Getting to the Door:

- Lock your car.
- Be prepared to drop items you are carrying.
- Do not stop to speak to strangers. If you must respond, keep walking.
- Before entering a fenced yard, make noise to see if any animals are present.
- Don't enter the home if an animal threatens your safety (ask the consumer to secure the animal).
- After knocking, stand away from the door and to one side if possible – hinge side is best for providing protection.
- In an elevator, stand near the control panel.
- Leave the area if your instincts tell you to.

Entering the Consumer's Home:

- Follow consumers up the stairs. Do not let them behind you.
- Scan the inside of the consumer's home before entering.
- Once in the home, look around for signs of dog. Ask if the dog is safe/friendly if it is locked up.
- Don't enter the home if you suspect that the consumer is under a chemical influence.
- Try to make eye contact with anyone present.
- Sit near an exit door and be prepared to leave at any sign of danger. Do not allow anyone between you and the door.

Acknowledge Anger if it Exists:

- People may escalate their anger if they aren't sure you know it exists.
- Remain calm, objective and in control.
- Avoid interviewing hostile people in the kitchen (knives).
- Use a problem-solving approach.

After the Visit:

- When returning to your car, have a co-worker or supervisor on the phone until you are in the car and on the road.
- Have your keys in your hand when returning to your car.
- Check the inside of your car before getting in.
- Document any unusual or unsafe conditions.
- Discuss concerns with your supervisor.
- Develop strategies to address concerns for future visits.

Vehicle Safety:

- Always check your tires and gas gauge before setting out on a visit.
- Park in a well lit area.
- Keep doors and windows locked.
- Do not leave anything on the seat of the car. Put all items in a trunk prior to arriving at your destination.

If a Crisis Arises:

- Talk softly.
- Try to keep calm.
- Tell the person you are expected elsewhere or a co-worker has been instructed to call for help if you are not out at an agreed time.

SOME SUGGESTIONS ABOUT DOGS

What to do when approached by or you approach a strange dog:

- Treat all breeds the same – all dogs bite.
- NEVER look the dog in the eye.
- NEVER pat the dog on top of its head.
- Don't give the dog undue attention.
- Be aware of your body language and voice tone (do/say nothing threatening).
- Older dogs are more likely to bite.
- NEVER turn your back on a dog or run away (walk slowly).

What to do when approached by an apparently vicious dog:

- Don't get out of your car if you're already in it.
- Do nothing that seems threatening to the dog. This includes spraying with pepper spray.
- Throw dog treats and/or tennis balls to distract the dog.
- Protect your face and neck. Do not play dead.
- Larger breeds have larger mouths.
- If bitten, go to your doctor. Bites must be reported to the Humane Society.

THE INTERVIEW

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. This conveys a sense of honesty and makes them feel that 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 assess with this consumer. Are there any cues from the initial information that help you to come up with an approach to the interview? For example: Is the consumer a native English speaker, blind, mentally-impaired?

Pre-interview Planning – Be Prepared

- Review case file and gather cues about consumer
- Formulate questions based on cues
- Plan interview approach

Meeting the Consumer – Establish Rapport

- Introductions should be formal and cordial
- Small talk to get the conversation going
- 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 – Next steps
- Explain – Additional paperwork needed before authorization of services
- Discuss – Notification process of authorized hours
- Answer – Questions the consumer may have

The Interview: Choosing the Right Questions

Direct or Closed-ended Questions –
- Are questions that seek a simple "yes" or "no" answer.
- Specifically ask for information. 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' 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 are you able to bath yourself?"

Indirect Questions –
- Ask questions without seeming to.
- They are not stated as a question.
- In these 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."

Open-ended Questions for Interviews

Open-ended questions cannot be answered by yes or no. These questions usually begin with "who", "what", "why", "where", and "when."

1. How have you been managing at home since I saw you last/since you got home from the hospital?
2. What do you need in the way of help right now?
3. Let's talk about things you are able and not able to do.
4. Help me understand….
5. What do you mean by________?
6. Would you tell me more about…?
7. What else can you tell me that might help me understand?
8. Could you tell me more about what you're thinking?
9. I'd be interested in knowing…
10. Would you explain…?
11. Is there something specific about __________that you are asking for?
12. Would you explain that to me in more detail?
13. I'm not certain I understand…Can you give me an example?
14. I'm not familiar with____________, can you help me to understand?
15. What examples can you give me?
16. You say that you're not able to [cook/bathe/…_] . How have you been managing [your meals/bathing/…]?
17. When you say _______, what do you mean?
18. I'd like to help you get the best possible service; what more can you tell me that will help me understand your need?

Adapted from: *Understanding Generalist Practice*, Kirst-Ashman and Hull Nelson-Hall Publisher

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 wrongly. Make certain that your facial expressions are congruent with your other non-verbal behavior. (Crossing arms, hands on hips, other…not portraying your interest) What do I see in the other person's face? If unclear, ask for interpretation.

Body Positioning

Posture, open arms versus crossed. When interviewing consumers look for cues in their body positioning, and be aware of your own. Sitting in an attentive manner communicates you are interested.

Environmental Cues:

- Discrepancies between the way the environment looks and what consumer reports as service needs.
- Importance of observations (i.e., house condition, cleanliness of consumer, tour 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:

1. **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 and 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 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.

2. **Unrealistic expectations of the program.**
   For example, the consumer had fallen and broken her hip. When she fell, she had lain 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 Program scope. 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.

3. **Safety issues.**
   For example, a consumer says she is independent bathing. Thought 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 her is not a properly installed grab bar but 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 a grab bar and shower bench. If she discusses this with her physician and obtains a prescription for these items, it's 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, and you have a complete picture of the situation. The following are a few methods that can be used to verify information and to decrease the risk of misunderstanding what the consumer has said.

1. <u>Paraphrasing</u> – Feedback 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 close to the toilet. How long does that last?"

2. <u>Stating your observations</u> – 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.

3. <u>Demonstration</u> – 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. That gives you the opportunity to see the consumer transfer without specifically asking the consumer to demonstrate.

4. <u>Asking clarifying questions</u> – These questions are questions that get to details. For example:
   - "What do you mean by that? You said that you were tired a lot; tell me what the mean to you." If the consumer doesn't explain what they mean it is open to interpretation.
   - "Could you explain that, tell me more about that?"
   - "I'm not sure I understand." The 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, but 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.

1. The angry consumer – 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.
2. The consumer who is very sad / grieving – If the consumer is overcome by sadness and starts to cry.
   - Don't ignore or pretend they are not upset, 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 grief/sadness. Be direct but polite and sensitive. Let them talk briefly about the reason for the 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 OK 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 are 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 most appropriate to offer to reschedule the interview.

3. 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, "I understand there have been many issues with your personal care. Do you need help with bathing?", if so you can then probe for specifics.

4. The consumer who answers with only a word or two – This can be very difficult because without information it is hard to get a good 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, "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.

5. 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 these may be embarrassing questions but that you need the information so they can get the assistance they need. "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 if difficult for you to get to the bathroom in time and causes you to have accidents."

6. Communication blocks:
   - Hearing difficulties –
     - Ask the consumer if they have a hearing aide. If they do check to see if it is in and if it is 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 that another and position yourself on that side.
     - You may need to follow up with a family member to get clarification of information.

   - Language barriers –
     - If they understand and speak some English make sure you go 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.

COMMUNICATING IN DIFFICULT SITUATIONS

1. Listen for full understanding of the person's perspective. Allow them the opportunity to give you a clear picture of what they are trying to say.

2. Put the person at ease using non-verbal cues that show interest and concern.

3. Take the time you need to really understand the situation. In the long run, spending a few more minutes now will save time in avoiding conflict.

4. Respond to concerns the consumer may have in an affirming manner. Restate their concerns in a way that shows you have heard their issues.

5. Focus on the overall goal of the situation. Avoid personalization of the issues. Keep the conversation professional.

6. Understand what you do Today will have an Effect on Tomorrow. The more effective you are in dealing with the issue at hand, the less the issue will grow and consume your energies.

HANDLING HOSTILITY

The following are suggestions for handling consumer hostility:

1. Don't get angry or defensive. Recognize your own reactions. Remember that this is a professional, not personal, issue.

2. Don't patronize or lecture. Saying things such as, "why don't you just calm down" will only escalate the problem and is disrespectful to the consumer.

3. Allow the consumer to voice his/her concerns. Respond with acceptance and understanding. Be empathetic. Listen to understand the situation from the consumer's perspective.

4. Be positive – don't attack them. Show them respect for their discomfort.

5. Greet anger with calmness – set the mood for calm discussion and resolution.

6. Understand the facts regarding the situation that is upsetting the consumer. If you don't have the facts, state what you will need to find out and when you will get back to them.

7. Focus on present and future. Avoid allowing the consumer to get stuck in the past. Emphasize what can be done positively in the future, not what has happened in the past.

8. Ask questions – "How can I help?" Often the consumer knows what they want from you. If you understand their wants you will be able to discuss future possibilities with that in mind.

9. Summarize for clarification and understanding.

10. Be honest about your next steps. If you can't fix the problem outright, don't make promises that you cannot keep. If there are consequences to the behavior, let the consumer know.

Adapted from: *Understanding Generalist Practice*, Kirst-Ashman and Hull Nelson-Hall Publishers and *Connecting with self and others*, Sherod Miller et.al. Interpersonal Communications Programs, Inc.

THINGS TO CONSIDER WHEN DEALING WITH SOMEONE WHO IS HOSTILE

1. Try to evaluate as honestly as you can by reasoning with yourself whether his/her anger is justified.

2. Put hostile people in perspective. You are probably nothing but an afterthought to them, so don't take their antics personally. They're not concerned about you because they're too busy worrying about themselves.

3. Take your pick – positive or negative. You cannot concentrate on constructive, creative alternatives or solutions while you cling to negative feelings. Vent your emotions to a fellow worker or your supervisor and cool off. Think about the result you really want, the consequences or outcome that will benefit the consumer the most.

4. Don't expect hostile people to change. They will not, and in a way that is good because their behavior is predictable. They may not change but by choosing a better approach you can change the outcome.

5. Learn to respond as well as listen. Ask questions instead of making accusations. If you let others save face, you give them room to change their minds.

6. Request feedback. Use open-ended questions to let emotional people vent their feelings before you try to reason with them and explore options.

7. Be straightforward and unemotional. The more you remain calm and matter-of-fact, the sooner you gain another's confidence. People want to feel you are leveling with them, that they can trust you. Remember that respect from other begins with self-respect.

8. Be gracious. Someone else's rudeness does not give us the right to be rude. Treat the other with the kindness you would like to be shown and allow them to feel important. When our own egos are healthy, we are rich; we can afford to be generous.

SHARED LIVING PRORATION CHART

Living Arrangement	**Domestic/Heavy Cleaning**	**Related Services**			
		Meal Preparation/ Meal Cleanup	**Laundry**	**Food Shopping**	**Other Shopping/ Errands**
Lives only with A/A Spouse	**Not prorated - MPP 30-701(s)(2) provides that a shared living arrangement does not exist if consumer resides only with A/A Spouse**				
Lives with A/A Spouse and Others, or Spouse not A/A	Follow Shared Living rules **MPP 30-763.31**	Follow Shared Living rules **MPP 30-763.32**	Follow Shared Living rules **MPP 30-763.32**	Follow Shared Living rules **MPP 30-763.32**	Follow Shared Living rules **MPP 30-763.32**
Shared	• Assess need in room(s) used exclusively by consumer. • No need assessed in rooms used exclusively by others. • Determine consumer's share of rooms used in common. **MPP 30-763.31**	When need is met in common, divide household need by all housemates involved. **MPP 30-763.32**	When need is met in common, divide household need by all housemates involved. **MPP 30-763.32**	When need is met in common, divide household need by all housemates involved. **MPP 30-763.32**	When need is met in common, divide household need by all housemates involved. **MPP 30-763.32**
Live-in Provider	• No need assessed in rooms used solely by provider. • Assess need in rooms used by consumer. • Determine consumer's share of rooms used in common. **MPP 30-763.471**	Prorate if provider and consumer agree and need met in common. **MPP 30-763.471**	Prorate if provider and consumer agree and need met in common. **MPP 30-763.471**	Prorate if provider and consumer agree and need met in common. **MPP 30-763.471**	Prorate if provider and consumer agree and need met in common. **MPP 30-763.471**
Consumer moves in with relative to receive IHSS	Need is assessed only in room used solely by consumer. **MPP 30-763.43**	Follow Shared Living rules **MPP 30-763.32**	Follow Shared Living rules **MPP 30-763.32**	Follow Shared Living rules **MPP 30-763.32**	Follow Shared Living rules **MPP 30-763.32**
Landlord/Tenant (Consumer is Tenant)	Need is assessed only on the living area used solely by the consumer. **MPP 30-763.421**	Follow Shared Living rules taking into account any services landlord is obligated to perform under the rental agreement **MPP 30-763.32; 30-763.421**			
Landlord/Tenant (Consumer is Landlord)	Need is assessed for all living areas not used solely by the tenant. **MPP 30-763.422**	Follow Shared Living rules taking into account any services tenant is obligated to perform under rental agreement. **MPP 30-763.32; 30-763.422**			

Note: When prorating services, the natural or adoptive children <u>of the consumer</u> who are under 14 are not considered (MPP 30- 763.46). Other children in the household (i.e., grandchildren, nieces, nephews, etc.) under 14 are considered.

SHARED LIVING PRORATION CHART

Living Arrangement	Personal Care Services/ Paramedical Services	Accompaniment to Medical Appts./ Alt. Resources	Teaching/Demonstration	Yard Hazard Abatement/ Removal of Ice/Snow	Protective Supervision
Lives only with A/A Spouse	**Not prorated - MPP 30-701(s)(2) provides that a Shared living arrangement does not exist if consumer resides only with A/A Spouse**				
Lives with A/A Spouse and Others, or Spouse not A/A	Not prorated **MPP 30-763.351**	Not prorated **MPP 30-763.351**	Prorate, if feasible, if consumers live together and have a common need which is met in common. **MPP 30-763.34**	Not assessed unless one or more of following apply to all housemates: • Other IHSS recipients unable to provide • Other persons physically or mentally unable • Children under age 14 **MPP 30-763.34**	**MPP 30-763.33**
Shared	Not prorated **MPP 30-763.351**	Not prorated **MPP 30-763.351**	Prorate, if feasible, if consumers live together and have a common need which is met in common. **MPP 30-763.34**	Not assessed unless one or more of following apply to all housemates: • Other IHSS recipients unable to provide • Other persons physically or mentally unable • Children under age 14 **MPP 30-763.34**	**MPP 30-763.33**
Live-in Provider	Not prorated **MPP 30-763.351**	Not prorated **MPP 30-763.351**	Prorate, if feasible, if consumers live together and have a common need which is met in common. **MPP 30-763.34 & 30-763.471**	Not prorated **MPP 30-763.471**	**MPP 30-763.33**
Consumer moves in with relative to receive IHSS	Not prorated **MPP 30-763.351**	Not prorated **MPP 30-763.351**	Prorate, if feasible, if consumers live together and have a common need which is met in common. **MPP 30-763.34**	No need assessed **MPP 30-763.43**	**MPP 30-763.33**
Landlord/Tenant (Consumer is Tenant)	Not prorated **MPP 30-763.351**	Not prorated **MPP 30-763.351**	Prorate, if feasible, if consumers live together and have a common need which is met in common. **MPP 30-763.34**	No need assessed **MPP 30-763.421**	**MPP 30-763.33**
Landlord/Tenant (Consumer is Landlord)	Not prorated **MPP 30-763.351**	Not prorated **MPP 30-763.351**	Prorate, if feasible, if consumers live together and have a common need which is met in common. **MPP 30-763.34**	Not prorated unless tenant agrees to provide as part of rental agreement. **MPP 30-763.422**	**MPP 30-763.33**

SHARED LIVING SCENARIOS

Basic Proration

Rick and Anne Strand are 87 and 83 years old, respectively, and have been married 22 years. Rick had a stroke in 1999, leaving his left side partially paralyzed, and he is aphasic. Anne recovered from rectal cancer that was diagnosed in 1983. She is able to irrigate her colostomy herself. She has arthritis so bad in her knees that she uses a walker. She also has high blood pressure and currently, she has a flare-up of gout. They both receive IHSS. They live in a one-bedroom apartment in a senior housing complex.

You have assessed their needs and have determined that, in addition to the personal care they each need, they have a shared need as follows:

- Domestic – 6 hours per month
- Meal preparation – 6 hours per week
- Meal cleanup – 3 hours per week
- Laundry – 1 hour per week because there are laundry facilities in the building
- Shopping – 1 hour per week
- Errands – ½ hour per week

Rick					
	Total Need	**Adjustments**	**Individual Assessed Need**	**Alternative Resources**	**Auth to be Purch**
AA Domestic					
BB Meal Prep					
CC Meal Cleanup					
DD Laundry					
EE Shopping					
FF Errands					
Anne					
	Total Need	**Adjustments**	**Individual Assessed Need**	**Alternative Resources**	**Auth to be Purch**
AA Domestic					
BB Meal Prep					
CC Meal Cleanup					
DD Laundry					
EE Shopping					
FF Errands					

Changes to the Scenario

How would authorization and completion of the SOC 293 grid change in the following circumstances? For each, specify the type of living arrangement you are considering, the regulations that apply, and how you would complete lines AA through FF of the SOC 293 grid:

1. Same situation as originally written above except that Rick is bedbound and he only uses the bedroom. The provider uses the bathroom on his behalf to empty the urinal and bedside commode and for tasks related to his bed bath and grooming and the kitchen on his behalf to prepare his meals. Assume that cleaning the apartment still takes 6 hours per month, and the bedroom that he shares with his wife takes 1½ hours per month of that time and the bathroom (shared with his wife) takes 1 hour per month and the kitchen, also shared with his wife, 1½ hour per month.

Rick					
	Total Need	**Adjustments**	**Individual Assessed Need**	**Alternative Resources**	**Auth to be Purch**
AA Domestic					
BB Meal Prep					
CC Meal Cleanup					
DD Laundry					
EE Shopping					
FF Errands					
Anne					
	Total Need	**Adjustments**	**Individual Assessed Need**	**Alternative Resources**	**Auth to be Purch**
AA Domestic					
BB Meal Prep					
CC Meal Cleanup					
DD Laundry					
EE Shopping					
FF Errands					

SHARED LIVING SCENARIOS

2. Same situation as originally written above except that Anne's colostomy bag she wears between colostomy irrigation leaks an average of twice a week. About once a week, it leaks when she is in bed, soiling the sheets and her nightgown. About once a week, it leaks when she is up and dressed, soiling the clothing she is wearing.

Rick					
	Total Need	**Adjustments**	**Individual Assessed Need**	**Alternative Resources**	**Auth to be Purch**
AA Domestic					
BB Meal Prep					
CC Meal Cleanup					
DD Laundry					
EE Shopping					
FF Errands					
Anne					
	Total Need	**Adjustments**	**Individual Assessed Need**	**Alternative Resources**	**Auth to be Purch**
AA Domestic					
BB Meal Prep					
CC Meal Cleanup					
DD Laundry					
EE Shopping					
FF Errands					

3. Same situation as originally written above except that Anne is impaired but Rick is not. He does not need IHSS and is feeling quite well. He participates in aerobics classes offered by the housing complex 3 times a week which seems to keep him strong and healthy.

Rick					
	Total Need	**Adjustments**	**Individual Assessed Need**	**Alternative Resources**	**Auth to be Purch**
AA Domestic					
BB Meal Prep					
CC Meal Cleanup					
DD Laundry					
EE Shopping					
FF Errands					
Anne					
	Total Need	**Adjustments**	**Individual Assessed Need**	**Alternative Resources**	**Auth to be Purch**
AA Domestic					
BB Meal Prep					
CC Meal Cleanup					
DD Laundry					
EE Shopping					
FF Errands					

4. Same situation as originally written above except that Anne's daughter is worried about her mother and stepfather so they move in with her, her husband and her 10-year-old daughter so she can care for them. Anne's daughter lives in a three-bedroom, two-bath house. The Strands have exclusive use of their bedroom and bathroom and otherwise share the rest of the house with Anne's daughter's family. They eat together as a family all meals on the weekends. They all only share dinner during the week. Anne's daughter shares all meals with her mother and stepfather.

Rick					
	Total Need	**Adjustments**	**Individual Assessed Need**	**Alternative Resources**	**Auth to be Purch**
AA Domestic					
BB Meal Prep					
CC Meal Cleanup					
DD Laundry					
EE Shopping					
FF Errands					
Anne					
	Total Need	**Adjustments**	**Individual Assessed Need**	**Alternative Resources**	**Auth to be Purch**
AA Domestic					
BB Meal Prep					
CC Meal Cleanup					
DD Laundry					
EE Shopping					
FF Errands					

								BIRTHDATE		
	CNTY	RECIPIENT #	CD	SEQ #	AID CODE	SOCIAL SECURITY NO.	SEX	MONTH	DAY	YEAR
A	(1)			(2)	(3)	(4)	(5) M F	(6)		

	LAST NAME	FIRST NAME	MI
B	(1)	(2)	(3)

	STREET	CITY	STATE	ZIP CODE / CT
C	(1)	(2)	(3)	(4)

	TELEPHONE #	DIS. PREP.		GUARDIAN / CONSERVATOR
D	(1)	(2)	(3)	(4)

	STREET	CITY	STATE	ZIP CODE / CT
E	(1)	(2)	(3)	(4)

	STATUS	PRIM. DIAG.	CITIZEN	ETHNIC	LANG.	OTH. / COV.	SSNV	HIC. / RR.#	FBU. #
F	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)

	SPOUSE / PARENT	# HH	# RCP	RES	L/A	# ROOMS	YARD	WASHER	DRYER	STOVE	REFRIG.
G	(1)	(2)	(3)	(4)	(5)	(6)	(7) Y N	(8) Y N	Y N	Y N	Y N

H (1) HOUSEWORK, LAUNDRY, SHOPPING & ERRANDS, MEAL PREP & CLEAN-UP, MOBILITY INSIDE, BATHING & GROOMING, DRESSING, BOWEL, BLADDER & MENSTRUAL, TRANSFER, EATING, RESPIRATION, MEMORY, ORIENTATION, JUDGMENT, FUNCTIONAL INDEX; (2) FUNCTIONAL INDEX HOURS; (3) W/O IHSS; (4) NEED PROVIDER

	SHARE OF COST DATE	LINK	DEP	SOURCE	INCOME	DEDUCT	COUNTABLE INCOME
I	(1)	(2)	(3)	(4) 3			(5)

	SOURCE	INCOME	DEDUCT				BENEFIT CODE / LEVEL
J	(1) 1			(2) 4			(3)

							SHARE OF COST
K	(1) 2			(2) 5			(3)

	MODE	RATE	HOURS	MODE	RATE	HOURS	RECOVERY
L	(1)			(2)			(3)

	ACT	BEGINNING DATE	ENDING DATE	GROSS AMOUNT	MODE	RATE	HOURS	SHARE OF COST	TYPE	PAY OPT
M	D (1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)
N	D (1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)
O	D (1)	(2)	(3)	(4)	(5)			(6)	(7)	(8)

	APPLICATION DATE	REF	FACE TO FACE DATE	COUNTY USE
P	(1)	(2)	(3)	(4)

	D / O	SERVICE WORKER NAME	SW. #	SERVICE WORKER PHONE #
Q	(1)	(2)	(3)	(4)

R ALERT MESSAGE

NOA MESSAGE

S AUTHORIZATION: DATE: REMARKS:

T VALIDATION: DATE: REMARKS:

Fig. V-A- 1 – SOC 293 – Page 1

	LAST NAME & #	SEQ #	TOTAL NEED	ADJUSTMENTS	INDIVIDUAL ASSESSED NEED	ALTERNATIVE RESOURCES	AUTH TO BE PURCH	UNMET NEED	COUNTY USE
AA	Domestic Services								
BB	* Preparation of Meals								
CC	** Meal Clean Up								
DD	Routine Laundry, Etc.								
EE	Shopping for Food								
FF	Other Shopping & Errands								
GG	Heavy Cleaning								
HH	* Respiration								
II	* Bowel & Bladder Care								
JJ	* Feeding								
KK	* Routine Bed Baths								
LL	* Dressing								
MM	* Menstrual Care								
NN	* Ambulation								
OO	* Moving In/Out of Bed								
PP	* Bathing, Oral Hygiene, Grooming								
QQ	* Rubbing Skin, Repositioning, Etc.								
RR	* Care and Assistance with Prosthesis								
SS	Accompaniment To Medical Appointment								
TT	Accompaniment To Alternative Resources								
UU	Remove Grass Weeds, Rubbish								
VV	Remove Ice, Snow								
WW	Protective Supervision								
XX	Teaching & Demonstration								
YY	* Paramedical Services								

	NOA	RSN. CD.	RSN. CD.	RSN. CD.	RSN. CD.	BEGINNING DATE	ENDING DATE	ADVANCE	MEAL ALLOW
ZZ	(1) M C N	(2)				(3)	(4)	(5) Y N	(6) Y N

	MONTHLY HRS. AUTHORIZED.	WKLY. HRS.	MEAL HRS (BB + CC + EE)		MO. HRS.	TOTAL	PURCHASE	UNMET NEED
aa		(1) =	(2) −	(3) X4.33 =	(4) +	(5) =	(6) −	(7) =

Fig. V-A- 2 – SOC 293 – Page 2 – Assessment Grid

In Home Supportive Services Assessment, SOC 293

The IHSS SOC 293 is used by the county staff to document recipient specific case details regarding eligibility, need assessment and resources available to the recipient. The SOC 293 is available for purchase by counties. See ***Section II-B – Ordering CMIPS Forms*** for order details and costs.

Field-by-Field Description

The following fields appear on the SOC 293 and the RELA, RELB and RELC screens in CMIPS unless otherwise indicated.

Page 1

Field: Untitled – CIN – System Generated, Alphanumeric
Length: 10
Description: CIN – Client Index number assigned to an IHSS Recipient by the Statewide Client Index. This field is not titled on the SOC 293 document, but is printed in the upper right corner above Field A1. The RELA screen field name is CIN.

Field: REPRINT – Optional, Alpha – **RELA Screen display only**
Length: 1
Description: Reprint – Allows the reprint of the most recent SOC 293 or NOA. The RELA screen field name is REPRINT. Valid field entry:

- N – System default
- Y – Print SOC 293
- A – Print NOA

Refer to ***Section V-B - Special Instructions*** – Producing a Reprint of the Most Recent SOC 293 or Producing a Reprint of the Most Recent Notice of Action for detailed instruction requesting a reprint of an SOC 293 or NOA.

Field A1: CNTY / RECIPIENT# / CD – Required, Numeric
Length: 10 2/7/1
Description: County/Recipient Number/Check Digit – A ten (10) digit number representing a specific case. The first two digits identify the county, the next seven digits a county-assigned case number, and the 10th digit is a system generated check digit. This field does not appear on the RELA screen, but the case number will appear on the NEXT line in CMIPS.

Field A2: SEQ # – System Generated, Numeric
Length: 3
Description: Sequence Number – A system generated chronological number indicating the most recent turnaround document. The RELA screen field name is SEQ#.

Field A3: AID CODE – Required, Numeric
Length: 2
Description: Aid Code – The IHSS Aid Code applicable to the recipient. The RELA screen field name is AID.
10 Aged, SSI/SSP

18 Aged, IHSS Income Eligible
20 Blind, SSI/SSP
28 Blind, IHSS Income Eligible
60 Disabled, SSI/SSP
68 Disabled, IHSS Income Eligible

- Aid Codes 10, 20, 60 – Used for status eligible recipients
- Aid Codes 18, 28, or 68 – Used for income eligible recipients

Refer to Section V-B, Special Instructions – CMIPS/MEDS Interface for issuing and eligible recipient a Medi-Cal card.

Field A4: SOCIAL SECURITY NO. – Required, Numeric
Length: 9
Description: Social Security Number (SSN) – A nine (9) digit number assigned to the recipient by the Social Security Administration. An SSN pattern match table, created by the Social Security Administration, is loaded into CMIPS, then each SSN entered validated against this table. This SSN Pattern Match table is updated monthly. The RELA screen field name is SSN. Completion of fields F7 and F8 generates the issuance of a Medi-Cal card. If either of these fields is completed and the SSN entered in Field A4 is invalid, eligibility for the Medi-Cal card may be denied or discontinued (Title 22, California Code of Regulations, Section 50187).
Refer to Section V-B, Special Instructions, Person List Screen *for detailed information regarding the functionality associated with SSN and Name matching in CMIPS.*

Field A5: SEX – Required, Alpha
Length: 1
Description: Sex – Circle the code that identifies the recipient's gender.
M – Male
F – Female
The RELA screen field name is SEX.

Field A6: BIRTHDATE, MONTH/DAY/YEAR – Required, Numeric
Length: 8 Format: MMDDYYYY
Description: Birthdate – The month, day and year of the recipient's birth. The RELA screen field name is BIRTH DATE.

Field B1, B2 B3: LAST NAME/FIRST NAME/MI – Required, Alphanumeric/Special Characters (. , / -)
Length: 17/12/1
Description: **Last Name** – A specific recipient's family name (Required). Jr., II, etc., should be included as part of the last name. Enter the single name in this field for those of Samoan descent who only have a single name. The RELA screen field name is LAST NAME.
First Name – Name given at birth to identify an individual (Required). When code M = Samoan, is entered in Field F4, Ethnic, entry in this field is Optional. The RELA screen field name is FIRST.

MI – The middle initial of a recipient (Optional). The RELA screen field name is MI.
Refer to Section V-B, Special Instructions, Person List Screen for detailed information regarding the functionality associated with SSN and Name matching in CMIPS.

Field C1: STREET – Required, Alphanumeric
Length: 28
Description: Street – The street address of the recipient's place of residence. The RELA screen field name is ST.

- Disaster preparedness requires information about the residence location of all recipients
- If the recipient has a mailing address different from the residence address, the mailing address is entered in Fields E1 through E4. Counties using CMIPS for MEDS interface should note that the MEDS field length is only 26 characters.

Refer to Section V-B Special Instructions, Address Verification Screen, for detailed explanation regarding the function of the screen.

Field C2: CITY – Required, Alpha
Length: 17
Description: City – Recipient's city of residence. The RELA screen field name is CY.

Field C3: STATE – Optional, Alpha
Length: 2
Description: State – Recipient's state of residence. Defaults to "CA" if not entered. The RELA screen field name is ST.

Field C4: ZIP CODE – Required, Numeric CT – Optional Numeric
Length: 10 Format: XXXXX XXXX
Description: Zip Code/CT – A nine-digit zip code assigned by USPS that relates to the recipient's address of residence. The RELA screen field name is Z.

Field D1: TELEPHONE # – Optional, Numeric
Length: 10 Format: XXX XXX XXXX
Description: Telephone Number – The recipient's telephone number. The RELA screen field name is PHONE #.

Field D2: DIS. PREP. – Optional, Alpha
Length: 3 Format: XXX
Description: Disaster Preparedness – A three letter code that identifies IHSS recipients who require contact by emergency personnel in the aftermath of a disaster. Counties have the option to participate in the Disaster Preparedness program. If they do participate, entry in this field is required. ***Refer to Section V-B, Special Instructions, IHSS Disaster Preparedness Assessment Plan.*** The RELA screen field is named DP.
The first letter indicates the degree of contact necessary:

A Critical E Urgent but consumer declines advance

B	Urgent		notification of emergency services
C	Moderate		
D	Critical but consumer declines advance notification of emergency services	F	Moderate but consumer declines advance notification of emergency services
		Z	Contact by emergency staff not needed

The second letter indicates the predominant special impairment

A	Deaf	D	Wheelchair bound
B	Blind	E	Mental disability
C	Bed-bound	Z	Recipient does not have any listed special impairment

The third letter indicates the predominant life support supply need.

A	Respirator	E	Dialysis
B	Oxygen	F	Bowel and Bladder
C	Insulin	G	Nasal/Gastrointestinal Tubes/Suctioning
D	Life Support Medications	Z	Recipient does not have any listed supply needs

Field D3: BLANK FIELD – System Generated, Alphanumeric
Length: 2
Description: This field was previously (prior to November 2005) used to reflect the recipient's Medi-Cal categorically needy Aid Code. Currently, (October 2007) some CMIPS cases retain previous indications, but this field is no longer populated. For current Medi-Cal eligibility, see Field F2.

Field D4: GUARDIAN/CONSERVATOR – Optional, Alphanumeric/Special Characters (. , / -)
Length: 30
Description: Guardian/conservator – Individual legally responsible for a recipient. Designated individual will receive any mail, warrant, or Notice of Action issued to the recipient. If no guardian/conservator, leave blank. If an entry is made for guardian/conservator, Fields E1 through E4 must be completed. The RELA screen field name is GUARDIAN.

Field E1: STREET – Optional, Alphanumeric
Length: 28
Description: Street – Guardian/conservator's street number and name, including apartment and/or space number. If there is no guardian/conservator related to the case, but the recipients mailing address differs from residence address, fields C1-C4, enter the mailing address in fields E1-E4. The RELA screen field name is ST. This address will be:

- Used as the address on any mail, warrant, or Notice of Action issued to a recipient if a guardian/conservator is entered in Field D4.
- Used as the mailing address of the recipient when there is no guardian/conservator in Field D4 and residence address is present
- Counties using CMIPS for MEDS interface should note the MEDS street field length is 26 characters.

See ***Section V-B Special Instructions, Address Verification Screen.***

Field E2: CITY – Optional, Alpha
Length: 17
Description: City – Guardian/conservator's city of residence or the city of the recipient's mailing address. The RELA screen field name is CY.

Field E3: STATE – Optional, Alpha
Length: 2
Description: State – Guardian/conservator's State of residence, or the State of the recipient's mailing address. Defaults to "CA". The RELA screen field name is ST.

Field E4: ZIP CODE – Optional, Numeric
Length: 9 Format: XXXXX XXXX
Description: Zip + 4 Code – Guardian/conservator's nine-digit zip code assigned by USPS that relates to the address. The RELA screen field name is Z.

Field F1: STATUS – Required, Alpha
Length: 1
Description: Status – Code which indicates the current eligibility status of the recipient. The RELA screen field name is STATUS. Enter one of the following:

- R Record – Indicates an application has been taken. May be used for a county's central index reporting purpose. Generate an alert message that a recipient's eligibility status must be completed. If Status R is used, only Fields A1 through F1, P1 and P2, and Q1 through Q4 are valid fields.
- I Interim Eligible – Provisional approval pending a disability or blind determination. Only Aid Codes 28 and 68 are valid in Field A3 when using Status I.
- E Eligible – The recipient is approved for services under the IHSS program
- L Leave of absence – Temporarily without need for IHSS services, e.g., hospitalized
- D Deny – Eligibility has been denied
- T Terminated – Eligibility has been terminated

Field F2: PRIM. DIAG. – System Generated, Alphanumeric
Length: 5 Format : XX/2X
Description: Medi-Cal Primary and Secondary Aid Code – CMIPS system generates the Medi-Cal Primary and Secondary Aid Code. The Primary Aid Code is displayed from the Medi-Cal Eligibility data received from MEDS. The Secondary Aid Code is derived from Medi-Cal Eligibility data and IHSS Recipient and Provider data. The RELA screen field name is MC AID.

Field F3: CITIZEN – Optional, Alphanumeric
Length: 2
Description: Citizen – Not currently in use. The RELA screen field name is CITIZEN.

Field F4: ETHNIC – Required, Alphanumeric
Length: 1

Description: Ethnic – Code designating the ethnicity of the recipient. The RELA screen field name is ETHNIC.

Code	Ethnicity	Code	Ethnicity
1	White	J	Japanese
2	Hispanic	K	Korean
3	Black	M	Samoan
4	Other Asian or Pacific Islander	N	Asian Indian
5	American Indian or Alaskan Native	P	Hawaiian
7	Filipino	R	Guamanian
C	Chinese	T	Laotian
H	Cambodian	V	Vietnamese

Field F5: LANG – Required, Alphanumeric
Length: 1
Description: Language – Code designating the primary language of the recipient. The RELA screen field name is LANG.

Code	Language	Code	Language
0	American Sign Language (AMISLAN or ASL)	F	Ilocano
1	Spanish – NOA will be issued in Spanish	G	Mien
2	Cantonese	H	Hmong
3	Japanese	I	Lao
4	Korean	J	Turkish
5	Tagalog	K	Hebrew
6	Other non-English	L	French
7	English	M	Polish
8	Unassigned code	N	Russian
9	Spanish – NOA will be issued in English	P	Portuguese
A	Other Sign Language	Q	Italian
B	Mandarin	R	Arabic
C	Other Chinese Languages	S	Samoan
D	Cambodian	T	Thai
E	Armenian	U	Farsi
		V	Vietnamese

Field F6: OTH./COV. – Optional, Alphanumeric
Length: 5 Format: X,XXXX
Description: Other Coverage – The first digit indicates insurance coverage, if any, of the recipient. Other digits are reserved for future use and may be used to indicate Medi-Cal cost avoidance codes. The RELA screen field name is OTH/COV. Only the following company codes are valid:

Code	Carrier	Code	Carrier
A	Any carrier other than Blue Shield or Blue Cross (Partial Coverage	S	Blue Shield
B	Blue Cross	T	Travelers
C	CHAMPUS	U	Connecticut General
D	Prudential	V	Variable – any other carrier
E	Aetna	W	Great West Life Assurance Company
F	Medicare HMO	X	Blue Shield (partial coverage)
G	American General	Y	Blue Cross – North
H	Mutual of Omaha	Z	Blue Cross – South

I	Metropolitan Life	2	Provident Life and Accident
J	John Hancock Mutual Life Ins. Co.	3	Principal Financial Group
K	Kaiser	4	Pacific Mutual Life Insurance
M	Two or more carriers (partial coverage)	5	Alta Health Strategies Inc.
N	None	6	American Association of Retired Persons
P	Prepaid Health Plan or Health Maintenance Organization	7	Allstate Life Insurance
Q	Equicor/Equitable	8	New York Life Insurance
R	Ross Loos	9	Crown Life Insurance Company

Field F7: SSNV – Optional, Numeric
Length: 1
Description: Social Security Number Verification – Code indicating how the recipient SSN was verified or why it was not verified. The RELA screen field name is SSNV. For Medi-Cal card issuance, the SSN must be verified.

0 SSA-VER previously submitted to MEDS
1 SSN verified by SSA (MC 194 Completed)
2 Confirmed by county on SSA district office application
3 Sight verified by county welfare office
4 SSN not verified by SSA
5 SSN not sight verified, recipient sent to SSA office
6 No SSN, recipient sent to SSA office
7 No valid input from county
8 SSN not attainable, undocumented person
9 SSN not attainable, pre-adoptive person

Field F8: HIC./RR. # – Optional, Alphanumeric
Length: 12
Description: Health Insurance Coverage/Railroad Retirement Number – This is used for Medi-Cal purposes. Do not leave spaces between numbers. The RELA screen field name is HIC./R.R #.

Field F9: FBU. # – Optional, Numeric
Length: 3
Description: Family Budget Unit Number – Designates who in the family will be included in Medi-Cal eligibility. In addition, enter Person # in field as well. The RELA screen field name is FBU #.

- Family Budget Unit is a one-digit number assigned by the county to each recipient as part of a unique recipient identifier
- Person # is a two-digit number assigned by the county to each recipient as part of a unique recipients identifier
- Enter 101 if the county does not wish to use this field.

Field G1: SPOUSE/PARENT – Required, Numeric
Length: 2
Description: Spouse/Parent – Indicates the status of the spouse or parent in terms of providing services. The parent code is used only when the IHSS recipient is

under age 18. The RELA screen field is SPOUSE/PARENT.
Enter one of the following codes:

00 None
11 Spouse – able and available
12 Spouse – able/partially available due to employment, other unavoidable absence
13 Spouse – able/not available
14 Spouse – available/not able
15 Spouse – IHSS recipient
21 Parent – provides all services
22 Parent – provides some services
23 Parent – provides no services
24 Parent – IHSS recipient

Field G2: #HH – Required, Numeric
Length: 2
Description: Number in Household – The total number of people living in the recipient's household, including other IHSS recipients. Exclude recipient's non-IHSS children under 14 years of age. The RELA screen field name is # HH.

Field G3: # RCP – Required, Numeric
Length: 2
Description: Number of Recipients – The number of IHSS recipients in the household. The RELA screen field name is RCP.

Field G4: RES – Required, Numeric
Length: 2
Description: Residence – Code indicating the recipient's type of residence. The RELA screen field name is RES.

01 House
02 Apartment
03 Mobile Home
04 Hotel
05 Other

Field G5: L/A – Required, Numeric
Length: 2
Description: Living Arrangement – Code indicating the recipient's living arrangement. The RELA screen field name is L/A.

01 Independent (living alone)
02 Shared
03 Live-in provider
04 Tenant/Landlord
05 Board and room

Field G6: # ROOMS – Required, Numeric
Length: 2
Description: Number of Rooms – The number of rooms contained in the recipient's residence, include bathrooms. The RELA screen field name is ROOMS.

Field G7: YARD – Required, Alpha
Length: 1

Description: Yard – Circle Y (Yes) or N (N0) to indicate whether the recipient's residence has a yard. The RELA screen field name is YARD.

Field G8: WASHER/DRYER/STOVE/REFRIG – Required, Alpha
Length: 8
Description: Washer/Dryer/Stove/Refrigerator – Indicate the appliances in a recipient residence. Circle Y (Yes) or N (No) for each item. There are four separate fields on the RELA screen named WASH, DRY, STOVE, REFRIG. The RELA screen field accepts a Y (Yes) or N (No).

Untitled: ICT TO, Optional, Numeric
Length: 2
Description: Inter County Transfer TO – Allows the indication of the two digit county number to which the recipient case is being transferred. The RELA screen fields is ICT TO (B4).

Untitled: ICT FM, Optional, Numeric
Length: 10
Description: Inter County Transfer TO – Allows the indication of the ten-digit IHSS case number from which the recipient is being transferred. The RELA screen fields is FM (B5)

Field H1: FUNCTIONAL LIMITATIONS – Required, Numeric
Length: 14
Description: Functional Limitations – Each listed item is to be given one numeric ranking indicating the recipient's functional limitation. ***Refer to the Uniformity Training Guide****, Assessment Standards, for more guidance to apply rankings.*

Description of Numeric Ranking

Rank 1 Independent – Able to perform functions without human assistance though client may have difficulty. However, completion of the task with our without a devices poses no risk to his/her safety
Rank 2 Able to perform but needs verbal assistance such as reminding, guidance or encouragement
Rank 3 Can perform with some human help, i.e. direct physical assistance from the provider
Rank 4 Can perform with a lot of human assistance
Rank 5 Cannot perform function at all without human assistance
Rank 6 Paramedical services needed

Valid Ranks for Functional Limitations

HOUSEWORK (RELA field name HOUSE)	1	2	3	4	5	
LAUNDRY (RELA field name LNDRY)	1			4	5	
SHOPPING & ERRANDS (RELA field name SHOP)	1		3		5	
MEAL PREP & CLEANUP (RELA field name MEAL)	1	2	3	4	5	6
MOBILITY INSIDE (RELA field name MOBILITY)	1	2	3	4	5	
BATHING & GROOMING (RELA field name BATH)	1	2	3	4	5	
DRESSING (RELA field name DRESS)	1	2	3	4	5	
BOWEL, BLADDER & MENSTRUAL (RELA field name BB/M)	1	2	3	4	5	
TRANSFER (RELA field name TRANSFER)	1	2	3	4	5	

EATING (RELA field name EAT)	1	2	3	4	5	6
RESPIRATION (RELA field name BREATH)	1				5	6
MEMORY (RELA field name MEMORY)	1	2			5	
ORIENTATION (RELA field name ORIENT)	1	2			5	
JUDGMENT (RELA field name JUDGE)	1	2			5	

Field H2: FUNCTIONAL INDEX/FUNCTIONAL INDEX HOURS – System generated, Numeric
Length: 8 X.XX/XXX.X
Description: Functional Index – System generated number between 1 and 5 which indicates the relative need of a recipient for IHSS. Individual scores from Field H1, Functional Limitations, are weighted to provide the functional index ranking for each recipient.
Functional Index Hours – System generated sum of the Total Need Hours (Page 2, Column 2) considered in the Functional Index tasks. These are limited to the values indicated in the table below.
The RELA screen field names are INDEX and HOURS.

AA	Domestic Services	BB	Preparation of Meals
CC	Meal Cleanup	DD	Mending & Laundry
EE	Shopping for Food	FF	Other Shopping
HH	Respiration	II	Bowel & Bladder
JJ	Feeding	KK	Routine Bed Baths
LL	Dressing	MM	Menstrual Care
NN	Ambulation	OO	Moving In/Out of Bed
PP	Bathing	QQ	Rubbing Skin/Range of Motion
RR	Care & Assistance with Prosthesis/Medications		

Field H3: W/O IHSS – Required, Numeric
Length: 1
Description: Without IHSS – Rating of recipient's outcome with reduced services. The RELA screen field name is W/O IHSS. Indicate one of the following codes:
1 Recipient not at risk with services reduction
2 Recipient at risk with services reduction
3 Recipient will require out of home community care
4 Recipient will require out of home medical care
5 Recipient will become unemployed

Field H4: NEED PROVIDER – Required, Numeric
Length: 2
Description: Need Provider – Indicates whether IHSS recipient needs help to obtain a service provider. The RELA screen field name is NEED.
00 Recipient has own resources to obtain a provider
11 Recipient does need help to obtain a provider

Field H
Untitled: Provider to Recipient Relationship – ***SOC 293 Display Only***
Length: 3
Description: Indicates whether or not the Provider and Recipient have a one-to-one

Relationship. If the Recipient is services by a single provider, 1:1 will print in the field right of the NEED PROVIDER FIELD. This indication pulls from the Provider Eligibility (PELG). If the field is blank, the recipient may be served by multiple providers.

On the RELA screen, there are two dates at the bottom of the screen under the FUNCTIONAL section. Format of the following fields is MMDDYYYY.

- DATE LAST CHANGED – The date the last change was made to any of the information that displays on the RELA screen.
- DATE ADDED – The date the 293 was keyed.

Field I1: SHARE OF COST / INDICATOR – Optional, Alphanumeric – The word INDICATOR is not printed in this field on the SOC 293.
Length: 8/1 Format: MMDDYYYY X
Description: **Share of Cost Date** – The effective date of a recipient's share of cost. The date may be mid-month for intake cases, but must be the first of the month thereafter. This date must be greater than or equal to the Share of Cost Benefit Level Date which coincides with the recipient eligibility segment. See ***Section II-K - Share of Cost Benefit Level Updates*** for valid SOC dates. The RELB screen field name is SOC DATE.

- When a SOC COLA is processed the date will be updated if the case meets all other update conditions.

Indicator – To the right of the date the SOC IND must be entered. As of June 1, 2006 the only value allowed is **D** for any IHSS recipient case with an Aid Code 18, 28 or 68. CMIPS processes an automated share of cost computation when budget data is entered in the Source Income and Benefit Level fields. The RELB screen field name is IND.
Refer to Section V-B, Special Instructions, Share of Cost Computations - SOC 293

Field I2: LINK – Optional, Numeric
Length: 1
Description: Link – Enter the code indicating the recipient's income computation status and spouse/parent(s) linkage to Supplemental Security Income/State Supplemental Program (SSI/SSP) – Aged, Blind and Disabled. This field is required for an automated share of cost computation. The RELB screen field name is LINK.
Refer to Section V-B, Special Instructions, Share of Cost Computations - SOC 293.

1 IHSS Individual
2 IHSS individual/linked spouse
3 IHSS individual/non-linked spouse
4 IHSS individual/non-linked parent
5 IHSS individual/non-linked parents

Field I3: DEP – Optional, Numeric
Length: 2
Description: Dependents – The number of minor legal dependents with no income of their own to be considered in the automatic computation of countable income for an adult recipient with a non-linked spouse, or a child recipient whose parent(s)

income must be considered. This field is required for automated share of cost computation. The RELB screen field name is #DEP.

The position of Fields I1 through L2 on the RELB screen differ from the SOC 293. However, the field names are consistent.

Field I4, J1, J2, K1, K2: SOURCE/INCOME/DEDUCT – Optional, Numeric

Length: 1, 8, 8 Format: X, XXXXX.XX, XXXXX.XX

Description: Source/Income/Deduct – Source and amount of deductions from income of the recipient, parent, or spouse. This field is required for automated share of cost computation. The RELB screen field names are SOURCE / INCOME / DEDUCT. ***Refer to Section V-B, Special Instructions, Share of Cost Computation – SOC 293.***

Source	These codes indicate the source of the recipient's, spouse's, or parent(s) gross income.
1	Retirement, Survivors, Disability Insurance (RSDI) – Recipient
2	Veteran's administration – Recipient
4	Railroad Retirement – Recipient
5	Other pension – Recipient
6	Other unearned – Recipient
7	Earned – Recipient
8	Unearned – Spouse/parent
9	Earned – Spouse/parent
Income	Amount of gross income available to the recipient, spouse or parent.
Deduct	Dollar amount of total income deductions other than the income exclusions. The allowable deductions in this category include:

- Any amount that a recipient pays for services that are an alternative to IHSS may be entered in the deduct field. This deduction should not exceed the IHSS cost for the same service(s).
- Impairment related work expenses and expenses for a Plan for Achieving Self-Support (PASS). These are work and training related programs for recipients.
- Standard income exclusions that are included in the automated share of cost computation are:

\$20.00	Standard exclusion
\$65.00	Earned income exclusion
One half remainder of income – Earned income exclusion	
\$319.00	Needs of children/non-linked spouse
\$637.00 or \$956.00	Allowance for parent(s)

Field I5: COUNTABLE INCOME – Optional, Numeric

Length: 8 XXXXX.XX

Description: Countable Income – The sum of all net income available to recipient.

- For those recipients whose share of cost is automated, this field and the countable income will be system generated.
- The amount that has been manually computed (for those recipients whose

countable income is not automated) must be entered in this field to enable the correct share of cost information on an automated Notice of Action.

- For a linked couple, both of whom are income eligible IHSS recipients, either divide that countable income by 2 or allocate the countable income in unequal portions, whichever is the most advantageous to the couple. Enter the sum in I5.

The RELB screen field name is CNTBLE INCOME. ***Refer to Section V-B, Special Instructions: Share of cost computation - SOC 293.***

Field J3: BENEFIT CODE/LEVEL – Optional, Numeric
Length: 2,8 Format: XX, XXXXX.XX
Description: Benefit Code/Level – This field indicates the SSI/SSP benefit code and level used to determine the recipient's share of cost. The RELB screen field name is BNFT LVL allowing entry of a specific Benefit Code from which the Benefit Level will be auto-filled.

- The field includes both recipients who have countable income that is either automatically or manually computed
- For those recipients whose share of cost is automated, this field must have one of the following two digit codes entered.

Benefit Code		**Benefit Level**
01	Individual aged or disabled, own home	870.00
02	Individual blind, own home	935.00
03	Individual disabled minor, own home	756.00
04	Individual aged or disabled, household of another	658.67
05	Individual blind, household of another	739.67
06	Individual disabled minor, household of another	532.67
07	Individual aged or disabled, independent, living without cooking facilities	954.00
08	Couple aged or disabled, own home	1524.00
09	Couple both blind, own home	1751.00
10	Couple blind/aged or disabled, own home	1666.00
11	Couple aged or disabled, household of another	1233.00
12	Couple both blind, household of another	1460.00
13	Couple blind/aged or disabled, household of another	1374.00
14	Couple aged or disabled, independent, living without cooking facilities	1692.00

- Linked Couple – Both members of a couple are blind, disabled, or over age 65
- If one member of the linked couple is income eligible and the other receives SSI/SSP, is PCSP eligible, or has no need for any services, then use the appropriate code above (08-14) and the couple's income for the remaining member's share of cost computation.
- For a linked couple, both of whom are income eligible and need IHSS, enter the appropriate code below (15-21) for the partially automated share of cost computation, based on the countable income entered in Field I5.

Benefit Code		**Benefit Level**
15	Couple aged or disabled – own home, per person	762.00
16	Couple both blind – own home, per person	875.50

17	Couple blind/aged or disabled – own home, per person	833.00
18	Couple aged or disabled – without cooking facilities, person	845.00
19	Couple aged or disabled – household of another, per person	616.50
20	Couple blind – household of another, per person	730.00
21	Couple blind, aged or disabled – household of another, per person	687.00

Field K3: SHARE OF COST – System Generated, Numeric
Length: 8 XXXXX.XX
Description: Share of Cost – This field contains both the IHSS and MEDI-CAL Shares of Cost.

- The IHSS Share of Cost is the monthly amount of money to be paid by the recipient before IHSS services are paid. The RELB screen field is IHSS SOC.
  - When a SOC IND of "D" is entered in Field I1 combine with the entries in Fields I5 – COUNTABLE INCOME, and J3 – BENEFIT CODE/LEVEL, CMIPS will automatically calculate the IHSS SOC, displaying the calculated Share of Cost into the eligibility segment, fields M6, N6 or O6,
  - If a SOC IND of "E" is entered in the I1, the IHSS SOC amount will not populate to the eligibility segments, Fields M6, N6 or O6.
- The MEDI-CAL Share of Cost is a display only field and is system filled from the MEDS SOC amount indicated on the MEDS Daily Response and Monthly Renewal. The amount shown may be updated each month as the MEDS eligibility and SOC are applied to CMIPS. The RELB screen field is MEDI-CAL SOC.

Field L1, L2: MODE/RATE/HOURS – Required, Alphanumeric
Length: 2,4,4 Format: XX, XX.XX, XXX.X
Description: Mode/Rate/Hours – Indicates service deliver mode, provider's pay rate, and authorized hours of service(s) for the recipient. ***Refer to Section V-B, Special Instructions: Changing Service Delivery Mode, Rate and Hours – SOC 293.***

Delivery Mode – Code indicates the type of service delivery of IHSS. The RELB screen field name is MODE.

IP Individual Provider
CC County contract, either private vendor or inter-agency agreement
HM County-employed homemaker

Hourly Rate of Pay – The rate of pay per authorized service hour for the type of delivery mode. The RELB screen field name is RATE.

- If this amount is not entered for individual providers, the system will default to the current county rate.
- If this amount is not entered for contract or county homemaker providers, the system will default to the contract or homemaker base rate.

Hours of Service by Delivery Mode – The hours of authorized service will be system generated unless there is a mixed mode service deliver. The RELB screen field name is HOURS.

- If there are two IP modes with different hourly rates, enter IP twice, the

hourly rate and the hours of authorized service for one of them. The balance of the hours will be system generated.

- If there is a mixed mode of service deliver, enter both modes, the hourly rate for each (unless one or both are at the county base rate) and the hours of authorized service for one of them. The balance of hours will be system generated.

Field L3: RECOVERY – System generated, Numeric
Length: 6 Format: $X,XXX.XX
Description: Recovery – Indicates current, balance due by the recipient for prior overpayment(s). This field is system generated from entries on the OVER screen from the SOC 330 IHSS Overpayment Collection Transaction. The field displays the sum of all A-Active Status OVER screen sequences. The RELB screen field name is RECOVERY.

Field: R STATE HEARING HRS – ***RELB Screen Display Only***
Length:
Description: This field does not currently accept data entry.

The next three lines (M, N and O) are monthly payment segments used when building or updating a recipient's payment eligibility period. The following explanation (M1 through M8) will cover all three eligibility segments. All fields in these segments are system-generated based on entries from the SOC 293. Exceptions may include months that are prorated more than 5 times or recipients who have more than two service delivery modes.

Field:
Untitled SEGMENT SELECT – ***RELB Screen Display Only***
Length: 1
Description: When an eligibility segment (M, N, or O line) displays prorated hours, typically because the cases has been was on L-Leave Status for a period during a month, the user may view the actual eligibility dates and hours by tabbing to the SEGMENT SELECT field and keying one of the following, then press <Enter> to process to the RELC which displays the grid hours and eligibility dates associated to the designated eligibility segment.

- 1 – M Line eligibility
- 2 – N Line eligibility
- 3 – O Line eligibility

If it is necessary to update a prorated segment, see ***Section V-B – Special Instructions, Reason Code 999.***

Fields M1,
N1, and O1: ACT – Optional, Alpha
Length: 1 Format: D
Description: Action – Field used by the service worker to indicate the eligibility segment to be deleted. Circle D next to the eligibility segment to be deleted. The RELB screen field name is ACT and always displays as blank.

Fields M2,
N2, and O2: BEGINNING DATE – System generated, Numeric

Length: 8 Format: MMDDYYYY
Description: Beginning Date – Date on which recipient begins receiving IHSS. System generated from entry in Field ZZ3. The RELB screen field name is BEG DATE.

Fields M3, N3 or O3: ENDING DATE – System generated, Numeric
Length: 8 Format: MMDDYYYY
Description: Ending Date – Date indicating the time-limited service, a reassessment is due, leave status, or a termination of service. System generated from entry in field ZZ4. The RELB screen field name is END DATE.

Fields M4, N4 or O4: GROSS AMOUNT – System Generated, Numeric
Length: 6 Format: X,XXX.XX
Description: Gross Amount – RATE x HOURS = GROSS. The monthly amount authorized by the county to be paid for a recipient. This amount may be manually changed by the county if there is documented cause in the case record. The RELB screen field name is GROSS AMT.

Fields M5, N5 or O5: MODE/RATE/HOURS – Optional or System generated, Alphanumeric
Length: 2/4/4 Format: XX/XX.XX/XXX.X
Description: Mode/Rate/Hours – Two service delivery modes, pay rates, and monthly service hours are applied to each segment. The system generated information from fields L1 and L2 may be manually overridden. The RELB screen field name is MODE/RATE/HOURS.

Mode – Indicates the mode of service delivery. The following may be used:

- IP – Individual Provider
- CC – County Contract
- HM - Homemaker

Rate – The hourly rate of pay for the indicated delivery mode
Hours – The monthly hours of service, purchased by the county, to be rendered to the recipient.

Fields M6, N6 or O6: SHARE OF COST – Optional, Numeric
Length: 6 Format: XXXX.XX
Description: Share of Cost – Monthly amount of money determined by the county to be paid directly by the recipient. The RELB screen field name is SHR/COST. Two different share of cost figures, based on the mode, may be identified:

- Where the share of case is automated, these field will be system generated
- Where the share of case cannot be automated, Share of Cost documents must be completed and the results entered in fields M6, N6 or O6.
- For cases with mixed modes of service delivery, or the share of cost is to be paid to someone other than the Individual Provider (IP), Reason Codes 533 and 534 will prohibit Field K3, SHARE OF COST, from being system

generated into Field M6.
Refer to Section V-B, Special Instructions, Share of Cost Computations – SOC 293.

Fields M7,
N7 or O7: TYPE – System Generated, Alpha
Length: 1
Description: Type – Designates the recipient's impairment level, determined from the service assessment hours based upon the Individual Assessed Need column of the IHSS needs assessment grid. The RELB screen field name is TYPE.

- S A severely impaired recipient is one who has been assessed as requiring 20 or more hours of (*) services on the Individual Assessed Need column of the IHSS needs assessment grid
- N A non-severely impaired recipient is one who has been assessed as requiring less than 20 hours of starred (*) services on the Individual Assessed Need column of the IHSS needs assessment grid
- C A "C" prints beneath the S or N, in the TYPE field, on the SOC 293, when a recipient is PCSP eligible. PCSP indication is system generated when a "Y" is entered in "PCP?" field in the ZZ field on the RELC Screen.
- Blank PCSP eligible indicator default value "N"

Fields M8,
N8 or O8: PAY OPT – System Generated, Alpha
Length: 2
Description: Pay Option – Refers to the way payment is made to either the recipient or the provider. The RELB screen field name is OPT.

- P Payee is Provider (Arrears) – System default – occurs when no pay option is indicted in fields ZZ5 or ZZ6 and IP Mode is entered in fields L1 or L2
- R Payee is Recipient (Advance) – Displays when a "Y" Yes is entered in field ZZ5 on the RELC screen.
- M Restaurant Meal Allowance to Recipient – If Restaurant Meals have been authorized. Field ZZ6 on RELC will indicate "Y".
- F Direct Deposit (EFT) – When recipient is Advance Payment and case has been authorized for Electronic Funds Transfer. Field ZZ5 on RELC will indicate "Y".

Field P1: APPLICATION DATE – Required, Numeric
Length: 8 Format: MMDDYYYY
Description: Application Date – The day the recipient requested IHSS. This date also indicates the date from which there has been continuous service activity. If a termination has occurred due to an interruption in service activity, change the application date to reflect the re-application date for IHSS. If a case is terminated or denied in error, the original application date should be used with an applicable 400 series NOA code(s). The RELB screen field name is APPLICATION DATE.

Field P2: REF – Required, Numeric
Length: 2

Description: Referral Source – Indicates the identity of the person or agency which contacted the county to begin a referral. The RELB screen field name is REF.

Code	Source	Code	Source
01	Self	21	Senior Day Care Center
02	Linkage Program	22	Senior Center
03	Multipurpose Senior Services Center	23	Law Enforcement
04	Adult Day Health Care Center	24	Spouse
05	Early Hospital Discharge (Diagnostically Related Group)	25	Adult Son
06	Preadmission Screening (Gatekeeper)	26	Adult Daughter
07	Reported Adult Abuse	27	Mother
08	County Social Service Worker	28	Father
09	County Eligibility Worker	29	Other Relative
10	Medi-Cal Review (AB 3398)	30	Friend
11	Physician	31	Neighbor
12	Mental Health Department	32	Conservator
13	Health Services Department	33	Guardian
14	Rehabilitation Department	34	Religious Organization
15	Regional Center	35	Nutrition Center
16	Hospital Discharge Planner	36	Social Security Administration
17	Skilled Nursing Facility Discharge Planner	37	Other Community Agency
18	Intermediate Care Facility Discharge Planner	38	Other
19	Community Care Facility	39	Unknown
20	Area Agency on Aging	40	Home Health Agency

Field P3: FACE TO FACE DATE – Required, Numeric
Length: 8 Format: MMDDYYYY
Description: Face to Face Date – The date a county worker had face-to-face contact with the recipient. The RELB screen field name is FACE/FACE DATE.

Field P4: COUNTY USE – Optional, Alphanumeric
Length: 25 Format: Free form entry
Description: County Use – For the county's individual use. The RELB screen field name is COUNTY USE.

Field Q1: D/O – Optional, Alphanumeric
Length: 2
Description: District Office – Two digit code indicating the office within a county responsible for the case. System defaults to 01. The RELB screen field name is DO#.

Field Q2: SERVICE WORKER NAME – System generated, Alphanumeric
Length: 20
Description: Service Worker Name – First name or Initial and Last name of service worker responsible for the case. There are two corollary RELB screen fields, F NAME and L NAME. System generated from entry in field Q3.

Field Q3: SW# - Required, Alphanumeric

Length: 4
Description: Service Worker Number – The number assigned, by the county, to the service worker responsible for this case. The RELB screen field name is #.

Field Q4: SERVICE WORKER PHONE # – Required, Numeric
Length: 10
Description: Service Worker Phone # – The telephone name of the service worker identified in fields Q2 and Q3. The RELB screen field name is PH#.

Fields R through T **do not display** on the RELB screen.

Field R: ALERT MESSAGE/NOA MESSAGE – System generated, Numeric
Length: 31
Description: Alert Message/Notice of Action Message – Codes for messages to the service worker and for messages on Notice of Action.

Alert Message: Codes used to transmit messages to the service worker about the recipient. Refer to Codes 001 through 299 for the actual message that conveys an action that may need to be taken by the service worker. ***Refer to Section V-E RELA, RELB and RELC Alerts for alert descriptions.***

Notice of Action: Codes that reflect those messages printed on the recipient Notice of Action. Codes 300 through 399 are automated (system generate) messages; 400-599 are worker generated messages. ***Refer to Section V-F Notice of Action Message for code descriptions.***

Field S: AUTHORIZATION/DATE/REMARKS, Optional, Alphanumeric
Description: Authorization/Date/Remarks – Optional field for use by county personnel.

Field T: VALIDATION/DATE/REMARKS, Optional, Alphanumeric
Description: Validation/Date/Remarks – Optional field for use by county personnel.

Page 2 IHSS Service Assessment Grid

Top Row: LAST NAME & #/SEQ #/Fixed Column Headings
Description: Top Row – Includes both system generated identifiers: Last Name, Recipient Number and Sequence Number, and the fixed column headings: Total Need, Adjustments, Individual Assessed Need, Alternative Resources, Auth To Be Purch, Unmet Need, and County Use. The RELC screen field names are SEQ# and SEG#.

Left Column Field AA through YY: Row Headings
Description: Row Headings – The row headings in the column (AA - YY) include all In-Home Supportive Services, which may be authorized for a recipient. Only those services with asterisks (* or **) are included in the computation of those 20 hours of service needs which determine if a recipient is severely impaired and eligible to receive benefits totaling the higher maximum payment and advance payment. The double asterisk (**) service is included in the 20 hours only when assistance with Feeding, Preparation of Meals, and Meal Cleanup

are all required. The computation is based on the Individual Assessed Need hours. The RELC screen field names are AA – YY.

Shaded Areas: System Generated
Description: Shaded Area - The shaded areas of the IHSS assessment grid will be system-generated from those numbers entered in CMIPS. The service worker may wish to complete preliminary computations by filling in the shaded areas; however, the system-generated totals will be the accepted hours and dollars from which the payment segments Fields M4 and M5, N4 and N5, and O4 and O5 will be computed. There are no corollary RELC fields.

The following descriptions of the top column headings apply to each of the services (AA - YY) listed in the left column.

Heading: TOTAL NEED – Optional, Numeric
Length: 5 Format: XXX.XX
Description: Total Need – Total hours of service needed by the household, rounded to the nearest hundredth. Service needs are weekly with the exception of the following monthly services. The RELC screen header name is NEED.

AA	Domestic Services	UU	Remove Grass, Weeds, Rubbish
GG	Heavy Cleaning	XX	Teaching Demonstration

Heading: ADJUSTMENT – Optional, Numeric
Length: 5 Format: XXX.XX
Description: Adjustments – Hours of service prorated between the recipient and other members of the household, rounded to the nearest hundredth, to be subtracted from Total Need because of a(n)

- Shared living arrangement
- Parent Provider
- Able/Available spouse
- Other IHSS recipient(s)
- Other Protective Supervision Recipient(s) – WW Row only

The RELC screen header name is ADJS.

Heading: INDIVIDUAL ASSESSED NEED – System Generated, Numeric
Length: 5 Format: XXX.XX
Description: Individual Assess Need – The recipient's total need for IHSS minus adjustments equals the Individual Assessed Need. This is considered the recipient's actual need that determines if he/she is severely impaired. The RELC screen field name is IND ND.

Heading: ALTERNATIVE RESOURCES – Optional, Numeric
Length: 5 Format: XXX.XX
Description: Alternative Resources – Hours, rounded to the nearest hundredth, which are not to be considered for purchase with IHSS funds because services are available from another source. Refused services are indicated in this field by preceding the hours with a negative (-) sign. The RELC screen field name is ALT.

Refer to Section V-B, Special Instructions for Refused Services – SOC 293.

Heading: AUTH TO BE PURCH – System Generated, Numeric
Length: 5 Format: XXX.XX
Description: Authorization to be Purchased – The total need for IHSS minus any adjustments, alternative resources, and refused services. The number of IHSS hours to be authorized to be purchased for the recipient. If the total hours authorized to be purchased exceeds the allowable maximum, the excess hours will be displayed in the unmet need column on the printed 293 document for each service. On the RELC screen, the total excess hours will be displayed in field aa7 UNMET NEED. The RELC screen field name is PURCH.

Heading: UNMET NEED – System Generated, Numeric
Length: 5 Format: XXX.XX
Description: Unmet Need – This field will be system-generated with the service needs exceed the maximum authorized hours. The unmet need must be documented. This number represents the total amount of unmet need, prorated equally for each service authorized, except protective supervision that can have no unmet need. There is no associated RELC screen field name.

Heading: COUNTY USE – Reserved
Length: 5 Format: XXX.XX
Description: County Use – This column is reserved for future use. The RELC screen field name is CNTY USE.

Field ZZ1: NOA – Optional, Alphanumeric
Length: 1
Description: Notice of Action – Circle one to indicate where Notice of Action is to be sent. If an "M" is entered by the changes made are negative and the effective date is not timely, the "M" will be changed to a "C". The system can monitor a timely notice, so as to give the recipient a 13 day notice. Negative changes include a denial or termination, increase in the share of cost amount, or a decrease in total hours to be purchased. The RELC screen field name is NOA.
M – Mail to Recipient
C – Return to County
N – No Notice of Action

- If a C is entered and a NOA code is also entered, the NOA will come back to the service worker to enter added information such as the mailing date, dollar amount, etc
- If a Notice of Action is not timely (13 calendar days from date of entry) due to adverse action and M is circled, the system will print a question mark (?) under M and will print C - Return to County.
- Occasionally an M or C may have been circled, but the system was unable to complete a Notice of Action due to a change of birthdate, address or use of mode. The system will print a question mark (?) under M or C and print an N – No Notice of Action – because the action being taken does not meet the criteria for production of a NOA.

Refer to Section V-B, Special Instructions, Notice of Action Suppression - SOC 293.

Field ZZ2: RSN. CD. – Optional, Numeric
Length: 3/3/3/3 Format: XXX XXX XXX XXX
Description: Reason Codes(s) – Codes for actions described in Notice of Action that must be generated by a service worker and cannot be automated. This field allows the entry of up to four, three-character, codes. The RELC screen field name is REASON CODE. ***Refer to Section V-F under Worker Generated Message for specific codes 400 through 600.***

Field ZZ3: BEGINNING DATE – Required, Numeric
Length: 8 MMDDYYYY
Description: Beginning Date – Date on which recipient begins receiving IHSS services or when there is a change. This date is system generated to the payment segment, Fields M2, N2 or O2. The RELC screen field name is BEGIN DATE.

Field ZZ4: ENDING DATE – Required, Numeric
Length: 8 MMDDYYYY
Description: Ending Date – Date indicating the last date of any of the following: a time limited service, a reassessment is due, leave, or a termination. This date is system generated to the payment segment fields M3, N3 or O3. The RELC screen field name is END DATE.

Field ZZ5: ADVANCE – Optional, Alpha
Length: 1
Description: Advance – Indicates the payee has requested and is eligible for advance payment. Advance Pay recipients must be Severely Impaired and non-PCSP. Circle Y (Yes) or N (No). If nothing is entered, the system defaults to "N. The RELC screen field name is ADVANCE?

Field ZZ6: MEAL ALLOW – Optional, Alpha
Length: 1
Description: Meal Allowance – Circle Y (Yes) if a restaurant meal allowance is to be paid to the recipient. A "Yes" response will cause the system to deduct BB – Preparation of Meals, CC – Meal Cleanup, and EE – Shopping for Food, and to enter the M indicator in Pay Option fields M8, N8 or O8. If nothing is circled, the system defaults to N (No). The RELC screen name is ALLOW?.

Field ZZ: PCSP INDICATOR – Optional, Alpha - ***RELC field display only***
Length: 1
Description: PCSP Indicator – Designates whether or not the recipient has been flagged as PCSP eligible. RELC field displays immediately to the right of Field ZZ6, ALLOW?. The RELC screen field name is PCP? Valid indicators are:

- N – No – System Default – recipient is not indicated as PCSP eligible. An "N" entry will override other entries on the SOC 293 to ensure the recipient is classified as a Residual IHSS case.
- Y – Yes – Indicates recipient as PCSP eligible. A "C" will print below the TYPE, Field M7, N7 or O7, TYPE, on the SOC 293.

Fields aa1 through aa5, all part of MONTHLY HRS. AUTHORIZED, illustrate how hours of service authorized are computed.

- These fields may be completed by the service worker to determine the hours of service to be authorized and to ascertain if maximums have been exceeded, unmet need exists, eligibility continues, and/or share of cost will exceed needs assessment.
- There will be a system-generated computation reflected in Fields M5, N5, O5, and aa5 or aa6.

Field aa1: WKLY. HRS. – System generated, Numeric
Length: 5 Format: XXX.XX
Description: Weekly Hours – Sum of Authorized to be Purchased weekly hours. This computation does not include AA- Domestic Services, GG – Heavy Cleaning or UU – Removal Grass, Weeds, Rubbish. The RELC screen field name is WEEKLY.

Field aa2: MEAL HRS (BB+CC+EE) – System Generated, Numeric
Length: 1 Format: XXX.XX
Description: Meal Hours (BB+CC+EE) – Sum of BB – Preparation of Meals, CC – Meal Cleanup, and EE – Shopping for Food. This sum will be deducted from Field aa1 if the recipient elects to receive Restaurant Meal Allowance. The RELC screen field name is MEAL.
For Field aa2, the total of BB, CC and EE can be manually computed if the service worker wishes. However, there will be an automatic computation to assure BB, CC and EE are subtracted from the total if the recipient elects to receive a Restaurant Meal Allowance.

Field aa3: X 4.33= – System Generated, Numeric
Length: 5
Description: X 4.33= – The system multiplies the total weekly hours by 4.33 to determine the monthly service hours. The RELC screen field appears as *4.33.

Field aa4: MO. HRS. – System Generated, Numeric
Length: 5 Format: XX.XX
Description: Monthly Hours – Total monthly hours including AA – Domestic Services, GG – Heavy Cleaning, and UU – Remove Grass, Weeds, Rubbish. The RELC screen field name is MONTHLY.

Field aa5: TOTAL – System generated, Numeric
Length: 6 Format: XXX.XX
Description: Total – Sum of the converted weekly hours and the monthly hours representing the total IHSS hours for the recipient. The RELC screen field name is TOTAL.

Field aa6: PURCHASE – System generated, Numeric
Length: 5 Format: XX.XX
Description: Purchase – Monthly IHSS hours minus the unmet need hours (if applicable) authorized for a recipient. These hours display in Fields M5, N5 or O5 (rounded to the nearest tenth). The RELC screen field name is PURCHASE.

Field aa7: UNMET NEED – System Generated, Numeric
Length: 5 Format: XX.XX
Description: Unmet need – Hours of services in excess of IHSS benefit maximums. The RELC screen field name is UNMET NEED.

COMPLETING THE GRID PORTION OF THE SOC 293
OVERVIEW

All rows indicate hours per week except Domestic, Heavy Cleaning, Removal of Grass, Weeds and Rubbish, and Teaching and Demonstration. Those four tasks are monthly entries.

Columns:

- Total Need is the need for services. For tasks that might be prorated (Domestic, Related [Meal Preparation, Meal Cleanup, Laundry, Shopping, Errands], Heavy Cleaning, Removal of Ice and Snow, Teaching and Demonstration, and Protective Supervision), it is the household's need.

- Adjustment is the portion of the household's need that is not the consumer's portion.

- Individual Assessed Need is calculated by CMIPS. It is the balance when subtracting the Adjustments from the Total Need. That makes it the consumer's share of the household need.

- Alternative Resources is the portion of the Individual Assessed Need that is met by an agency or volunteered by a friend or family member. This column is also where Refused Services are recorded (services you've assessed as being needed for the consumer to live safely in his/her home but s/he declines assistance).

- Auth to be Purchased is also calculated by CMIPS. It is the difference between the Individual Assessed Need and the Alternative Resources. The weekly time from this column is totaled, multiplied by 4.33 weeks per month, and the monthly Auth to be Purchased is added to create the consumer's actual authorization.

- Unmet Need is also calculated by CMIPS. If the total monthly authorization would exceed the allowable maximum, CMIPS calculates the proportion of hours per task to the total hours and applies that proportion to the overage for each task. Cases with Protective Supervision authorized should never have an unmet need.

IX. Refused Services

As part of the Uniformity Assessment process, CMIPS generates an alert message when a need for service is indicated in Field H1, Functional Limitations, but no hours are entered in the Total Need Field on the assessment grid because the IHSS recipient has refused services. Take the following steps to document the need for service and the recipient's refusal of all, or some of the service.

A. If a service need exists, enter that need on the assessment grid completing the Total Need, Adjustments, and Alternative Resource Fields, as appropriate.

B. On the SOC 293 form, enter an "R" preceding the number of service hours in the Alternative Resources Fields will indicate refused services. The Alternative Resources Field is thereby a dual use field.

C. On the RELC screen, enter the hours NEED and ADJ as indicated on the SOC 293. In the ALT – Alternative Resources Field, enter a negative (-) sign followed by the service hours that are being refused.

D. CMIPS does not allow the entry of REFUSED hours greater than the individual assessed need less alternative resources. If such an entry occurs the edit message "REFUSED CANNOT BE > IHSS" displays. The user must correct the entry.

E. When there is an identified service need for protective supervision and the recipient refuses services, Alert Message 224 – "Effective MM/DD/YY functioning rank indicates need for Protective Supervision" will appear on the CMIPS Warning Alert Listing as a reminder that the recipient is potentially at risk.

X. IHSS Disaster Preparedness Assessment Plan

The IHSS Program serves elderly, disabled, and blind persons who could not live safely in their own homes without assistance. The Caseload Disaster Preparedness (DP) Assessment Plan provides a safety check for thousands of elderly and disabled IHSS recipients who might be unable to care for themselves, or even call for help, in the aftermath of a disaster. Therefore, under ideal conditions, all recipients would receive contact after a disaster.

The DP Plan involves some additional un-reimbursed workload for counties, therefore participation is voluntary.

A. Purpose

1. The primary purpose of Disaster Preparedness coding is to provide responding Emergency Personnel with the special conditions or needs of recipients
2. To provide counties with an assessment tool to identify recipients requiring contact in the aftermath of a disaster
3. To provide Service Workers with suggested criteria for considerations when assessing a recipient's post-disaster contact needs
4. To develop and maintain a CMIPS database identifying the need for contact, special impairments, and medical supply needs of recipients in a disaster situation
5. To generate a monthly report listing recipient, by need, for contact in disaster situations. The report indicates the primary language of non-English speaking recipients

B. Intent And Limitations

1. The following guidelines are provided for the use of Service Workers in the assessment of IHSS recipients in their need for contact in a disaster situation.
2. This DP guide does not attempt to cover all possible factors to be considered when predicting a recipient's contact needs in the aftermath of a disaster.
3. Although some criteria refer to the Functional Index, this guide does not use the same assessment approach or principles of the Uniformity Guide. Unlike the Uniformity Guide, determining a recipient's response need after a disaster is not entirely dependent upon functioning level. Instead, the recipient's support network and environment are the primary factors. These include:
   a. The quality and availability of the recipient's support systems
   b. The recipient's access to adequate transportation
   c. Whether or not the recipient lives in a geographically isolated area
4. These factors and other applicable criteria, will determine the recipient's level of contact necessary.
5. Special impairments, such as blindness, deafness and medical supply needs, do not by themselves determine a recipient's DP coding. These are secondary factors the Service Worker must consider with the recipient's environmental and other support needs.

6. A Service Worker's evaluation of a recipient relies heavily upon independent judgment and unique knowledge of the recipient's circumstances. Consequently, this guide does not replace the Service Worker's expertise and role in decision-making; it is merely an aid.

C. **IHSS Caseload Disaster Preparedness (DP) Designations**

The DP field, on the SOC 293 and in CMIPS, accepts one designation for each of the positions indicated below. All three positions must be filled. Indicate the appropriate designations on the SOC 293 for entry in CMIPS.

1. **FIRST POSITION – VULNERABILITY** – Indicates of the recipients' vulnerability during or after a disaster.

A	Critical – recipient authorizes contact
B	Urgent – recipient authorizes contact
C	Moderate – recipient authorizes contact
D	Critical – recipient declines contact by emergency services.
E	Urgent – recipient declines contact by emergency services.
F	Moderate – recipient declines contact by emergency services.
Z	Non-critical

2. **SECOND POSITION – SPECIAL IMPAIRMENT(S) IDENTIFIERS** – Indicates special impairment of the recipient. Enter the letter corresponding to the dominant impairment in Field D2 of the SOC 293.

A	Deaf	D	Wheelchair Bound
B	Blind	E	Mental Disability
C	Bed bound	Z	Recipient does not have any listed special impairment

3. **THIRD POSITION – SUPPLIES** – Indicates the life support supplies used by the recipient. Enter the letter corresponding to the most needed life support supply in Field D2 of the SOC 293.

A	Respirator	B	Oxygen
C	Insulin	D	Life Supporting Medications
E	Dialysis	F	Bowel and/or Bladder
G	Nasal/Gastrointestinal tubes/suctioning	Z	Recipient does not have any listed supply need

FIRST POSITION – VULNERABILITY – EXAMPLES

The following are examples used to determine First Position, VULNERABILITY, designations:

Recipient is vulnerable and needs contact in a major disaster, as adequate support systems for emergencies are not in place (socially isolated, conflicts with family, etc.).

If any of the following situations apply indicate letter A – F in the first position of Field D2 on the SOC 293 and RELA

- Recipient is severely impaired or bedfast with a Uniformity Functional Index (FI) score of 2.75 or higher (SOC 293 Field H2)
- Recipient relies heavily or completely on IHSS for need. Close to or at maximum hours/dollars (SOC 293 Field aa6)
- Recipient has a Functional Limitation of 4 or above for Meal Preparation, Transfer, Eating, or Bowel & Bladder care. (SOC 293, Field H1)
- Recipient is blind or significantly visually impaired. Aid Code 6A, 20, 24, 26 or 28. (SOC 293 Field A3)
- Recipient has a Functional Limitation of 5 or above for Respiration, Memory, Orientation or Judgment. (SOC 293, Field H1)
- Recipient receives Protective Supervision (SOC 293 Field WW)
- Recipient has a current or past Adult Protective Services (APS) case related to abuse, neglect, or abandonment – Not indicated on SOC 293
- Recipient is heavily medicated or a substance abuser – Not indicated on SOC 293
- Recipient is deaf or has a disability limiting communication (i.e., speech impairment)
- Recipient lives in a geographically isolated area inaccessible to community emergency services
- Recipient lacks access to adequate transportation
- Recipient's provider(s) or alternate resources are sometimes unreliable
- Other

Recipient does not need contact in a major disaster, as strong, adequate, and reliable support systems are in place. If any of the following situations apply, indicate a "Z" in the first position of Field D2 on the SOC 293 and RELA

- Recipient functions fairly independently and needs minimal IHSS (low hour recipients)
- Recipient's physical or mental functioning does not affect the ability to cope with a disaster to a great degree (has no Functional Limitations greater than 5 for Memory, Orientation or Judgment
- Recipient is non-severely impaired with an FI below 2.75
- Recipient FI is above 2.75, severely impaired, with shared living arrangement, live-in Provider, or dependable, accessible alternate resources.
- Recipient resides in a geographical area accessible to community emergency services.
- Other

E. Situations

The following situations are guidelines for the assessment of Position One. These criteria are not all inclusive. Determining a recipient's need for contact requires the Service Worker to use their independent judgment as they assess the recipient's vulnerability, special impairment, and life support supply needs.

Code A – Critical – Recipients designated under this category would receive first priority for contact should a major disaster occur. Recipients receiving this priority are bed bound, severely mentally disabled, in need of special life support supplies, and/or have minimal or no social supports. This designation also includes recipients in isolated locations or heavily dependent on IHSS and have problems with continuity of services.

Example 1

Mrs. S is diagnosed with Organic Brain Syndrome with the following characteristics:

- FI score is 2.75 or higher, mentally impaired and bedfast, and has a Functional Limitation of 4 or higher in Mobility.
- Limited communication ability
- Lives in a geographically isolated area, inaccessible to community emergency services, and lacks access to adequate transportation.
- Lacks adequate support systems for emergencies.
- Uses oxygen
- Recipient indicates desire for contact
- DP Coding = ABB

Example 2

Mr. H is a deaf, quadriplegic with the following characteristics:

- FI score is 2.75 or higher, severely impaired
- Functional Limitation of 4 or higher in Mobility
- Limited communication ability
- Lacks adequate transportation.
- Support systems are inadequate.
- On oxygen and requires tube feeding and suctioning.
- Provider(s) is sometimes unreliable
- Recipient indicates desire for contact
- DP Coding = AAB

Code B – Urgent – Recipients placed in this second priority category are considered less severe than critical cases and would receive contact after Code A recipients. These recipients have some reliable social supports. Some Code B's may be bed

bound or severely restricted, but not on critical life supports such as oxygen or dialysis.

Example 3

Mr. D is a heart patient on medication and with the following characteristics:

- Depends heavily upon IHSS, but his provider(s) is fairly reliable.
- Functional Limitation of 5 in Memory
- Lacks adequate transportation
- Support systems are somewhat reliable
- Recipient indicates desire for contact
- DP Coding = BED

Code C - Moderate – Recipients placed in this category would receive contact after the Critical (A) and Urgent (B) recipients. Typical these recipients may have special impairments (e.g. deafness) but do not have life support supply needs. They may have partially reliable support systems and do not live in geographically isolated areas.

Example 4

Mr. D is a heart patient on medication and with the following characteristics:

- Relies fairly heavily on IHSS
- Functional Limitation of 5 in Memory
- Somewhat visually impaired.
- Functional Limitation of 4 in Mobility
- Does not have access to transportation
- Social supports are good, and he does not live in a geographically isolated area
- Recipient indicates desire for contact
- DP Coding = CEZ

Code D – Critical but consumer declines advance notification of emergency services

Example 5

Mrs. P is diagnosed with chronic obstructive pulmonary disease, using oxygen with the following characteristics:

- FI score is 2.75 or higher, mentally impaired and bedfast, and has a Functional Limitation of 4 or higher in Mobility
- Limited communication ability
- Lives in a geographically isolated area, inaccessible to community emergency services, and lacks access to adequate transportation
- Lacks adequate support systems for emergencies
- Recipient declines contact

- DP Coding = DBB

Code E – Urgent but consumer declines advance notification of emergency services

Example 6

Mrs. E is an emphysema patient on oxygen and has the following characteristics:

- Depends heavily upon IHSS, but her provider(s) is fairly reliable.
- Visually impaired.
- Lives in a geographically isolated area but has somewhat reliable support systems
- Recipient declines contact
- DP Coding: EZB

Despite the apparent need for contact, Mrs. E has not given permission to the county to release her name to designated agencies in advance of an emergency. Although Mrs. E is considered vulnerable and in urgent need of contact, her case is coded using an E because she has not given her permission to be contacted.

Code F – Moderate but consumer declines advance notification of emergency service

Example 7

Mrs. Y is in the first stages of Alzheimer's and with the following characteristics:

- FI score of 2.75 or above, severely impaired, but not bedfast.
- Functional Limitation of 5 in Memory and Judgment.
- Slightly visually impaired.
- Social supports are basically reliable as several family members live with her.
- She has access to transportation
- Recipient declines contact
- DP Coding = FEZ

Despite the apparent need for contact, Mrs. Y has not given permission to the county to release her name to designated agencies in advance of an emergency. Therefore, although Mrs. Y is considered to be vulnerable and in moderate need of advance notification, this field would be coded F because she has not given permission.

Non-Critical Code "Z" - Recipients placed in this category would not require an emergency contact should a major disaster occur, primarily because they have strong or adequate support systems, have access to transportation or they do not live in a geographically isolated area.

Also, these recipients do not have physical or mental conditions that would affect their abilities to cope with a disaster. Their FI scores are low or moderate.

Example 8

Mr. T does not have a major medical impairment, or any medical supply needs, and has the following characteristics:

- Functions fairly independently and requires minimal IHSS (low hours).
- Physical and mental functioning do not affect ability to cope with a disaster
- FI score is less than 2.75, non-severely impaired
- Residence is not in a geographically isolated area.
- DP Coding = ZZZ

Example 9

Tom is a 12 year old child diagnosed with cerebral palsy from birth trauma with the following characteristics:

- Relies heavily on IHSS
- FI scores are well over 2.75 and confined to a bed or wheelchair.
- Functional Limitations of 5 in Judgment.
- Nonverbal
- Functional Limitations of 5 in Mobility
- Uses oxygen periodically
- Mother is the primary attendant, father is very helpful, and the family has other supports.
- The family has transportation and does not live in a geographically isolated area
- DP Coding = ZCB – Coding is Z because of the parental and other family support

F. Caseload Disaster Preparedness Assessment Profile

Each county has access to Caseload Disaster Preparedness Assessment through the CMIPS Online Reports website. Access is by County; or by County then Zip Code. Counties may print and distribute these report as needed to Social Workers and other authorized County Agencies who are responsible as Disaster Responders.

The report lists the recipient's name, address, telephone number, social service worker, and language along with narrative comments about the recipient's degree of risk and any special needs.

It is assumed recipient case files will not be available during an emergency. Counties are urged to integrate the report into a larger countywide emergency response master plan.

G. Implementation and Updates

Implementation for counties adopting the Disaster Preparedness plan will be discretionary. Cases may be phased-in by completing a guide on all new approved applications and/or when ongoing cases are reassessed. Counties may choose to allocate staff resources to implement the plan as soon as possible on a high priority basis. Thereafter, counties may wish to update the disaster preparedness assessment at least annually.

SOC 293 Warning Alert Messages

Alert messages notify Social Workers that entries on the SOC 293 require review and/or action. Most Alert messages may require some corrective action; however some may be informational only. The following facts relate to Alert Messages:

1. All Alert Messages are assigned a three-character numeric Alert Code value from 001-299
2. Alert Codes print in Field R, Alert Messages on the SOC 293 Turnaround Document
3. Some Alert Codes display on RHSD – See ***Section IV-A – Recipient History Screen***
4. Cases meeting the criteria for an Alert Code will appear on the monthly CMIPS Warning Alert Listing – See ***Section XIV-D – CMIPS Warning Alert Listing***.

Multiple Eligible Cases

Alert Code	Alert Message
001	Recipient {Recipient Case Number} in {Status} status in {County Name} County with Worker {Social Worker Name} at {SW Phone Number}.

Time Limited

Alert Code	Alert Message
003	Application pending over ____ days
004	Provisional approval over _____ days
005	Leave status since MM/DD/CCYY
006	Service (GG, UU, XX) time limited _____ month(s)
008	All services are time-limited. Discontinue case.

Adjustments

Alert Code	Alert Message
011	Shared Living, AA-GG, services not adjusted. Begin {MM/DD/YY} End {MM/DD/YY}.
012	Review UU, VV, WW, XX. Proration required?

Able & Available Spouse

Alert Code	Alert Message
013	A & A spse. AA, BB, CC, DD, EE, FF, GG, UU, VV, XX not allowed
014	A & A spse. Confirm employment, other unavoidable absence status for auth of BB, SS, TT, WW

Parent

Alert Code	Alert Message
015	Parent – AA not allowed
021	Recipient 18 or over, review Spouse/Parent code (G1); Benefit Code (J3).

Aid Code

Alert Code	Alert Message
023	Recipient becomes 18 during {Month}. Update Spouse/Parent (G1) and SOC Benefit Code (J3).

Electronic Funds Transfer

Alert Code	Alert Message
041	The electronic funds transfer (EFTS) is in Hold Status.

Address Change

Alert Code	Alert Message
052	Address change only. Review fields G1 through G8, and AA through YY for changes
053	Guardian/conservator change. Review address
054	Recipient has an out-of-state address

Income Eligibility

Alert Code	Alert Message
060	Share of Cost Date is not current

Overpayment Adjustment

Alert Code	Alert Message
072	Recovery amount, Field L3, generated from SOC 330. Issue manual NOA to recipient.

Functioning

Alert Code	Alert Message
108	Effective MM/DD/CCYY functioning ranks indicate Meal Preparation assessed as Paramedical Service (tube feeding)
119	Effective MM/DD/CCYY functioning rank indicates Feeding assessed as Paramedical Service (tube feeding)
122	Effective MM/DD/CCYY functioning rank indicates Respiration assessed Paramedical Service (suctioning)
200	Did you overlook the need for Domestic and Related Services?
203	Effective MM/DD/CCYY functioning rank indicates need for Domestic Services
204	Effective MM/DD/CCYY functioning rank indicates need for Laundry Services
205	Effective MM/DD/CCYY functioning rank indicates need for Shopping and/or Errands
207	Effective MM/DD/CCYY functioning rank indicates need for Meal Preparation and/or Cleanup
210	Effective MM/DD/CCYY functioning rank indicates Assistance with Ambulation
211	Effective MM/DD/CCYY functioning rank indicates need for Bathing, Oral, Hygiene and Grooming
214	Effective MM/DD/CCYY functioning rank indicates need for assistance with Dressing
215	Effective MM/DD/CCYY functioning rank indicates need for Bowel and Bladder Care
217	Effective MM/DD/CCYY functioning rank indicates need for assistance Moving In/Out of Bed or Other Transfers
218	Effective MM/DD/CCYY functioning rank indicates need for Feeding
221	Effective MM/DD/CCYY functioning rank indicates need for assistance with Respiration
224	Effective MM/DD/CCYY functioning rank indicates need for Protective Supervision

Provider Eligibility Update, SOC 311

State of California-Health & Welfare Agency-
Department of Social Services
IN-HOME SUPPORTIVE SERVICES

PROVIDER ELIGIBILITY UPDATE

	COUNTY	RECIPIENT #	CD.	PROVIDER NUMBER	SEQ. #	RECIPIENT NAME
A	(1)			(2)	(3)	(4)

	LAST NAME	FIRST NAME	MI.	STATUS	ETHNIC	LANG.
B	(1)	(2)	(3)	(4) E L D X	(5)	(6)

	STREET	CITY	STATE	ZIP CODE/CT
C	(1)	(2)	(3)	(4)

	SOCIAL SECURITY #	DED./EXEMPT	TELEPHONE #	SEX	BIRTHDATE MONTH DAY YEAR	W-5	W-4
D	(1)	(2) P S C B O	(3)	(4) M F	(5)	(6)	(7)

	COUNTY USE	REL OF PROV.	# OF PROV.	RECOVERY
E	(1)	(2)	(3)	(4)

	ACTION	BEGINNING DATE	ENDING DATE	HOURS	SHARE/COST	RATE	SPLIT SHIFT	
F	(1) DEL	(2)	(3)	(4)	(5)	(6)	(7)	(8)
G	(1) DEL	(2)	(3)	(4)	(5)	(6)	(7)	(8)
H	(1) DEL	(2)	(3)	(4)	(5)	(6)	(7)	(8)

	PROVIDER NUMBER
A	(2)

	LAST NAME	FIRST NAME	MI.	STATUS	ETHNIC	LANG.
B	(1)	(2)	(3)	(4) E L D X	(5)	(6)

	STREET	CITY	STATE	ZIP CODE/CT
C	(1)	(2)	(3)	(4)

	SOCIAL SECURITY #	DED./EXEMPT	TELEPHONE #	SEX	BIRTHDATE MONTH DAY YEAR	W-5	W-4
D	(1)	(2) P S C B O	(3)	(4) M F	(5)	(6)	(7)

	COUNTY USE	REL OF PROV.	# OF PROV.	RECOVERY
E	(1)	(1)	(3)	(4)

	ACTION	BEGINNING DATE	ENDING DATE	HOURS	SHARE/COST	RATE	SPLIT SHIFT	
F	(1) DEL	(2)	(3)	(4)	(5)	(6)	(7)	(8)
G	(1) DEL	(2)	(3)	(4)	(5)	(6)	(7)	(8)
H	(1) DEL	(2)	(3)	(4)	(5)	(6)	(7)	(8)

COUNTY VALIDATION

	AUTHORIZATION	DATE	REMARKS
I			

	VALIDATION	DATE	REMARKS
J			

SOC 311 10/05

Provider Eligibility Update Form (SOC 311)

Field-by-Field Description

The SOC 311 form and Provider Eligibility (PELG) screen are used to add new or update existing records for In-Home Supportive Services (IHSS) providers. The PELG screen displays IHSS provider information previously keyed from an SOC 311. When a PELG is added or updated a system generated turnaround document (TAD) is produced. This document should be kept in the recipient case file.

Data Entry/Display Fields

On the SOC 311 TAD, the district office number (DO), service worker number (SW), and print date are displayed in the top margin, above the A line.

Fields A2 and B1 through H8 are repeated on the SOC 311 for data entry purposes only. The field duplication permits the processing of two separate transactions with separate TADs for either one provider, or individual transactions for two providers working for the same recipient.

The information found on the SOC 311 is listed below. Sometimes the data elements are found under a different name or in a different field on the PELG screen. Where there are differences, the name/location is specified in the field.

Fields A1 through A4 appear as numbered fields on only the SOC 311. The related PELG screen fields are unnumbered fields above Line B.

Field A1: COUNTY/RECIPIENT #/CD – Required, Numeric
Length: 10
Description: County/Recipient Number/Check Digit – The first two digits designate the county, the next seven digits represent the recipient case number, and the 10th digit is a system generated check digit. On the PELG screen, this number is entered on the NEXT line and displays on the THIS line.

Field A2: PROVIDER NUMBER – Required, Numeric
Length: 6
Description: The provider number is a six-digit number used by the county to identify the provider, usually the last six digits of the provider's social security number. On the PELG screen, this number is entered on the NEXT Line and displayed on the THIS Line after the recipient number.

Field A3: SEQ # – System generated, Numeric
Length: 2
Description: Sequence Number - A chronological number generated by the system indicating the most recent TAD. The PELG screen field name is SEQ#.

Field: REPRINT – Optional, Alpha – ***PELG Screen display only***
Length: 1
Description: Reprint – Allows the reprint of the most recent SOC 311. The PELG screen field name is REPRINT. Valid field entry:

Blank – System default
Y – Yes
See ***Section VI-C-III - Special Instructions – Producing a Reprint of the most recent SOC 311.***

Field A4: RECIPIENT NAME – System generated, Alphanumeric
Length: 30
Description: Recipient Name – Identifies the IHSS recipient with whom the provider is associated. The PELG screen field name is RECIP.

Field Untitled: SW# – System generated, Alphanumeric – ***PELG Screen display only***
Length: 4
Description: Service Worker Number – The number of the service worker assigned to this case. The PELG screen field name is SW#.

The information found in fields B1 through H8 appears on both the SOC 311 and the PELG screen, but not necessarily in the same field order.

Field B1: LAST NAME – Required, Alphanumeric
Length: 17
Description: Last Name – The provider's last name, or the single name for those of Samoan descent where culturally only a single name is used. The PELG screen field name is LAST NAME

Field B2: FIRST NAME – Required, Alpha
Length: 12
Description: First Name – The provider's first name. When code M, Samoan, is entered in Field B (5), a first name is not required because culturally those of Samoan descent only have a single name. The PELG screen field name is FIRST.

Field B3: MI – Optional, Alpha
Length: 1
Description: Middle Initial – The provider's middle initial. The PELG screen field name is MI.

Field B4: STATUS – Required, Alpha
Length: 1
Description: Status – On the SOC 311, circle the code which indicates the provider's eligibility to render services to a recipient. The PELG screen field name is STAT.

- E **Eligible**
- L Leave of absence
- D **Discontinued – No longer a valid code**. To discontinue a case enter a "T" on the SOC 311 and key a "T" on the PELG.
- X **Delete** – When a provider is to be deleted from the system, circle the X on the SOC 311. Key a D on the PELG screen, followed by the 16 digit case number and press <**Enter**>**.** The system will **not** allow a delete entry by

the county or the State Contractor if any payment activity occurred in the previous 16 months prior to the delete entry. The State Contractor can delete a provider if he/she was enrolled 30 days or more prior to the delete entry, if there is no payment activity in the past 16 months.

T **Terminated** – May be manually entered on the SOC 311 and the PELG screen to indicate the termination (discontinuance) of the provider's eligibility.

Field B5: ETHNIC – Required, Alphanumeric
Length: 1
Description: Ethnic – The codes listed below identify the provider's national origin or ethnicity. The PELG screen field name is ETH.

Code	Ethnicity	Code	Ethnicity
1	White	J	Japanese
2	Hispanic	K	Korean
3	Black	M	Samoan
4	Other Asian or Pacific Islander	N	Asian Indian
5	American Indian or Alaskan Native	P	Hawaiian
7	Filipino	R	Guamanian
C	Chinese	T	Laotian
H	Cambodian	V	Vietnamese

Field B6: LANG – Required, Alphanumeric
Length: 1
Description: Language – The codes listed below identify the primary language of the provider. The PELG screen field name is LANG.

Code	Language	Code	Language
0	American Sign Language (AMISLAN or ASL)	F	Ilocano
1	Spanish – NOA will be issued in Spanish	G	Mien
2	Cantonese	H	Hmong
3	Japanese	I	Lao
4	Korean	J	Turkish
5	Tagalog	K	Hebrew
6	Other non-English	L	French
7	English	M	Polish
8	Unassigned code	N	Russian
9	Spanish – NOA will be issued in English	Q	Italian
A	Other Sign Language	R	Arabic
B	Mandarin	S	Samoan
C	Other Chinese Languages	T	Thai
D	Cambodian	U	Farsi
E	Armenian	V	Vietnamese

Address fields C1 through C4 are reviewed by a United States Postal Service (USPS) approved Coding Accuracy Support System (CASS) software. See ***Section VI-C Special Instructions, Address Verification Screen,*** for detailed explanation regarding the function of the screen.

Field C1: STREET – Required, Alphanumeric
Length: 28
Description: Street – Provider's residence street address or P.O. Box used for mail delivery.

Any mail to be delivered "in care of" must have the address preceded with the entry of c/o and a space for an accurate address verification. All other "in care-of" formats are read as part of the address and may result in erroneous address verification. The PELG screen field name is STR.

Field C2: CITY – Required, Alphanumeric
Length: 17
Description: City – Provider's city of residence. The PELG screen field name is CY.

Field C3: STATE – Required, Alpha
Length: 2
Description: State – Provider's state of residence. The PELG screen field name is ST.

Field C4: ZIP CODE/CT – Required, Numeric
Length: 9 Format: 99999 9999
Description: Zip Code/Census Tract – The nine-digit ZIP+4 code associated with the providers mailing address. The PELG screen field name is Z.

Field D1: SOCIAL SECURITY # – Required, Numeric
Length: 9
Description: Social Security Number – The number assigned by the federal Social Security Administration (SSA) to identify an individual's account number. The PELG screen field name is SSN. See ***Section VI-C – Special Instructions – Person List Screen.***

Field D2: DED/EXEMPT – Required, Alpha
Length: 1
Description: Deduction/Exempt – Indicates the provider's tax status, based on a familial relationship to the recipient, for Social Security and State Disability Insurance only. The PELG screen field name is DED.
Note – The code "B", although it still appears on the SOC 311 form, is no longer a valid code. **Do not mark B on the SOC 311**. Valid Codes are:
P Parent
S Spouse
C Recipient's child, regardless of his/her age
O Other

Field D3: TELEPHONE # – Optional, Numeric
Length: 10
Description: Telephone Number - The provider's area code and phone number. The PELG screen field name is PH#.

Field D4: SEX – Optional, Alpha
Length: 1
Description: Sex –The provider's gender. The PELG screen field name is SX.
M Male F Female

Field D5: BIRTHDATE – Required, Numeric

Length: 10 Format: MMDDYYYY
Description: Birthdate – The provider's birth date. The PELG screen field name is DOB.

Field D6: W-5 – Optional, Alphanumeric – ***State Contractor Access Only***
Length: 5 Format: X YY/YY
Description: W-5 – Earned Income Credit (EIC) Advance Payment Certificate. When a W-5 has been processed for a provider submitted the corresponding information prints on the SOC 311 in the following format, X 99/99.
First character – Display the providers W5 Status

- Blank – System default – W-5 not submitted
- S – Single
- M – Married

Next four characters – YY/YY – The first year (YY) provider submitted a W5. The second year (YY) indicates the year that the current W-5 expires
If the provider has not submitted a W5 the SOC 311 will print with 00/00.
The PELG screen field name is W5. When a W5 has been entered for a provider the PELG displays in three sections: X 9999 99999999
First character – Will display the providers W5 Status.

- S – Single
- M – Married

Next four characters – YYYY – The first year provider submitted a W5, System generated
Next eight characters – MMDDYYYY – The date on which the EIC expires – user filled. See ***Section XIII-E, W-5 Earned Income Credit.***

Field D7: W-4 – System Generated, Alphanumeric
Length: 3 Format: X 99
Description: W-4 – The provider's federal withholding allowances from the Federal Withholding Allowance Certificate form (W4). When a provider submits a W-4 to the designations appear on Line H1 of the PELG screen. Only the Federal Withholding Allowance specified on the W-4 will be displayed in Field D7 on the SOC 311. The following are valid indications
First Character – Marital Status

- Blank – Exempt – System Default
- E – Exempt – Indicates a provider has submitted a W-4 claiming "Exempt" status after having had taxes withheld under another status.
- S – Single
- M – Married

See ***Section XIII-C, Employee's Withholding Allowance Certificate.***

Field E1: COUNTY USE – Optional, Alphanumeric
Length: 40
Description: County Use – Used by county for case notations. The PELG screen field name is CNY USE.

Field E2: REL. OF PROV – Optional, Numeric
Length: 2

Description: Relationship Of Provider - This code identifies the relationship of the provider to the recipient. The PELG screen field name is REL. Values are:

01	Spouse	08	Neighbor
02	Parent of minor child	09	Landlord
03	Parent of adult child	10	Housemate
04	Minor child	11	Live-in Provider
05	Adult Child	12	Home Health Agency
06	Other relative	13	Other business
07	Friend	14	Other

Field E3: # OF PROV – Optional, Numeric
Length: 1
Description: Number Of Providers – The only code/entry allowed is a "1" indicating the provider as the only "E" Eligible status provider for the recipient case. Provider records indicated with a "1" are referred to as 1:1 providers. When entered, the system updates the provider's eligibility using the assessment data from the recipient's SOC 293. The PELG screen field name is #PROV. See ***Section VI-C Special Instructions,*** for detailed explanation of the "one-to-one" provider entries.

Field E4: RECOVERY – Optional, Numeric
Length: 6 Format: $X,XXX.XX
Description: Recovery – The existing balance to be recovered from the provider for prior overpayments. The PELG screen field name is RCVY and is located on the H1 line to the extreme right. See ***Section XII-C-III – Add an Arrears Pay Provider for Recovery of an Overpayment.***

Fields F1 through F7, on both the SOC 311 form and the PELG screen, are monthly payment segments which are used when building or updating a provider's payment eligibility period. The same descriptions are repeated for fields 1 through 7 on lines F, G and H.

Field F1, G1 and H1: ACTION – Optional, Alpha
Length: 1
Description: Action – Circle the DEL on the SOC 311 to indicate an eligibility segment to be deleted. The PELG screen field name is ACTION. To delete the eligibility segment, enter a "**D**" in the Action field of the correspond eligibility segment and press <**Enter**>.

Field F2, G2 and H2: BEGINNING DATE – Required, Numeric
Length: 8 Format: MMDDYYYY
Description: Beginning Date - The Month/Day/Year on which a provider will begin receiving payment according to the eligibility segment entered. The PELG screen field name is BEG DATE.

Field F3, G3 and H3: ENDING DATE – Required, Numeric
Length: 8 Format: MMDDYYYY

Description: Ending Date – The Month/Day/Year after which a provider will no longer be eligible for payment for the corresponding recipient case. If no eligibility end date is entered, the provider continues to be eligible and the ENDING DATE of the most current eligibility segment, Field F3, must be blank (zeroes are not accepted). An ending date is only required when:

- The provider is to be placed in "L" (leave) or "T" (terminated) status
- A rate change occurs
- Hours are changed for a pay period

The PELG screen field name is END DATE.

Field F4, G4 and H4: HOURS – Required, Numeric
Length: 8 Format: XXX.XX
Description: Hours – The portion of the county authorized monthly hours for the recipient that the provider may work. If the provider is a 1:1 provider, the system will automatically assign the hours from the recipient case. The PELG screen field name is HOURS.

Field F5, G5 and H5: SHARE/COST – Optional, Numeric
Length: 6 Format: $X,XXX.XX
Description: Share of Cost – The monthly amount of money the county determines the recipient must pay directly to the provider as their share-of-cost for services. Amount displayed on PELG is data from associated recipient case. The PELG screen field name is SHR/COST.

Field F6, G6 and H6: RATE – Optional, Numeric
Length: 5 Format: $XX.XX
Description: Rate – The hourly wage rate paid to the provider. When no entry is made on a new segment, the field defaults to the county's lowest hourly rate for the time period entered. The PELG screen field name is RATE.

Field F7, G7 and H7: SPLIT SHIFT – SOC 311 Only – ***For Future Use***
Length:
Description: Split Shift - This title only appears on the SOC 311 form. There is no corollary PELG screen field.

Fields F8, G8, and H8 are untitled fields on the SOC 311.

Field F8: SDI BEG DATE – Optional, Alpha
Length: 9 Format: X
Description: State Disability Insurance Beginning Date – The recipient must complete and submit to the county a SOC 409 – IHSS/CMIPS ELECTIVE STATE DISABILITY INSURANCE (SDI) FORM to enroll the provider in elective SDI. Valid field entries are:

- Y – Begin Elective SDI withholding.

When a "Y" has been entered, the date of entry will display in the SDI BEG DATE field in MMDDYYYY format.
No SDI information prints on the SOC 311 TAD.
See ***Section XIII-G – State Disability Insurance*** for complete information regarding Elective State Disability Insurance.

Field G8: SDI END DATE – Optional, Alpha
Length: 9 Format: X
Description: State Disability Insurance Ending Date – The date elective SDI contributions will stop. If the provider is a minor child, the SDI END DATE will display as the date of their 18th birthday in MMDDYYYY format.
No SDI information prints on the SOC 311 TAD.

Federal and State Tax indications

When added to CMIPS all provider records default to "EXEMPT" for Federal Income Tax (FIT) and State Income Tax (SIT) withholding, therefore the PELG fields default to blank. When a W-4 and/or DE-4 has been processed for a provider the results display as indicated.

Lines H1, H2 and H3 displays on PELG only. When indicated this information prints to the SOC 311 in the designated area. ***These fields are accessible by State Contractor only***. All other users have inquiry access only.

Line H1: FIT W4 – Optional, Alphanumeric
Length: 3 Format: X 99
Description: Federal Income Tax W-4 – The Federal withholding allowances claimed by the provider. The following may display:
First Character – Marital Status claimed by provider

- Blank – Exempt – System Default
- E – Exempt – Indicates a provider has submitted a W-4 claiming "Exempt" status after having had taxes withheld under another status.
- S – Single
- M – Married

Last two characters – The number of allowances claimed by the provider.
Valid entry is 00 to 99. See ***Section XIII-D – Employee's Withholding Allowance Certificate*** for W-4 and DE-4 processing information.
Information from field prints in field D7 on the SOC 311.

Line H1: FIT WHOLD – Optional, Numeric
Length: 5 Format: 999.99
Description: Federal Income Tax Withholding – The additional amount of tax dollars the provider has indicate to withhold over that withheld based upon indications in FIT W4.

Field H1: SIT W4 – Optional, Alphanumeric
Length: 3 Format: X 99
Description: State Income Tax W4 or DE-4 – The State withholding allowances claimed by the provider. If the provider submits a W4, but no DE-4, the allowances indicated on the W4 will be applied to State withholding. If a DE-4 is

submitted with a different status or withholding allowances than the W4, then the FIT and SIT withholding fields may be different. The following information may displays:

First Character – Marital Status claimed by provider

- Blank – Exempt – System Default
- E – Exempt – Indicates a provider has submitted a W-4 claiming "Exempt" status after having had taxes withheld under another status.
- S – Single
- M – Married

Last two characters – The number of allowances claimed by the provider. Valid entry is 00 to 99.

PELG H1: SIT WHOLD – Optional, Numeric
Length: 5 Format: XXX.XX
Description: State Income Tax Withholding W-4 or DE-4 – The State withholding claimed by the provider. If the provider submits a W4, but no DE-4, the withholding indicated on the W4 will be applied to the State. If a DE-4 is submitted, Federal and State withholdings fields may be different.

Line H1: RCVY – System Generated, Numeric
Length: 6 Format: $X,XXX.XX
Description: Recovery – The amount being recovered from the provider for prior overpayments. This field displays the remaining outstanding balance due of all SOC 330 processed. This information prints in Field E4 on the SOC 311.

LINE H1: FIT W4 ENTRY DATE – System generated, Numeric
Length: 8 Format: MMDDYYYY
Description: Indicates the date the W-4 information was entered.

Field H1 – PELG: SIT DE4 ENTRY DATE – System generated, Numeric
Length: 8 Format: MMDDYYYY
Description: Indicates the date the DE-4 information was entered.

Line H2: TIMESHEET – Optional, Alpha
Length: 1
Description: Timesheet – Request the pre-printed timesheet for the provider. This information prints below the H Fields in the TIMESHEET field on the SOC 311 TAD. Valid values are:

- Blank – System Default
- Y – Yes

Up to four timesheets may be requested. The requested pay period and three pay periods in the future. ***See Section VII-B – Initial and Replacement Timesheet instructions.***

Line H2: START DT – Optional, Numeric
Length: 8 MMDDYYYY
Description: Start Date – The first date of the pay period for the timesheet being requested.

This date will appear on the timesheet.

Line H2: STOP DT – Optional, Numeric
Length: 8 MMDDYYYY
Description: Stop Date – The last date of the pay period for the timesheet being requested. This date will appear on the timesheet.

Line H2: RECIP AIDE # – Optional, Alphanumeric – ***Future Use***
Length: 4
Description: Recipient Aide Number – ***Currently not used***

Line H2: PCP ELIG – Optional, Alpha
Length: 1 Format: X
Description: Personal Care Services Program (PCSP) Eligibility – Indicates if the provider is enrolled as Personal Care Services Program provider. Valid entry values are:

- N – No – System Default – Provider is not PCSP eligible
- Y – Yes – Provider is PCSP eligible

This information prints below the H Fields in the PCP ELG field on the SOC 311. The PELG screen field name is PCSP.

Line H3: UPDATE ALL PELG – Optional, Alpha
Length: 1 Format: X
Description: Update All PELG – Allows the automatic update of all PELG associated with current provider, regardless of status, within the initiating county. Action updates the address and/or phone number on all SOC 311 forms and PELG screens with the same social security number. Valid field entry is:

- N – No – Do not update other PELG screens
- Y – Yes – System Default

This information prints below the H Fields in the UPDATE ALL PELG field on the SOC 311 TAD.

Field H3: SSNV
Length: 1 Format: X
Description: Social Security Number Verification – This field, on the far right side, displays one of the following indications reflecting the status of the Provider SSN as confirmed by the Social Security Administration (SSA).

Blank Social Security Number has not yet been sent for verification.

- Once verified this field will be reset to blank if changes are keyed to PELG fields NAME (B1-B3), SSN (D1) , SX (D3), or DOB (D4)
- Provider records with verification indications other than S or V will be written to the SSN VERIFICATION REPORT. See ***Section XIV-Y – SSN VERIFICATION REPORT*** for information regarding processing.

S Submitted for verification, no response yet received
V Verified – SSA confirms Name, SSN, DOB and Gender
D Person indicate by SSA to be deceased

1 SSN submitted is not on file with the SSA
2 Name and DOB match; Gender code does not match SSA records
3 Name and Gender code match; DOB does not match SSA records
4 Name match; Gender code and DOB do not match SSA records
5 DOB and Gender code match; Name does not match SSA records
6 Contact SSA

Line H4: WORKER COMP PHYSICIAN – System Generated, Required
Length: 1 Format: X
Description: SOC 311 display of PELG screen WC field indication. The following are valid indications:

- Blank – System Default – Worker Comp Physician
- P – Provider's Personal Physician
- W – Provider has changed from Personal Physician designation to Worker Comp Physician.

The PELG screen field name is WC and is located after field E3. This information prints below the H Fields in the WORKER COMP PHYSICIAN field on the SOC 311.

Fields I and J appear at the bottom of the SOC 311 form only. The PELG screen does not display these fields.

Field I: AUTHORIZATION/DATE/REMARKS – Optional
Description: Authorization/Date/Remarks – Enter the county authorization signature, the date of the signature and any remarks pertinent to the case provider in the designated fields.

Field J: VALIDATION/DATE/REMARKS – Optional
Description: Validation/Date/Remarks – Enter the county validation signature, the date of the signature and any remarks which pertinent to the case provider in the designated fields.

FORMS COMMONLY USED IN IHSS PROGRAM

Form Number	Title	Status[1]	Form Use
Assessment			
SOC 293	Assessment Document	M	To record consumer information, Functional Index rankings, and authorization information.
SOC 293A	Face Sheet	O	To record important information regarding consumer, emergency contacts, diagnosis, physician information, medications, and household composition.
SOC 321	Request for Order and Consent – Paramedical Services	MIA/MSA	To be signed by physician indicating type of paramedical services required; amount of time to perform service and frequency of service.
SOC 332	In-Home Supportive Services – Recipient/Employer Responsibility Checklist	M	Lists consumer responsibility as an employer. Social worker to review with consumer. Must be signed by consumer, social worker and provider. Copy provided to consumer.
SOC 426	Personal Care Services Program Provider/Enrollment Agreement	MIA	Required for all programs that receive federal financial participation (PCSP and IPW). Must be completed before timesheets processed.
SOC 431	Personal Care Services Program Contract Agency Enrollment	M	Required for employees of contract agencies for programs that receive federal financial participation.
SOC 450	Voluntary Services Certification	MIA	Required when someone volunteers services when they could otherwise be paid by IHSS.
SOC 821	Assessment of Need for Protective Supervision for In-Home Supportive Services Program	O	To be used together with information obtained during assessment and information from other individuals/organizations in assessing the need for Protective Supervision.
SOC 825	Protective Supervision 24-hours-A-Day Coverage Plan	O	Used to document how 24 hour per day need for Protective Supevision is being met.
SOC 827	Individual Emergency Backup Plan	M	To be completed for each PCSP and IPW consumer at the time of initial assessment or reassessment.
PUB 13	Civil Rights Pamphlets	M	Required for every case, every year.
No Number	Documentation Worksheet	O	Optional form developed through IHSS Training Academy to document

[1] O = Optional; M = Mandatory for all cases; MIA = Mandatory if applicable; MSA = Mandatory, but county may request State Approval for Modification.

			authorized hours.
NA 690	Notice of Action	M	Required for every action.

Eligibility			
SOC 294A	IHSS Income Eligibility – Adult	MIA	Used when applicant is an adult to determine whether Medi-Cal or IHSS Share of Cost is lower. 0
SOC 294C	IHSS Income Eligibility - Child	MIA	Used when applicant is a minor child to determine whether Medi-Cal or IHSS Share of Cost is lower
SOC 295	Application for Social Services	M	Required for all social service programs.
SOC 310	Statement of Facts for In-Home Supportive Services	MIA	Used only for IHSS Residual Program. (MC-210, Medi-Cal Statement of Facts, is an alternative to using SOC 310.)

Case Management, Information, and Payrolling (CMIPS)			
PUB 203	In-Home Supportive Services Guide to Workers' Compensation Benefits for Individual Providers	MIA	Every Individual Provider must be given this brochure that describes their Workers' Compensation coverage and their responsibility to report an accident or injury that occurs while working as an IHSS provider and explains the timeframes required.
SCIF 3167 IHSS	Employer's Report of Occupational Accident or Injury	MIA	Within 7 calendar days of notification of on-the-job injury, county staff must complete and submit this form that describes the injury as they understand it.
SCIF 13268	Provider's Predesignation of Personal Physician	MIA	If the Individual Provider chooses, s/he may designate the physician of choice to treat him/her in the event of an on-the-job injury. It must be completed before any injury on this form.
SOC 311	Provider Eligibility Form	MIA	Puts providers into the CMIPS system. Links provider and consumer.
SOC 404	IHSS Direct Deposit Enrollment/Change/Cancellation	MIA	To be completed by IHSS consumers who have received services for at least one year and are paid directly in advance. Allows payments directly into bank account of consumer.
SOC 409	IHSS/CMIPS Elective State Disability Insurance (SDI) Form	MIA	Form allows certain providers (parents of minor children who receive IHSS or spouses of IHSS consumers) to elect to participate in State Disability Insurance (SDI) program.

FORMS COMMONLY USED IN IHSS PROGRAM

SOC 412	IHSS Employee's Claim for Workers' Compensation Benefits/Notice of Potential Eligibility for Benefits	MIA	The county must provide a copy of this form to any IP who claims to have been injured on the job within 24 hrs of notification of an injury. The form must be completed by the IP and submitted to SCIF within 7 calendar days.
SOC 413	Notice to Employees DSS/IHSS State Compensation Fund Insurer	MIA	County must provide every consumer, (or the consumer's guardian or conservator if applicable), served by an Individual Provider a copy of this form about Workers' Compensation

APS			
SOC 341	Report of Suspected Dependent Adult/Elder Abuse	MIA	Required to report of suspected dependent adult/elder abuse. Must be completed by county staff when report is made by telephone.
SOC 341A	Statement Acknowledging Requirement to Report Suspected Abuse of Dependent Adults and Elders	M	All county IHSS staff must sign this form.
SOC 342	Report of Suspected Dependent Adult/Elder Financial Abuse – For Use By Financial Institutions	M	Form used by financial institutions to report suspected dependent adult/elder financial abuse. Officers or employees of institutions are mandated reporters.
SOC 343	Investigation of Suspected Dependent Adult/Elder Abuse	M	Form used to document investigation of suspected dependent adult/elder abuse.

CPS			
SS 8572	Suspected Child Abuse Report Form	MIA	Required whenever child abuse is suspected. Consumer or not. Must be completed by county staff when report is made by telephone.

FORM SAMPLES

ASSESSMENT

IN-HOME SUPPORTIVE SERVICES NEEDS ASSESSMENT-FACE SHEET

A. RECIPIENT INFORMATION

NAME:	CASE NO:	TELEPHONE: ( )	DOB (MO/DATE/YR)	SEX: *(CIRCLE ONE)* M F

ADDRESS (NUMBER, STREET):			IHSS COMPANION CASE(S), NAME(S) AND NUMBERS:
CITY:	STATE:	ZIP CODE:	

RECIPIENT'S STATEMENT OF NEED:	SPECIAL DIRECTIONS:
EMERGENCY CONTACTS/INSTRUCTIONS:	ALTERNATE RESOURCES USED: *(LIST SOURCE AND SERVICE PROVIDED)*
SPECIAL CONDITIONS/MEDICAL PROBLEMS:	

B. MEDICAL INFORMATION

DIAGNOSIS/PROGNOSIS:	DATE OF MEDICAL REQUEST:

PHYSICIAN:	TELEPHONE: ( )	PHYSICIAN:	TELEPHONE: ( )
PHYSICIAN:	TELEPHONE: ( )	PHYSICIAN:	TELEPHONE: ( )

MEDICATIONS/PURPOSE

1.	4.	7.
2.	5.	8.
3.	6.	9.

C. OTHER PERSONS IN HOUSEHOLD

NAME	AGE	RELATIONSHIP	RECEIVE IHSS		HOURS AT SCHOOL/ WORK	REASON PERSON CANNOT PROVIDE IHSS TO RECIPIENT
			YES	NO		

COMMENTS:

WORKER:	TELEPHONE: ( )	DISTRICT OFFICE:	DATE:

REQUEST FOR ORDER AND CONSENT - PARAMEDICAL SERVICES

PATIENT'S NAME
MEDI-CAL IDENTIFICATION NUMBER

TO:

Dear Doctor:

This patient has applied for In-Home Supportive Services (IHSS) and stated that he/she needs certain paramedical services in order for him/her to remain at home. You are asked to indicate on this form what specific services are needed and what specific condition necessitates the services.

In-Home Supportive Services is authorized to fund the provision of paramedical services, if you order them for this patient. For the purpose of this program, paramedical services are activities which, due to the recipient's physical or mental condition, are necessary to maintain the recipient's health and which the recipient would perform for himself/herself were he/she not functionally impaired. These services will be provided by In-Home Supportive Services providers who are not licensed to practice a health care profession and will rarely be training in the provision of health care services. Should you order services, you will be responsible for directing the provision of the paramedical services.

Your examination of this patient is reimbursable through Medi-Cal as an office visit provided that all other applicable Medi-Cal requirements are met.

If you have any questions, please contact me.

SIGNED	TITLE	TELEPHONE NUMBER	DATE

TO BE COMPLETED BY LICENSED PROFESSIONAL

NAME OF LICENSED PROFESSIONAL	OFFICE TELEPHONE
OFFICE ADDRESS (IF NOT LISTED ABOVE)	
TYPE OF PRACTICE	

TYPE OF PRACTICE

☐ Physician/Surgeon ☐ Podiatrist ☐ Dentist

CONTINUED ON BACK

RETURN TO: (COUNTY WELFARE DEPARTMENT)

Does the patient have a medical condition which results in a need for IHSS paramedical services?" ☐ **YES** ☐ **NO**
Is YES, list the condition(s) below:

List the paramedical services which are needed and should be provided by IHSS in your professional judgement.

TYPE OF SERVICE	TIME REQUIRED TO PERFORM THE SERVICE EACH TIME PERFORMED	FREQUENCY*		HOW LONG SHOULD THIS SERVICE BE PROVIDED?
		# OF TIMES	TIME PERIOD	

* Indicate the number of times a service should be provided for a specific time period: (Example: two times daily, etc.)

Additional comments:

☐ IF CONTINUED ON ANOTHER SHEET, CHECK HERE

CERTIFICATION

I certify that I am licensed to practice in the State of California as specified above and that this order falls within the scope of my practice. In my judgement the services which I have ordered are necessary to maintain the recipient's health and could be performed by the recipient for himself/herself were he/she not functionally impaired.

I shall provide such direction as is needed, in my judgement, in the provision of the ordered services.

I have informed the recipient of the risks associated with the provision of the ordered services by his/her IHSS provider.

SIGNATURE ▶	DATE

PATIENT'S INFORMED CONSENT

I have been advised of risks associated with provision of the services listed above and consent to provision of these services by my In-Home Supportive Services provider.

SIGNATURE ▶	DATE

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 limitied 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, which ever is longer.

5) Ensure standards of compensation, work scheduling and working conditions for my provider.

6) Provide my Social Worker with the following information regarding my provider, and any future change in my provider.

   __ Name
   __ Address
   __ Social Security Number
   __ Date of Birth*
   __ Ethnicity*
   __ Primary Language*
   __ Telephone Number
   __ Relationship to me, if any
   __ Hours to be worked and services to be performed by each provider

   *Please provide this information if it is available to you.

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 or State Income Taxes be deducted from his/her wages. Instruct the provider to complete Form W-4 so Form W-2 (Wage and Tax Statement) will be sent at the end of January for income tax filing.

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 of the services authorized and the 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, directly to my provider or directly to the county social services department.

12) Verify and sign my provider's timesheet for each pay period, showing the correct day and the correct total number of hours worked. I understand that any falsification or concealment of information may be prosecuted under Federal and State laws.

13) Ensure my provider signed his/her timesheet.

14) Advise my provider to mail his/her signed timesheet to the appropriate county social services department at the end of each pay period.

I HAVE EXPLAINED THE RESPONSIBILITIES LISTED ON THIS FORM TO THE IHSS RECIPIENT.

Social Worker	Telephone	Date
Recipient		Date
Provider		Date

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. Sign and date the form.
5. Leave a copy of the form with the recipient and provider.

PERSONAL CARE SERVICES PROGRAM PROVIDER/ENROLLMENT AGREEMENT

Instructions:

- *This form is to be completed in triplicate.*
- *This form must be completed prior to enrollment for* ***each*** service provider/client relationship. *Part I is to be completed by the service provider*
- *Part II is to be completed by the client or authorized representative as long as the authorized representative is* ***NOT the service 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 - SERVICE PROVIDER

SERVICE PROVIDER NAME				SOCIAL SECURITY NUMBER
ADDRESS (Street, City, Zip)				PHONE ( )
DATE OF BIRTH (Month, Day, Year)	SEX	ETHNIC ORIGIN	RELATIONSHIP TO CLIENT	START OF SERVICE (Month, Day, Year)

CERTIFICATION STATEMENT

- I certify that all claims, which I submit, for services to clients of the Personal Care Services Program will be provided as authorized for the client.
- I certify that all information submitted to the county will be accurate and complete to the best of my knowledge.
- 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 that services will be offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

SERVICE PROVIDER'S SIGNATURE	DATE

PART II - CLIENT CERTIFICATION

I certify that the service provider named above is qualified to provide personal care services for me as authorized by the county.

CLIENT'S NAME	CASE NUMBER
CLIENT'S SIGNATURE (Or Authorized Representative)	DATE

PART III - RECORD RETENTION

On behalf of the service provider, the county shall keep all records which are necessary to fully disclose the extent of services to the client for a minimum of three years from the date of service; and on request shall furnish the records for audit to the State of California or the U.S. Department of Health and Human Services or their duly authorized representatives.

AUTHORIZED COUNTY REPRESENTATIVE'S SIGNATURE	SERVICE WORKER NUMBER	DATE

PART IV - HEALTH SERVICES APPROVAL

The Department certifies that the person named above will be an enrolled Medi-Cal provider of personal care services.

California Department of Health Services

PERSONAL CARE SERVICES PROGRAM
CONTRACT AGENCY ENROLLMENT

Instructions:

- *This form is to be completed in duplicate.*
- *This form must be completed for each contract and prior to enrollment by each public or private agency contracted to provide services under the Personal Care Services Program.*
- *Part I is to be completed by the authorized representative of the contract agency.*
- *Part II is to be completed by the County.*
- *The original form is to be maintained by the County and a copy given to the contract agency.*

PART I - CONTRACT AGENCY

CONTRACT AGENCY NAME	STATE CONTRACT NUMBER
ADDRESS (Street, City, Zip)	PHONE ( )

CERTIFICATION STATEMENT

- I certify that all employees of this agency are qualified to provide the care authorized.
- I certify that all claims submitted to the County for services to recipients of the Personal Care Services Program and provided by this agency will be provided as authorized for the recipient.
- 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 that services will be offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

SIGNATURE AND TITLE OF AUTHORIZED REPRESENTATIVE	DATE

PART II - RECORD RETENTION

The County shall ensure that the contract agency shall keep all records which are necessary to fully disclose the extent of services to the client for a minimum of three years from the date of service during the effective dates of this contract. At the expiration of this contract the County shall keep said records for a minimum of three years from the date of service. On request, the County shall furnish records for audit to the State of California or the U.S. Department of Health and Human Services or their duly appointed representatives.

SIGNATURE AND TITLE OF AUTHORIZED COUNTY REPRESENTATIVE	COUNTY	DATE

PART III - HEALTH SERVICES APPROVAL

The Department certifies that the agency named above will be an enrolled Medi-Cal provider of personal care services.

California Department of Health Services

VOLUNTARY SERVICES CERTIFICATION

(PLEASE TYPE OR PRINT CLEARLY)

RECIPIENT NAME	RECIPIENT CASE NUMBER	COUNTY
PROVIDER NAME	PROVIDER TELEPHONE NUMBER	PROVIDER SOCIAL SECURITY NUMBER (OPTIONAL)*
PROVIDER STREET ADDRESS	CITY	ZIP CODE

SERVICES TO BE PROVIDED	DAYS AND/OR HOURS PER MONTH SERVICES ARE TO BE PROVIDED

I agree to provide the above listed services voluntarily. I know that I have the right to be compensated but choose not to accept any payment, or reduced payment for the provision of these services

PROVIDER SIGNATURE	DATE
SOCIAL SERVICE WORKER SIGNATURE	DATE

* FOR IDENTIFICATION PURPOSES ONLY (AUTHORITY: WELFARE & INSTITUTIONS CODE SECTION 12302.2)

ASSESSMENT OF NEED FOR PROTECTIVE SUPERVISION FOR IN-HOME SUPPORTIVE SERVICES PROGRAM

☐ Release of Information Attached

Attending Physician's / Medical Professional's mailing address	PATIENT'S NAME:		PATIENT'S DOB: / /
	MEDICAL ID#: (IF AVAILABLE)	COUNTY ID#:	
	IHSS SOCIAL WORKER'S NAME:		
	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 safeguard against accident or hazard by observing and/or monitoring the behavior of non self-directing, confused, mentally impaired or mentally ill persons. This service is not available in the following instances:

(1) When the need for protective supervision is caused by a physical condition rather than a mental impairment;
(2) For friendly visitation or other social activities;
(3) When the need for supervision is caused by a medical condition and the form of supervision required is medical;
(4) In anticipation of a medical emergency (such as seizures, etc.);
(5) To prevent or control antisocial or aggressive recipient behavior.

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

(Welfare and Institutions Code §12301.21)

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 RECIPIENT:	RECIPIENT'S TELEPHONE #:
ADDRESS OF IHSS RECIPIENT:	
NAME OF PRIMARY CONTACT RESPONSIBLE:	CONTACT'S TELEPHONE #:
RELATIONSHIP TO RECIPIENT:	

As the primary contact for arranging the 24-hour-a-day coverage plan for the above named Recipient, 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-a-day coverage plan can be met regardless of paid In-Home Supportive Service (IHSS) hours along with various alternate resources (i.e.; Adult or Child Day Care Centers, community resource centers, Senior Centers, respite centers, etc.)

- 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. hospitalization, attendance in day-care programs, travel, etc.) I will immediately **notify the IHSS social worker.**
- The above name Recipient 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 implementation of the Protective Supervision 24-Hour-A-Day Coverage Plan:

SIGNATURE OF PRIMARY CONTACT RESPONSIBLE:	DATE:
SIGNATURE OF IHSS SOCIAL WORKER:	CONTACT PHONE #:

State of California – Health and Human Services Agency
IN-HOME SUPPORTIVE SERVICES (IHSS)
PROTECTIVE SUPERVISION
24-HOURS-A-DAY COVERAGE PLAN (SOC 825)

INSTRUCTIONS

The IHSS Protective Supervision 24-Hours-A-Day Coverage Plan (SOC 825) is an optional form for County use. The SOC 825 is intended to ensure that recipients who need Protective Supervision have the 24-hours of care needed for their health and safety 24 hours a day. The recipient's social service worker and the IHSS care provider(s), whether a family member, friend, or no relation at all, should discuss together a plan or schedule of 24 hours a day of coverage for the recipient.

NAME OF IHSS RECIPIENT: Enter the full name of the IHSS recipient.

RECIPIENT'S TELEPHONE NUMBER: Enter the contact telephone number for the recipient.

ADDRESS OF IHSS RECIPIENT: Enter the recipient's home address where the majority of the 24-hours-a-day coverage will be performed.

NAME OF PRIMARY CONTACT RESPONSIBLE: Enter the name of the person with primary responsibility for coordinating the recipient's 24-Hours-A-Day Coverage Plan.

PRIMARY CONTACT'S TELEPHONE NUMBER: Enter the telephone number for the primary contact responsible.

RELATIONSHIP TO RECIPIENT: Enter the relationship of the primary contact to the recipient, (i.e., family member, IHSS care provider, friend, etc.).

NAME OF CARE PROVIDER(S) (1), (2), (3), and CONTACT TELEPHONE NUMBER(S): Enter the name(s) of each care provider responsible for the recipient's care during the 24 hours a day of coverage. Enter a contact telephone number for each care provider.

If more than three (3) care providers are responsible for this recipient, an additional sheet of paper can be attached with name(s) and contact telephone number(s).

Describe the implementation of the Protective Supervision 24-Hours-A-Day Coverage Plan:

Enter the planned schedule, or explanation of the plan in which the above provider(s) will ensure the recipient is cared for the entire 24-hour period. An additional sheet of paper can be attached if more space is needed to describe the 24-Hours-A-Day Coverage Plan.

SIGNATURE OF PRIMARY CONTACT RESPONSIBLE and DATE: Once the 24-Hours-A-Day Coverage Plan is developed, the primary contact responsible will sign and date the form when the Plan is discussed with the social worker authorizing the need for Protective Supervision.

SIGNATURE OF IHSS SOCIAL WORKER and CONTACT TELEPHONE NUMBER: When the 24-Hours-A-Day Coverage Plan is discussed and signed and dated by the primary contact, the county social service worker will sign the form and add their contact telephone number.

A copy of the form is to be provided to the primary contact and retained in the County case file.

In-Home Supportive Services (IHSS) Program

INDIVIDUAL EMERGENCY BACK-UP PLAN

Participant Name: ______________________ Date: __________

Case #: ______________________ Declined to participate: ☐

If your Care Provider does not arrive and you need assistance, call:

Family Member: ______________________

Friend: ______________________

Neighbor: ______________________

County Social Services Worker: ______________________

County IHSS Social Services Office: ______________________

Public Authority: ______________________

If you need to report abuse and/or neglect of elderly or disabled individuals, call:

Adult Protective Services: ______________________

Other important numbers:

Doctor's Office: ______________________

Medi-Cal Office: ______________________

Advocacy Group(s): ______________________

Police Department: ______________________

Fire Department: ______________________

Other: ______________________

If you have an emergency, call 911

Social services staff discussed the above information with the recipient and/or his/her Authorized Representative and all parties are aware of what to do in case of an emergency.

Signature of Participant: ______________________ Date: __________

Signature of: ______________________ Date: __________
Authorized Representative, if applicable

Signature of: ______________________ Date: __________
County Social Services Staff

AT THE HEARING

If you have notified the State Hearings Division before your hearing that you need language services, a state-approved interpreter will be present at your hearing to assist you and the other participants. You should be prepared to present your best case at the hearing. You will have an opportunity to tell the Administrative Law Judge why you disagree with the county's action and the county representative will have an opportunity to explain why the action was taken. It is up to the county to prove that its action is correct. You and the county representative may question each other and any witnesses who are present. The Administrative Law Judge may also ask questions to bring out all the facts.

State law requires that all hearings are to be tape recorded. The recording is for use in making the decision and is kept in case there is a dispute about the decision.

THE DECISION

After the hearing is completed, the Administrative Law Judge will either send a proposed decision to the Director of the California Department of Social Services or Health Services or will issue a final decision on behalf of the Director. If a proposed decision is sent to the Director, the facts presented during the hearing will be studied and the Director will either adopt the proposed decision, order a further hearing, or issue his/her own decision. If the Director issues his/her own decision, that decision is binding, but you will also receive a copy of the Administrative Law Judge's original proposed decision. Immediately upon receipt of a decision, the county must comply with the decision even if a rehearing is requested. If the decision is a denial, any aid pending which you had been receiving will stop. In addition, the county can demand repayment of excess cash aid or food stamps which were paid as aid pending. If you disagree with the decision, you may request a rehearing by following the instructions on the first page of the State Hearing decision you receive.

If you disagree after receiving either a decision or a rehearing decision, you can seek judicial review by appealing to Superior Court. The request for judicial review must be filed with the court within one year after receiving notice of the Director's final decision.

WITHDRAWING FROM A STATE HEARING

You may withdraw (cancel) your request for a State Hearing any time before the Director has issued a decision by sending a written request to the State Hearings Division in Sacramento. If you withdraw before the hearing, it will be cancelled. If you withdraw after the hearing, no decision will be issued. In both cases, the county's action will take effect. If you received aid at a level greater than you should have received if you had not requested the hearing, and you later withdraw before the decision is issued, the county has a right to demand repayment of the overpaid amount of cash aid or food stamps. The result is the same as a written decision supporting the county's action.

RECORDS ARE IMPORTANT

Every hearing is different. The Administrative Law Judge will want to see papers or records which give facts and provide verification regarding your case. You should bring to the hearing records that will prove or disprove a fact upon which you and the county disagree. Records relating to the specific disputed matter are often required to correctly resolve a case. Examples are:

- Records relating to real property, such as tax receipts, deeds, contracts and mortgages.
- Records relating to personal property, such as bank books, insurance policies, automobile ownership papers, stocks, bonds, notes and contracts.
- Records relating to disability, such as medical reports, hospital records, or doctor's notes.
- Records regarding money you receive, such as: wage stubs; award letters showing how much you receive from Social Security; Unemployment Insurance; Veterans Benefits; court-ordered support payments; student financial aids; from property rental; boarders; roomers; stocks; bonds; or payments made on your behalf, including gifts, etc.
- Bills and receipts showing the amount you are paying for housing, utilities (including telephone), medical care (including health insurance and medical transportation), union dues, attendant and child care, school tuition and fees, disaster and casualty losses.

Discrimination

Under State law, welfare agencies may not, on the basis of race, color, national origin, age, disability, religion, sex, sexual orientation, political affiliation or marital status, provide aid, benefits or services to an individual or group which is different from that provided to others. Federal laws also prohibit discrimination on several, although not all, of the bases listed above.

Federal law prohibits: (1) delaying or denying the placement of a child for adoption or into foster care on the basis of the race, color or national origin of the adoptive or foster parent, or the child involved; (2) denying to any individual the opportunity to become a foster or adoptive parent on the basis of the race, color or national origin of the individual or child involved.

If you believe you have been discriminated against by the welfare agency, you may take any of the following actions:

1. Speak to the County Welfare Department's Civil Rights Representative. The county will investigate the complaint and inform you of the outcome.
2. You may file a discrimination complaint with CDSS by e-mail, writing or calling:

   California Department of Social Services
   Civil Rights Bureau (CRB)
   P.O. Box 944243, M.S. 15-70
   Sacramento, CA 94244-2430
   Call (916) 654-2107 or toll free 1-866-741-6241
   E-Mail: crb@dss.ca.gov

   TDD/TTY Users may call direct at (916) 654-2098 or collect by calling (800) 688-4486 or you may call via the California Relay Service operator at (800) 735-2929.
3. If your complaint involves the Food Stamp Program, you may file a federal discrimination complaint with:

   USDA , Director
   Office for Civil Rights
   Room 326-W, Whitten Building
   14th and Independence Avenue, SW
   Washington, D.C. 20250-9410
   1-800-795-3272 (voice)
   (TTY) 202-720-6382
4. If your complaint involves assistance programs other than Food Stamps, and if you believe that the alleged discriminatory action was based on race, color, national origin, age, or disability, you may file a federal discrimination complaint with:

   U.S. Department of Health and Human Services
   Office for Civil Rights
   50 United Nations Plaza, Room 322
   San Francisco, CA 94102
   1-800-368-1019

A complaint must be filed within 180 days of the occurrence of the alleged discrimination. In your complaint, state the basis of discrimination (e.g., race, disability, sex), what happened, why you believe that the action was taken, and the resolution you are seeking.

If you disagree with the county's decision on your discrimination complaint, you may appeal the finding to the California Department of Social Services or, if it involves the Food Stamp program, to the U.S. Department of Agriculture. THE DISCRIMINATION COMPLAINT PROCESS DIFFERS FROM THE STATE HEARING PROCESS. YOU HAVE THE RIGHT TO REQUEST A STATE HEARING IF YOU BELIEVE THAT THE COUNTY MADE AN INCORRECT DECISION ON YOUR BENEFITS IN ADDITION TO FILING A DISCRIMINATION COMPLAINT.

In Conclusion

If you have any question about the information in this paper—your rights or what you should do if you think your rights have been violated—ask someone in your county welfare department or talk with someone at Public Inquiry and Response, California Department of Social Services.

Also, it may be helpful to obtain written information which explains the public assistance for which you are applying or receiving. It is available at your county welfare department. If a leaflet about the program is not offered to you, ask for it. **One way to ensure that you are treated fairly is to know what you are entitled to receive.**

STATE OF CALIFORNIA

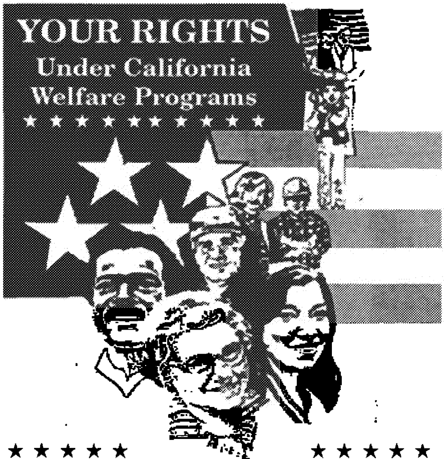
HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF SOCIAL SERVICES

This publication is available in large print and also on audio tape upon request from your county.

You should tell the county if you have a disability and need help applying for or continuing to receive aid, benefits, and services.

PUB 13 (3/07)



★ ★ ★ ★ ★ ★ ★ ★ ★ ★

If you are applying for, receiving, or have received public assistance in California, you have specific rights.

This brochure describes your rights and explains what you can do if you have a complaint. The information is for persons applying for, receiving, or who have received aid or services in any of the following assistance programs:

- **Adoption Assistance Program (AAP)**
- **Alcohol and Drug Program**
- **California Food Assistance Program (CFAP)**
- **California Medical Assistance (Medi-Cal)**
- **California Work Opportunity and Responsibility to Kids (CalWORKs)**
- **CalWORKs Child Care**
- **CalWORKs Welfare to Work Program**
- **Cash Assistance Program for Immigrants (CAPI)**
- **Child Welfare Services**
- **Denti-Cal**
- **Early & Periodic Screening, Diagnosis, and Treatment (EPSDT)**
- **Food Stamps**
- **Foster Care**
- **In-Home Supportive Services (IHSS)**
- **Kinship Guardian Assistance Payment (Kin-GAP)**
- **Mental Health**
- **Multipurpose Senior Service Program (MSSP)**
- **Personal Care Services Program (PCSP)**
- **Refugee Cash Assistance**
- **Social Services**

If you have a complaint concerning a grant issued by the county (general assistance/general relief), you must file a request with the county in order to get your complaint resolved.

If you have a complaint concerning the Supplemental Security Income/State Supplementary Program, you must discuss the problem with someone at the Social Security Administration Office nearest your home. The Social Security Administration handles complaints and conducts hearings in the aid programs for aged, blind and disabled persons.

Multi-Lingual Services

If you or someone you know has problems applying for or receiving public assistance because you or that person do not speak English, ask for help from someone who speaks your language. You have a right to interpreter services provided by the county. If your county welfare office does not have an employee with whom you can talk, call 1-866-741-6241 for help. You will not have to pay for the call.

Your Rights

As a person applying for or receiving public assistance in California, you have the right:

- ★ **To receive a written explanation of the decision on your application.**
- ★ **To receive a written explanation when any change is made in your eligibility, benefits or services plan.**
- ★ **To appeal any decision on your eligibility, benefits or service plan.**
- ★ **To see any information related to your eligibility which you provide to the county. You may inspect your entire case record if you request a State Hearing (see the "What You Can Do" section of this brochure).**
- ★ **To file a complaint when you believe you have been discriminated against because of race, color, religion, sex, sexual orientation, national origin, political affiliation, disability, marital status or age.**
- ★ **To be treated with courtesy, consideration and respect.**
- ★ **To be given the same consideration and treatment as all other applicants or recipients regardless of race, color, religion, sex, sexual orientation, national origin, political affiliation, disability, marital status or age.**
- ★ **To have the information in your case record kept confidential except as otherwise stated by State and federal law.**
- ★ **To have personal privacy. However, certain personal information is required to determine your eligibility and need for public assistance.**

When applying for or receiving public assistance, your rights must be respected by all persons and organizations, including county welfare departments, boarding homes and institutions, day nurseries, work or training program personnel, hospitals, nursing homes, doctors, dentists and druggists.

A Telecommunication Device for the Deaf (TDD) is available at the California Department of Social Services (CDSS). If you have a complaint about public assistance services, you may contact us using a TDD by calling toll free 1-800-952-8349.

What You Can Do

If you don't agree with an action on your application, public assistance benefits or service plan, you can do any or all of the things listed below.

1. Talk with someone at your county welfare department. Explain why you disagree and ask for help.
2. File a formal complaint against the county with the California Department of Social Services. To do so, call toll free or write:

   Public Inquiry and Response
   P.O. Box 944243, M.S. 6-23
   Sacramento, California 94244-2430
   Phone 1-800-952-5253 (Voice)
   1-800-952-8349 (TDD)
   FAX 1-916-229-4110

   State that you want your problem to be handled as a "complaint" and give the reason for the complaint. Social Services will notify the county welfare department of the complaint, and the county will review the facts in your case. If the county determines that you are entitled to an adjustment, your complaint may be settled without further action on your part or on the part of Social Services.
3. Request a State Hearing before an Administrative Law Judge. **YOU MUST MAKE YOUR REQUEST FOR THE STATE HEARING WITHIN 90 DAYS (NOT THREE MONTHS) OF THE COUNTY'S ACTION.** The 90-day period applies even though you have filed a complaint. The 90-day period begins to run when the county mails you a notice of action.

   If you decide to request a State Hearing because your aid is going to be reduced or stopped, **you may continue to receive the same aid you have been getting until the hearing, if you make your request for hearing before the effective date of the action. Your food stamps can continue unchanged only until the end of your current certification period. If the hearing decision is not in your favor, an overpayment may occur in the amount of excess cash aid and extra value of food stamps you received while the hearing was pending.**

   Also, it is a good idea to save the envelope from the Notice of Action to show to the Administrative Law Judge. The date is important.

   To make a request for a State Hearing, fill in the "Request for State Hearing" space on the back of the Notice of Action form. If you have trouble understanding English, tell us your language and dialect. You may write a letter which explains the county action which you believe was incorrect and your need for language help. Send your hearing request to the county welfare department at the address indicated on the Notice of Action.

A request for a State Hearing may also be made orally. This can be done by telephoning the toll free number at 1-800-952-5253 or if you are hearing impaired call 1-800-952-8349 (TDD).

State Hearings

This is a hearing with you, an Administrative Law Judge from the California Department of Social Services, and a representative of the county. It is not a court hearing. You may, if you wish, have a lawyer or other representative present with you at your cost. You may bring witnesses.The Administrative Law Judge is in charge of the hearing, which is not open to the public.

TIME AND PLACE OF HEARING

At least 10 days before your hearing, the California Department of Social Services will send you a letter with the exact date and place of the hearing. In some counties, you will also be told an exact time for the hearing. In other counties, you will be scheduled for either a morning or afternoon time slot. Most hearings will begin at either 8:30 a.m. or 1:00 p.m. Because several hearings will be scheduled to begin at these times, you should anticipate that there may be some delay before your hearing actually starts. There is no child care provided at the hearing location.

Hearings are usually held at public buildings in the county. If you are unable to attend the hearing at the hearing location for reasons of poor health or disability, the hearing may be held in your home, in another agreed upon location, or by telephone with your agreement. To have a home hearing, medical verification may be required. If you believe you may qualify for a home hearing or wish to have a telephone hearing, call or write the State Hearings Division to explain your reason(s):

State Hearings Division
P.O. Box 944243 MS 19-37
Sacramento, CA 94244-2430
1-800-743-8525

If you move after requesting a State Hearing but before it is heard or a decision issued, you should notify the State Hearings Division of your new address by calling toll free 1-800-743-8525 (Voice/TDD).

If you are no longer a resident of the State of California, arrangements will be made to conduct your hearing by telephone. Instructions concerning telephone hearing procedures will be sent to you in advance of the hearing.

POSITION STATEMENTS

You are allowed to have a copy of the county's typewritten Position Statement before the hearing. This is a typewritten statement which explains what the county has done and the reasons for the county action. You may pick up this statement any time during business hours in the two working days before your date of hearing unless the county is not involved with the hearing. You may call your county appeals unit to make sure that these papers are ready.

If the papers are not ready, or if the county substantially changes the papers after giving them to you, you have the right to have the hearing postponed for good cause. This means that your hearing will be rescheduled and any aid pending the hearing will be continued. You may pick up the statement from the Appeals Worker at the County Welfare Department.

At the hearing you also may submit a written statement explaining your position on the issue to be considered by the Administrative Law Judge. Both the county's Position Statement and your written statement will become part of the hearing record and will be reviewed by the Administrative Law Judge.

POSTPONEMENTS

If you want to postpone the hearing and your hearing involves the Food Stamp program, you may request and will receive an automatic first postponement. In any other case in which you wish to receive a postponement, you must notify the state prior to the hearing and present a good reason for the postponement. Send a written request to the State Hearings Division or call toll free at 1-800-743-8525 (Voice/TDD).

If you do not appear at a scheduled hearing and still want a hearing, you must request that the hearing be reopened within 10 days from the date of the scheduled hearing and show a good reason why you did not attend your scheduled hearing.

BEFORE THE HEARING

You must either attend the hearing yourself or authorize someone to appear for you. If you plan to have someone appear for you, send the name, address and telephone number of your representative to the State Hearings Division before your scheduled hearing date. You may obtain a list of legal services representatives, voluntary legal service persons, or welfare rights organizations from the county. You must also sign a written statement authorizing your representative to appear on your behalf. This statement should be sent to the county and to the State Hearings Division.

You may go to the hearing with your representative and you may ask others who know the facts to be present at the hearing to tell the Administrative Law Judge what they know about the case. If you want to have a person or papers important to your case at your hearing, you may request that a subpoena be issued. To request a subpoena **before** the date of the hearing, write or call the office listed below which is closest to you:

State Hearings Division
P.O. Box 944243
M.S. 19-44
Sacramento, CA 94244-2430
Phone (916) 229-4187

State Hearings Division
Bay Area Regional Office
1515 Clay Street, #1203
Oakland, CA 94612
Phone (510) 622-4000

State Hearings Division
811 Wilshire Boulevard,
Suite 1118
Los Angeles, CA 90017
Phone (213) 833-2200

State Hearings Division
355 West Grand Ave.,
Suite 4
Escondido, CA 92025-2649
Phone (760) 735-5070

State Hearings Division
2550 Mariposa Mall,
#3088
Fresno, CA 93721
Phone (559) 445-5775

Tell us the name of the person or describe the documents you want subpoenaed, and tell why they are important to your hearing. The Presiding Administrative Law Judge will determine if a subpoena should be issued. It will be your responsibility to serve the person you want subpoenaed, or the custodian of the records if you want to obtain a document.

You have a right to look at your case records and the regulations before the hearing. Call your county appeals unit to arrange this review.

IN-HOME SUPPORTIVE SERVICES
NOTICE OF ACTION

Note: This notice relates ONLY to your Social Services.
It does NOT affect your receipt of SSI/SSP or Social Security.
KEEP THIS NOTICE WITH YOUR IMPORTANT PAPERS.

YOUR IHSS OFFICE

IF REQUESTING A STATE HEARING, PLEASE SEND TO:

Case Number

Date Mailed

NOW		WAS	
Your Countable Income:	$	Your Countable Income:	$
Minus SSI/SSP Benefit Level:	$	Minus SSI/SSP Benefit Level:	$
Your Share of Cost:	$	Your Share of Cost:	$
Minus Assessed IHSS Cost:	$	Minus Assessed IHSS Cost:	$
Income in Excess of Assessed Cost:	$	Income in Excess of Assessed Cost:	$

SERVICES	HOURS NOW	PREVIOUS HOURS	(+) INCREASE OR (-) DECREASE
DOMESTIC SERVICES per month: Clean floors, wash kitchen counters, stoves, refrigerators, bathroom; store food, supplies; take out garbage; dust, pick up; bring in fuel; change; make bed and miscellaneous.			
HEAVY CLEANING (one month only):			
RELATED SERVICES per week:			
* Prepare Meals:			
** Meal Cleanup:			
Routine Laundry:			
Shopping for Food:			
Other Shopping Errands:			
NON-MEDICAL PERSONAL SERVICES per week:			
* Respiration Assistance:			
* Bowel, Bladder Care:			
* Feeding:			
* Routine Bed Baths:			
* Dressing:			
* Menstrual Care:			
* Ambulation:			
* Move In/Out of Bed:			
* Bathe, Oral Hygiene/Grooming:			
* Rub Skin, Repositioning, Help On/Off Seats, In/Out of Vehicle:			
* Care/Assistance with Prosthesis:			

SERVICES	HOURS NOW	PREVIOUS HOURS	(+) INCREASE OR (-) DECREASE
ACCOMPANIMENT SERVICES per week:			
Medical Appointments:			
To Alternative Resources:			
YARD HAZARD ABATEMENT:			
Remove Grass, or Weeds, Rubbish (one month only):			
Remove Ice, Snow, per week:			
PROTECTIVE SUPERVISION per week:			
TEACHING/DEMONSTRATION per week (no more than three months duration):			
* PARAMEDICAL SERVICE per week:			
TOTAL WEEKLY HOURS X 4.33:			
ADD DOMESTIC SERVICE HOURS:			
ADD HEAVY CLEANING:			
ADD REMOVE GRASS, ETC.:			
TOTAL MONTHLY HOURS (rounded to the nearest tenth)			

	NOW	WAS
Restaurant Meal Allowance:	$	$

☐ "Since you meet the criteria for 20 hours or more in starred (*) services you can get an advance payment to pay your own provider. If you want to get advance payment, contact your service worker. The double-starred (**) service is included in the 20 hours only when assistance with feeding, preparation of meals and meal cleanup are all required."

The above action(s) is supported by Federal Law (Social Security Act), State Law (Welfare and Institutions Code), Federal Regulations (Code of Federal Regulations), State Regulations (California Administrative Code and State Department of Social Services Manual of Policies and Procedures):

You must report immediately any changes that might affect your eligibility or need for In-Home Supportive Services such as change in income, property, living arrangement, medical condition or ability to work. If you have any questions or [illegible] should be considered contact

District Office: Service Worker: SW#: Telephone:

YOU HAVE THE RIGHT TO FILE A WRITTEN OR ORAL REQUEST FOR A STATE HEARING. PLEASE SEND YOUR WRITTEN REQUEST TO THE COUNTY ADDRESS ON THE TOP RIGHT HAND CORNER OF THIS FORM.

NA 690 (1-01) PLEASE SEE REVERSE SIDE OF THIS NOTICE FOR FURTHER DETAILS

Fig. V-F- 1 – English Language – Notice of Action

FORM SAMPLES

ELIGIBILITY

IHSS INCOME ELIGIBILITY - ADULT

Name ______________ Case No. ______________ Month/Year ______________

RECIPIENT

A. Income of aged, blind or disabled individual or couple (if individual has spouse not aged, blind or disabled, also complete Part B).

	UNEARNED	EARNED
1. Unearned income (list) (Do not show exempt income)		
a.	$	
b.	$	
c.	$	
2. Total unearned income (A1a to A1c)	$ 0.00	
3. Any income exclusion	$ 20	
4. Net unearned income (A2 minus A3)	$	
5. Earned income (Do not show exempt income)		$
6. Unused $20 exclusion (If A3 is greater than A2, enter the difference)		$
7. Earned income exclusion		$ 65
8. Total exclusions (A6 plus A7)		$ 65.00
9. Remaining earned income (A5 minus A8)		$
10. Net earned income (A9 x 1/2)		$ 0.00
11. Other earned income deductions		$
12. Total net earned income (A10 minus A11)		$
13. Total countable income (A4 plus A12)	$ 0.00	
14. SSI/SSP payment level	$	
15. IHSS share of cost (A13 minus A14)	$	

** If there is also a blind or disabled child in the family, the share of cost shown in Line C is not paid. Enter this amount on Form SOC 294C, Line A9. The share of cost will be the amount detemined in SOC 294C, Line B16.

SPOUSE

B. Income of aged, blind or disabled individual and spouse who is not aged, blind or disabled.

				UNEARNED	EARNED
1. Income of client's spouse				$	$
2. Allowance for children not blind or disabled					
a. Children's needs	$	$	$		
b. Children's income	$	$	$		
c. Net needs (a – b)	$	$	$		
d. Total allowance (add B2c's)				$ 0.00	
3. Remaining unearned income (B1 minus B2d)				$	
4. Unmet children's needs (If B2d is greater than B1 unearned, enter the difference)					$
5. Remaining earned income (B1 minus B4)					$
6. Net income of spouse (B3 plus B5) -- If equal to or less than A15 is entered in C -- If greater than complete B7 through B20				$	
7. IHSS client's income (From A2 and A5)				$	$
8. Income of couple (B3 plus B7 unearned, B5 plus B7 earned)				$ 0.00	$ 0.00
9. Any income exclusion				$ 20	
10. Net unearned income (B8 minus B9)				$	
11. Unused $20 exclusion (If B9 is greater than B8 unearned, enter the difference)					$
12. Earned income exclusion					$ 65
13. Total exclusions (B11 plus B12)					$ 65.00
14. Remaining earned income (B8 minus B13)					$
15. Net earned income (B14 x 1/2)					$
16. Other earned income deductions					$
17. Total net earned income (B15 minus B16)					$
18. Total countable income (B10 plus B17)				$ 0.00	
19. SSI/SSP couple payment level				$	
20. IHSS share of cost (B18 minus B19)				$	
C. SHARE OF COST (higher of A15 or B20) **				$	

WORKER ______________ DATE ______________

IHSS INCOME ELIGIBILITY - CHILD

NAME	CASE NUMBER	MONTH

PARENT

A. Income deemed to a blind or disabled child living at home who is under 18.

☐ Income of parent and parent's spouse where neither is aged, blind or disabled.				Unearned	Earned
1. Gross income				$	$
2. Allowance for children not blind or disabled					
a. Children's needs					
b. Children's income	$	$	$		
c. Net needs (a minus b)	$	$	$		
d. Total allowance (add A2c's)				$	
3. Remaining unearned income (A1 minus A2d)				$	
4. Unmet children's needs (If A2d is greater than A1 unearned, enter the difference)					$
5. Remaining earned income (A1 minus A4)					$
6. Any income exclusion				$ 20	
7. Net unearned income (A3 minus A6)				$	
8. Unused $20 exclusion (If A6 is greater than A3, enter the difference)					$
9. Earned income exclusion					$ 65
10. Total exclusions (A8 plus A9)					$
11. Earned income (A5 minus A10)					$
12. Net earned income (A11 x 1/2)					$
13. Total income (A7 plus A12)				$	
14. Allowance for parent and spouse (1) (2)				$	
15. Income deemed to child (A13 minus A14)				$	
☐ Income parent(s) where one or both are aged, blind or disabled.					
16. Parent(s) income in excess of SSI/SSP payment level (from SOC 294A C)				$	

RECIPIENT

B. IHSS share of cost computation for blind or disabled child who is under 18.

	Unearned	Earned
1. Income deemed to child (from A15 or A16)**	$	
2. Unearned income (list) (Do not show exempt income)		
a.	$	
b.	$	
c.	$	
3. Total unearned income (B1 plus B2)	$	
4. Any income exclusion	$ 20	
5. Net unearned income (B3 minus B4)	$	
6. Earned income (Do not show exempt income)		$
7. Unused $20 exclusion (If B4 is greater than B3, enter the difference)		$
8. Earned income exclusion		$ 65
9. Total exclusions (B7 plus B8)		$
10. Remaining earned income (B6 minus B9)		$
11. Net earned income (B10 x 1/2)		$
12. Other earned income deductions		$
13. Total net earned income (B11 minus B12)		$
14. Total countable income (B5 plus B13)	$	
15. SSI/SSP payment level	$	
16. IHSS share of cost (B14 minus B15)	$	

** Note: If more than 1 eligible child, divide deemable income equally among them, except that if one child has exces income, it is deemed to other eligible children.

WORKER	DATE

APPLICATION FOR SOCIAL SERVICES

TO THE APPLICANT: *Please complete Section 1 - 7 on this form. This form is subject to verification.*
NOTE: *Retain your copy of this application. If you have not received a response within 30 days notify the county representative at the telephone number provided below in the "FOR AGENCY USE ONLY" Section.*

* **SOCIAL SECURITY NUMBER:** It is mandatory that you provide your Social Security Number(s) as required in 42 USC 405 and MPP 30-769.71. This information will be used in eligibility determination and coordinating information with other public agencies.

CASE NUMBER:	DATE OF APPLICATION:

1. NAME | *SOCIAL SECURITY NUMBER

ADDRESS | SEX ☐ Male ☐ Female

CITY | ZIP CODE | TELEPHONE ( ) | BIRTHDATE

2. Are you a veteran? ☐ Yes ☐ No | ARE YOU A SPOUSE/CHILD OF A VETERAN? ☐ Yes ☐ No | IF "YES", GIVE VETERAN NAME AND CLAIM NUMBER:

3. Do you receive SSI/SSP benefits? ☐ Yes ☐ No | IF "YES", CHECK YOUR TYPE OF LIVING ARRANGEMENT: ☐ Independent Living ☐ Board and Care ☐ Home of Another

SERVICES BEING REQUESTED:

4. Have you received In-Home Supportive Services (IHSS) in the past? ☐ Yes ☐ No
If "YES", complete the following:

DATE AND PLACE OF SERVICE LAST RECEIVED	NUMBER OF HOURS	NAME USED (IF DIFFERENT FROM ABOVE)

5. LIST FAMILY MEMBERS IN HOUSEHOLD	BIRTHDATE	*SOCIAL SECURITY NUMBER
NAME OF SPOUSE ☐ NAME OF PARENT ☐		
CHILD/OTHER RELATIVE		
CHILD/OTHER RELATIVE		

6. The law requires that information on ethnic origin and primary language be collected. If you do not complete this section, social service staff will make a determination. The information will not affect your eligibility for service.

A. My ethnic origin is *(see reverse side for correct code)*: ☐

B. I speak and understand English: ☐ Yes ☐ No
My primary language is *(see reverse side for correct code:)* ☐

7. I affirm that the above information is true to the best of my knowledge and belief. I agree to cooperate fully if verification of the above statements is required in the future.

SIGNATURE OF APPLICANT:	DATE:	SIGNATURE OF APPLICANT'S REPRESENTATIVE:	DATE

REPRESENTATIVE'S ADDRESS	REPRESENTATIVE'S TELEPHONE NUMBER:	RELATIONSHIP TO APPLICANT:
	( )	

FOR AGENCY USE ONLY

INCOME ELIGIBLE:	STATUS ELIGIBLE:	VERIFICATION:	SIGNATURE OF SOCIAL WORKER OR AGENCY REPRESENTAIVE:	TELEPHONE NUMBER:
☐ Yes ☐ No	☐ Yes ☐ No		▶	( )

RECIPIENT STATUS:	SOURCE OF VERIFICATION FOR REFUGEE OR ENTRANT STATUS (EXPLAIN)
☐ Refugee ☐ Cuban/Haitian Entrant	

RECERTIFICATION OF ELIGIBILITY FOR SERVICES OF STATUS ELIGIBLES

DATE	SOURCE OF VERIFICATION	WORKER SIGNATURE	DATE	SOURCE OF VERIFICATION	WORKER SIGNATURE

STATEMENT OF FACTS FOR IN-HOME SUPPORTIVE SERVICES

Note: *Your eligibility for In-Home Supportive Services (IHSS), under Welfare and Institutions Code Section 12300, will be determined by the information you provide on this form.*

FOR COUNTY USE ONLY

1. APPLICANT INFORMATION

NAME (FIRST, MIDDLE, LAST)			BIRTHDATE
HOME ADDRESS		CITY	ZIP CODE
MAILING ADDRESS (IF DIFFERENT)		HOME PHONE ( )	MESSAGE PHONE ( )
PLACE OF BIRTH	SOCIAL SECURITY NUMBER	MEDI-CAL CARD NUMBER	

ARE YOU: ☐ AGE 65 OR OVER? ☐ DISABLED? ☐ BLIND?

MARITAL STATUS: ☐ SINGLE ☐ MARRIED (Date / /) ☐ SEPARATED (Date / /) ☐ WIDOWED (Date / /) ☐ DIVORCED (Date / /)

COMPLETE THE FOLLOWING:

NAME OF SPOUSE OR PARENT(S) *(IF YOU ARE UNDER 18 YEARS OF AGE)*

IS SPOUSE/PARENT(S): ☐ AGE 65 OR OVER? ☐ DISABLED? ☐ BLIND?

SPOUSE/PARENT(S) SOC. SEC. NO.	SPOUSE/PARENT(S) ADDRESS *(IF DIFFERENT THAN APPLICANT'S)*

2. DO YOU RESIDE IN CALIFORNIA WITH THE INTENTION TO CONTINUE RESIDING HERE? ☐ YES ☐ NO

3. ARE YOU A CITIZEN OF THE UNITED STATES? *(IF "YES", GO TO "ITEM 4")* ☐ YES ☐ NO

(A.) IF YOU ARE NOT A UNITED STATES CITIZEN, ARE YOU LAWFULLY ADMITTED TO PERMANENT RESIDENCE OR LEGALLY PERMITTED TO REMAIN IN THE U S.? ☐ YES ☐ NO

(B.) WHAT IS YOUR ALIEN REGISTRATION NUMBER?

(C.) WHAT IS NAME OF SPONSOR?

(D.) WHAT IS SPONSOR'S ADDRESS?

4. WHAT IS YOUR LIVING ARRANGEMENT?

MY HOME IS A: ☐ HOUSE ☐ APARTMENT ☐ ROOM ☐ ROOM & BOARD ☐ TRAILER/ MOTOR HOME ☐ OTHER

IN WHICH I: ☐ OWN/ AM BUYING ☐ RENT ☐ LIVE COST FREE ☐ RECEIVE BOARD AND CARE

LANDLORD'S NAME	AMOUNT OF RENT, BOARD AND/OR MORTGAGE PAID $________/MONTH	
ADDRESS	CITY	ZIP CODE

5. ARE THERE OTHERS LIVING IN THE HOUSEHOLD? *(IF "YES", GIVE THE INFORMATION BELOW:)* ☐ YES ☐ NO

NAME	RELATIONSHIP	AGE

6. DO YOU, YOUR SPOUSE OR YOUR PARENT(S) OWN REAL PROPERTY OTHER THAN YOUR HOME? *(If "YES", GIVE THE INFORMATION BELOW: OR ON PAGE 4 PARAGRAPH 21.)* ☐ YES ☐ NO

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ADDRESS	CITY	COUNTY

STATE	ZIP CODE	PARCEL NUMBER

ASSESSED VALUE	TOTAL AMOUNT OWED ON MORTGAGE(S)	MONTHLY PAYMENT
$	$	$

ANNUAL TAXES	ANNUAL INSURANCE	ANNUAL ASSESSMENTS
$	$	$

HOW IS PROPERTY UTILIZED?	IF USED AS RENTAL, INDICATE AMOUNT OF RENT.	ARE TAXES INCLUDED IN THE MONTHLY PAYMENT? ☐ YES ☐ NO
OTHER PROPERTY EXPENSES		IS INSURANCE INCLUDED IN THE MONTHLY PAYMENT? ☐ YES ☐ NO

7. DO YOU, YOUR SPOUSE OR YOUR PARENT(S) OWN MOTOR VEHICLES (CARS, TRUCKS, MOTORCYCLES, BOATS, MOTORHOMES)? *(IF "YES", GIVE THE INFORMATION BELOW:)* ☐ YES ☐ NO

MAKE AND MODEL	YEAR	ESTIMATED VALUE	CHECK IF USED FOR		MODIFIED FOR DISABLED PERSON?
			WORK	MEDICAL TRANS.	

8. WHAT IS THE VALUE OF YOUR LIQUID RESOURCES?
(IF APPLICANT IS A BLIND OR DISABLED CHILD UNDER AGE 18, INCLUDE RESOURCES OF PARENT(S) RESPONSIBLE FOR CHILD, INDICATE IF ANY RESOURCE IS EXCLUSIVELY FOR BURIAL EXPENSES FOR YOU OR YOUR IMMEDIATE FAMILY.)

LIQUID RESOURCES	(✓) IF NONE	ENTER VALUE UNDER OWNER			(✓) FOR BURIAL
		SELF	SPOUSE/PARENTS	JOINTLY	
CASH ON HAND AND/OR MONEY KEPT IN THE HOME		$	$	$	
CHECKING ACCOUNT		$	$	$	
SAVINGS ACCOUNT, CREDIT UNION TRUST FUNDS		$	$	$	
CHECKS OR CASH IN SAFETY DEPOSIT BOX		$	$	$	
STOCKS, BONDS, OR MUTUAL FUNDS NOTES, MORTGAGES, DEEDS		$	$	$	
IRA, CERTIFICATES OF DEPOSIT, MONEY MARKET		$	$	$	
OTHER *(SPECIFY)*:		$	$	$	

9. DO YOU, YOUR SPOUSE OR PARENT(S) (IF APPLICANT IS UNDER 18) HAVE ANY PERSONAL GOODS OR HOUSEHOLD EFFECTS WITH A COMBINED EQUITY VALUE OF MORE THAN $2,000? (E: G., HOUSEHOLD FURNISHINGS, CLOTHING, AND JEWELRY.) *(IF ADDITIONAL SPACE IS NEEDED, SPECIFY IN ITEM 21.)* *(IF "YES", GIVE INFORMATION BELOW:) (EXCLUDE REHABILITATION DEVICES AND EQUIPMENT.)* ☐ YES ☐ NO

DESCRIPTION	CURRENT MARKET VALUE	AMOUNT OWED
A.	$	$
B.	$	$
C.	$	$

10. DO YOU, YOUR SPOUSE OR YOUR PARENT(S) HAVE ANY LIFE INSURANCE? ☐ YES ☐ NO
(IF "YES", GIVE THE INFORMATION BELOW:)

NAME OF OWNER	NAME OF INSURED	NAME AND ADDRESS OF INSURANCE COMPANY

POLICY NUMBER	TOTAL FACE VALUE OF POLICY	CASH SURRENDER VALUE	WHEN WAS THE POLICY PURCHASED	IF THERE IS A LOAN AGAINST THE POLICY WHAT IS THE AMOUNT

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(11.) DO YOU, YOUR SPOUSE OR YOUR PARENT(S) HAVE ANY BURIAL FUNDS, INSURANCE, TRUSTS, SPACES OR CONTRACTS? *(IF "YES", GIVE THE INFORMATION BELOW:)* ☐ YES ☐ NO

OWNER OF EACH ITEM	NAME OF EACH ITEM	TOTAL PURCHASE VALUE OF EACH ITEM	HOW MUCH IS OWED ON EACH ITEM	NAME AND ADDRESS OF COMPANY/SOURCE
			$	
			$	

(12.) HAVE YOU, YOUR SPOUSE OR PARENT(S) (IF A MINOR IS APPLYING) SOLD, TRANSFERRED OR GIVEN AWAY ANY PROPERTY, INCLUDING MONEY, IN THE LAST 36 MONTHS? *(IF "YES", GIVE THE INFORMATION BELOW:)* ☐ YES ☐ NO

DESCRIPTION	DATE OF TRANSFER	ESTIMATED VALUE	AMOUNT RECEIVED
		$	$
		$	$

(13.) ARE YOU OR YOUR SPOUSE EMPLOYED OR SELF—EMPLOYED? *(IF "YES", GIVE THE INFORMATION BELOW:) (IF APPLICANT IS A BLIND OR DISABLED CHILD UNDER I8 INCLUDE EMPLOYMENT OF PARENT(S).)* ☐ YES ☐ NO

NAME OF EMPLOYER	ADDRESS OF EMPLOYER	
OCCUPATION	GROSS SALARY PER PAY PERIOD $	HOW OFTEN PAID?

IF SELF-EMPLOYED, ATTACH VERIFICATION OF ALL ORDINARY AND NECESSARY BUSINESS EXPENSES, PRINCIPAL PAYMENTS OR ENCUMBRANCES AND PERSONAL INCOME TAX.

(14.) DO YOU, YOUR SPOUSE OR YOUR PARENT(S) HAVE ANY BUSINESS EQUIPMENT INVENTORY, OR MATERIAL? *(IF "YES", GIVE THE INFORMATION BELOW:)* ☐ YES ☐ NO

DESCRIPTION	PURPOSE	ESTIMATED VALUE	AMOUNT OWED
		$	$
		$	$

(15.) IF YOU ARE BLIND OR DISABLED AND WORKING, DO YOU HAVE ANY WORK—RELATED EXPENSES DUE TO BLINDNESS OR DISABILITY? *(IF "YES", GIVE THE INFORMATION BELOW:)* ☐ YES ☐ NO

COST OF TRANSPORTATION TO AND FROM WORK	COST OF ITEMS OR SERVICES TO PREPARE FOR WORK	COST OF ITEMS OR SERVICES NEEDED FOR JOB PERFORMANCE
$	$	$

(16.) LIST INCOME RECEIVED EACH MONTH FROM SOURCES OTHER THAN EMPLOYMENT. IF APPLICANT IS A BLIND OR DISABLED CHILD UNDER AGE 18, INCLUDE INCOME OF PARENT(S) RESPONSIBLE FOR CHILD.

TYPE OF INCOME	(✓) NONE	ENTER MONTHLY AMOUNT RECEIVED BY: SELF	SPOUSE/PARENT(S)	CLAIM NUMBER
A. SOCIAL SECURITY *(RETIREMENT, SURVIVOR, DISABILITY INSURANCE)*		$	$	
B. CASH CONTRIBUTIONS		$	$	
C. STATE DISABILITY/ UNEMPLOYMENT INSURANCE		$	$	
D. VETERAN'S PENSION/COMPENSATION		$	$	
E. V.A. AID AND ATTENDANCE CARE/ HOUSEBOUND ALLOWANCE		$	$	
F. GOVERNMENT PENSION		$	$	
G. PRIVATE AND/OR MILITARY RETIREMENT PENSION		$	$	
H. ALIMONY, CHILD SUPPORT		$	$	
I. RENTAL INCOME		$	$	
J. INTEREST, DIVIDENDS, ROYALTIES		$	$	
K. RAILROAD RETIREMENT PENSION		$	$	
L. WORKER'S COMPENSATION		$	$	
M. AFDC PAYMENTS		$	$	
N. OTHER: *(SPECIFY)*		$	$	

(17) HAVE YOU, YOUR SPOUSE OR YOUR PARENT(S) APPLIED FOR OR DO YOU EXPECT TO START RECEIVING INCOME FROM ANY OF THE SOURCES LISTED IN "ITEM 16"? ☐ YES ☐ NO

(IF "YES", GIVE THE INFORMATION BELOW:)

TYPE OF INCOME	PLACE APPLIED	DATE APPLIED	DATE EXPECTED

(18) HAVE YOU, YOUR SPOUSE OR YOUR PARENTS HAD MEDICAL EXPENSES WITHIN THE LAST 3 MONTHS AND WANT MEDI-CAL FOR THOSE EXPENSES? ☐ YES ☐ NO

(19) (A.) DO YOU, YOUR SPOUSE OR YOUR PARENT(S) RECEIVE ANY NON-CASH GIFTS OR CONTRIBUTIONS OF RENT, FOOD, CLOTHING OR OTHER ITEMS OF NEED? ☐ YES ☐ NO

(B.) DO YOU, YOUR SPOUSE OR YOUR PARENT(S) RECEIVE NON-CASH COMPENSATION IN RETURN FOR WORK? ☐ YES ☐ NO

(IF "YES" TO "(A)" OR "(B)", GIVE THE INFORMATION BELOW:)

ITEM CONTRIBUTED	FREQUENCY OF RECEIPT	CASH EQUIVALENT
		$
		$

(20) DO YOU, YOUR SPOUSE OR YOUR PARENT(S) HAVE HEALTH OR HOSPITALIZATION INSURANCE (INCLUDING PAID BY AN EMPLOYER)? ☐ YES ☐ NO

(IF "YES", GIVE THE INFORMATION BELOW:)

INSURANCE CARRIER (CHECK APPLICABLE(S))	PERSON(S) INSURED
☐ MEDICARE *(CLAIM NO.)*	
☐ CHAMPUS	
☐ VETERAN'S ADMINISTRATION COVERAGE	
☐ KAISER	
☐ ROSS—LOOS	
☐ BLUE SHIELD	
☐ BLUE CROSS	
☐ PREPAID HEALTH PLAN	
☐ HEALTH MAINTENANCE ORGANIZATION *(SPECIFY:)*	
☐ OTHER CARRIER *(SPECIFY:)*	

(21) ITEM NUMBER	ADDITIONAL INFORMATION (ATTACH ADDITIONAL SHEETS IF NECESSARY)

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EXPECTED INCOME

How Verified:

a. ____________

b. ____________

c. ____________

IN-KIND INCOME

30-775.11

How Verified: ____________

PREMIUM PAYMENTS

Amount Paid: $ ____________

How often: ____________

How Verified: ____________

SOC 310 VERIFICATION

☐ ELIGIBLE ☐ INELIGIBLE

REASON (IF INELIGIBLE):

SOCIAL SERVICE WORKER:

DATE:

BE SURE YOU HAVE READ EVERY ITEM AND ANSWERED ALL THE QUESTIONS THAT APPLY TO YOU. READ THE FOLLOWING CAREFULLY BEFORE SIGNING:

I HEREBY STATE BY MY SIGNATURE THAT THE ANSWERS I HAVE GIVEN ARE CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE.

I AGREE TO TELL THE COUNTY DEPARTMENT OF SOCIAL SERVICES WITHIN 10 DAYS IF THERE ARE ANY CHANGES IN MY INCOME, POSSESSIONS. OR EXPENSES, OR IN THE NUMBER OF PERSONS IN MY HOUSEHOLD, OR IF ANY CHANGE OF ADDRESS. AND I AGREE TO MEET ALL OTHER RESPONSIBILITIES EXPLAINED IN THE "MEDI–CAL RESPONSIBILITIES CHECKLIST" I HAVE RECEIVED.

I UNDERSTAND THAT I MAY BE ASKED TO PROVE MY STATEMENTS, BUT THAT THE COUNTY IS REQUIRED BY LAW TO KEEP THEM CONFIDENTIAL.

I UNDERSTAND THAT IF I AM DISSATISFIED WITH ANY ACTIONS TAKEN BY THE COUNTY DEPARTMENT OF SOCIAL SERVICES, I HAVE THE RIGHT TO A STATE HEARING.

I UNDERSTAND THAT I MUST DISPOSE OF ANY EXCESS RESOURCES WITHIN A SIX–MONTH PERIOD IN THE CASE OF REAL PROPERTY AND WITHIN THREE MONTHS IN THE CASE OF PERSONAL PROPERTY AND REPAY ANY OVERPAYMENTS WITH THE PROCEEDS OF THE DISPOSED PROPERTY.

I UNDERSTAND THAT IF I AM ELIGIBLE FOR IHSS SERVICES, I WILL BE PROVIDED A MEDI–CAL CARD AT NO SHARE–OF–COST TO ME IF I PAY THE IHSS SHARE OF COST I AM OBLIGATED TO PAY.

I UNDERSTAND THAT FEDERAL AND STATE LAW REQUIRE THE RECOVERY OF ALL MEDI-CAL BENEFITS RECEIVED AFTER AGE 55 FROM THE ESTATE OF A MEDI–CAL BENEFICIARY IF THERE IS NO SURVIVING SPOUSE, MINOR CHILDREN, OR PERMANENTLY AND TOTALLY DISABLED CHILDREN.

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

SIGNATURE OF APPLICANT	DATE	SIGNATURE OF WITNESS *(REQUIRED IF APPLICANT SIGNED BY MARK)*	DATE
SIGNATURE OF PERSON ACTING FOR APPLICANT (RELATIONSHIP: PARENT, GUARDIAN, CONSERVATOR)	DATE	SIGNATURE OF PERSON HELPING APPLICANT COMPLETE FORM	DATE