willfully causes or permits any elder or dependent adult to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any elder or dependent adult, willfully causes or permits the person or health of the elder or dependent adult to be injured, or willfully causes or permits the elder or dependent adult to be placed in a situation in which his or her person or health is endangered, is punishable by imprisonment in a county jail not exceeding one year, or by a fine not to exceed six thousand dollars ($6,000), or by both that fine and imprisonment, or by imprisonment in the state prison for two, three, or four years.

(2) If in the commission of an offense described in paragraph (1), the victim suffers great bodily injury, as defined in Section 12022.7, the defendant shall receive an additional term in the state prison as follows:

(A) Three years if the victim is under 70 years of age.

(B) Five years if the victim is 70 years of age or older.

(3) If in the commission of an offense described in paragraph (1), the defendant proximately causes the death of the victim, the defendant shall receive an additional term in the state prison as follows:

(A) Five years if the victim is under 70 years of age.

(B) Seven years if the victim is 70 years of age or older.

(c) Any person who knows or reasonably should know that a person is an elder or dependent adult and who, under circumstances or conditions other than those likely to produce great bodily harm or death, willfully causes or permits any elder or dependent adult to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any elder or dependent adult, willfully causes or permits the person or health of the elder or dependent adult to be injured or willfully causes or permits the elder or dependent adult to be placed in a situation in which his or her person or health may be endangered, is guilty of a misdemeanor. A second or subsequent violation of this subdivision is punishable by a fine not to exceed two thousand dollars ($2,000), or by imprisonment in a county jail not to exceed one year, or by both that fine and imprisonment.

(d) Any person who is not a caretaker who violates any provision of law proscribing theft, embezzlement, forgery, or fraud, or who violates Section 530.5 proscribing identity theft, with respect to the property or personal identifying information of an elder or a dependent adult, and who knows or reasonably should know that the victim is an elder or a dependent adult, is punishable by imprisonment in a county jail not exceeding one year, or in the state prison for two, three, or four years, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value exceeding four hundred dollars ($400); and by a fine not exceeding one thousand dollars ($1,000), by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value not exceeding four hundred dollars ($400).

(e) Any caretaker of an elder or a dependent adult who violates any provision of law proscribing theft, embezzlement, forgery, or fraud, or who violates Section 530.5 proscribing identity theft, with respect to the property or personal identifying information of that elder or dependent adult, is punishable by imprisonment in a county jail not exceeding one year, or in the state prison for two, three, or four years when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value exceeding four hundred dollars ($400), and by a fine not exceeding one thousand dollars ($1,000), by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value not exceeding four hundred dollars ($400).

(f) Any person who commits the false imprisonment of an elder or a dependent adult by the use of violence, menace, fraud, or deceit is punishable by imprisonment in the state prison for two, three, or four years.

(g) As used in this section, "elder" means any person who is 65 years of age or older.

(h) As used in this section, "dependent adult" means any person who is between the ages of 18 and 64, who has physical or mental limitations which restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age. "Dependent adult" includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code.

(i) As used in this section, "caretaker" means any person who has the care, custody, or control of, or who stands in a position of trust with, an elder or a dependent adult.

(j) Nothing in this section shall preclude prosecution under both this section and Section 187 or 12022.7 or any other provision of law. However, a person shall not receive an additional term of imprisonment under both paragraphs (2) and (3) of subdivision (b) for any single offense, nor shall a person receive an additional term of imprisonment under both Section 12022.7 and paragraph (2) or (3) of subdivision (b) for any single offense.

(k) In any case in which a person is convicted of violating these provisions, the court may require him or her to receive appropriate counseling as a condition of probation. Any defendant ordered to be placed in a counseling program shall be responsible for paying the expense of his or her participation in the counseling program as determined by the court. The court shall take into consideration the ability of the defendant to pay, and no defendant shall be denied probation because of his or her inability to pay.

Assessment of Need for Protective Supervision for In-Home Supportive Services Program

☐ *Release of Information Attached*

Attending	Patient's Name:	DOB: / /
Physician's /	Medical ID#:	County ID#:
Medical Professional's	IHSS Social Worker's Name:	
mailing address	County Contact Telephone #:	County Fax #:

Your patient is an applicant/recipient of **In-Home Supportive Services** (IHSS) and is being assessed for the need for Protective Supervision. Protective Supervision is available to monitor the behavior of non self-directing, confused, mentally impaired or mentally ill persons.

Protective Supervision is **not** available when : (1) the need for supervision is caused by a physical condition rather than a mental impairment;
(2) prevention or control of antisocial or aggressive behavior is necessary, (including self-destructive behavior, destruction of property, or harming others); or
(3) a medical emergency (such as seizures, etc.,) is anticipated.

Please complete this form and return it promptly. Thank you for your assistance in determining eligibility for Protective Supervision.

Date patient last seen by you:	Length of time you have treated patient:
Diagnosis / Mental Condition:	Prognosis: ☐ Permanent ☐ Temporary – Timeframe: _____

Please check the appropriate boxes

MEMORY

☐ No deficit problem ☐ Moderate or intermittent deficit (explain below) ☐ Severe memory deficit (explain below)

Explanation: _____

_____

ORIENTATION

☐ No disorientation ☐ Moderate disorientation / confusion (explain below) ☐ Severe disorientation (explain below)

Explanation: _____

_____

JUDGMENT

☐ Unimpaired ☐ Mildly Impaired (explain below) ☐ Severely Impaired (explain below)

Explanation: _____

_____

1. Are you aware of any injury or accident that the patient has suffered due to deficits in memory, orientation or judgment? ☐ Yes ☐ No
   If yes, please specify: _____
   _____
2. Does this patient retain the mobility or physical capacity to place him/herself in a situation which would result in injury, hazard or accident? ☐ Yes ☐ No
3. Do you have any additional information or comments? _____
   _____

CERTIFICATION: I certify that I am licensed to practice in the State of California and that the information provided above is correct.

Signature of Physician or Medical Professional: _____ **Medical Specialty:** _____ **Date:** _____

Address: _____ **License No.** _____

_____ **Telephone**: (_____)_____

RETURN THIS FORM TO: COUNTY'S MAILING ADDRESS, CITY, CA,;ATTN: SW-NAME

PROTECTIVE SUPERVISION
24-HOURS-A-DAY COVERAGE PLAN

Please Print

Name of IHSS Consumer:	**Consumer's Telephone #:**
IHSS Consumer Address:	
Name of Primary Contact Responsible:	**Contact's Telephone #:**
Relationship to Consumer:	

As the primary contact for arranging the 24-hour-a-day coverage plan for the above named consumer, I acknowledge my understanding of the following:

- A 24-hour-a-day coverage plan has been arranged and is in place.
  The continuous 24-hour coverage plan can be met regardless of paid In-home Supportive Service (IHSS) hours, through any of the following, or combination of services:
  1. *IHSS;*
  2. *Alternate resources;*
  3. *A reassurance phone service when feasible and appropriate.*
- The 24-hour-a-day coverage plan will be provided at all times.
- If there is any change to the 24-hour-a-day coverage plan (i.e. hospitalizations, attendance in day-care programs, travel, etc., I will immediately **notify the IHSS social worker.**
- The above named consumer has an established need for 24-hour-a-day Protective Supervision if he/she is to remain safely in the home. The IHSS social worker has also discussed with me the appropriateness of out-of-home care as an alternative to 24-hour-a-day Protective Supervision.

Name of Care Provider (1):	**Contact Phone #:**
Name of Care Provider (2):	**Contact Phone #:**
Name of Care Provider (3):	**Contact Phone #:**

Describe the Protective Supervision 24-Hour-A-Day Coverage Plan implementation

Signature of Primary Contact Responsible:	Date:
Signature of IHSS Social Worker:	**Contact Phone #:**