FORM SAMPLES

CASE MANAGEMENT, INFORMATION, AND PAYROLLING (CMIPS)

State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

STATE COMPENSATION INSURANCE FUND
ADJUSTING AGENCY
Riverside, CA 92517-1901
BOTH SIDES OF THIS FORM MUST BE COMPLETED.

OSHA Case No.

☐ Fatality

NOTICE: California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME
1a. CONTRACT NUMBER: **CONTØU**
2. MAILING ADDRESS (Number and Street, City, Zip)
2a. Phone Number
3. LOCATION, if different from Mailing Address (Number, Street, City and Zip)
3a. Location Code
4. NATURE OF BUSINESS, e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc.: **HOME CARE**
5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.
6. TYPE OF EMPLOYER: ☒ PRIVATE ☐ STATE ☐ COUNTY ☐ CITY ☐ SCHOOL DIST. ☐ OTHER GOVERNMENT - SPECIFY

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)
8. TIME INJURY/ILLNESS OCCURRED ____ A.M. ____ P.M.
9. TIME EMPLOYEE BEGAN WORK ____ A.M. ____ P.M.
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ YES ☐ NO
12. DATE LAST WORKED (mm/dd/yy)
13. DATE RETURNED TO WORK (mm/dd/yy)
14. IF STILL OFF WORK, CHECK THIS BOX ☐
15. PAID FULL DAY'S WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ YES ☐ NO
16. SALARY BEING CONTINUED? ☐ YES ☐ NO
17. DATE OF EMPLOYER'S KNOWLEDGE/NOTICE OF INJURY/ILLNESS (mm/dd/yy)
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy)
19. SPECIFIC INJURY/ILLNESS AND MEDICAL DIAGNOSIS if available
19a. BODY PART AFFECTED
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED
20a. ZIP
20b. COUNTY
21. ON EMPLOYER'S PREMISES? ☐ YES ☐ NO
21a. WAS ANOTHER PERSON RESPONSIBLE? ☐ YES ☐ NO
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED
23. OTHER WORKERS INJURED OR ILL IN THIS EVENT? ☐ YES ☐ NO
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS.
27. NAME AND ADDRESS OF PHYSICIAN
27a. Phone Number
28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? ☐ NO ☐ YES
28a. Phone Number
29. Employee treated in Emergency Room? ☐ YES ☐ NO

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

EMPLOYEE

30. EMPLOYEE NAME
31. SOCIAL SECURITY NUMBER
32. DATE OF BIRTH
33. HOME ADDRESS (Number, Street, City, Zip)
33a. PHONE NUMBER
34. SEX ☐ MALE ☐ FEMALE
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)
36. DATE OF HIRE
37. EMPLOYEE USUALLY WORKS ____ hours per day ____ days per week ____ total weekly hours
37a. EMPLOYMENT STATUS
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WERE WAGES ASSIGNED?
38. GROSS WAGES/SALARY $ ____ per ____
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY? ☐ YES ☐ NO

Completed By (type or print) | Signature & Title | Date (mm/dd/yy)

Please do not use this Column: Case Number, Ownership, Industry, Occupation, Sex, Age, Daily hours, Days per Week, Weekly Hours, Weekly Wage, County, Nature of Injury, Part of body, Source, Event, Secondary Source, Extent of Injury

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY. A CLAIM FORM MUST BE GIVEN TO THE INJURED WORKER WITHIN ONE

Fig. XIII-G- 3 – SCIF 3167

Employee's Predesignation of Personal Physician Form

• In order for an employee to predesignate a personal physician, the employer must offer group health insurance.

• The employee may use the predesignation of personal physician form to name a medical doctor or doctor of osteopathic medicine or the personal physician's integrated multispecialty medical group if all other requirements are met.

• The physician is not required to sign this form, but in lieu of a signature, other documentation of the physician's agreement is required.

For the employee:

If I am injured on the job, I wish to be treated by my personal physician or my personal physician's integrated multispecialty medical group, who meets all the following requirements: (1) is my regular physician; (2) is my primary care physician or integrated multispecialty medical group; (3) is licensed per Business & Professions Code; (4) has previously provided my treatment; (5) retains my records; (6) agrees to be my predesignated physician.

Or, I wish to be treated by my personal chiropractor or acupuncturist, who has treated me before and has my records. I understand my identification of a personal chiropractor or acupuncturist is allowed only if there is no medical provider network (MPN) applicable. If the MPN is not applicable, my personal chiropractor or acupuncturist may treat my injury during the first 30 days of the employer's medical control, but I must first be evaluated by my employer's physician before I may request a change to my personal chiropractor or acupuncturist.

EMPLOYEE'S INFORMATION:

NAME

ADDRESS

CITY STATE ZIP

YOUR DOCTOR'S INFORMATION:

NAME OF DOCTOR AND/OR NAME OF PERSONAL PHYSICIAN'S MULTISPECIALTY MEDICAL GROUP

ADDRESS

CITY STATE ZIP

PHONE

DOCTOR'S SIGNATURE

EMPLOYEE'S SIGNATURE DATE

Formulario de Designación Previa del Médico Personal del Empleado

• Para que un empleado pueda previamente designar su médico personal, el empleador debe ofrecer seguro médico de grupo.

• Si se han cumplido todos los otros requerimientos, el empleado puede utilizar el formulario de designación previa del médico personal para nombrar a un doctor médico o un doctor de medicina osteopática o el grupo de médicos de multiespecialidades integradas de su médico personal.

• No se requiere la firma del médico en este formulario, pero en lugar de una firma, otra documentación del acuerdo del médico es requerida.

Para el empleado:

Si me lesiono en el trabajo, deseo que me atienda mi doctor personal o el grupo de médicos de multiespecialidades integradas de mi doctor personal, quien llena todos los siguientes requisitos: 1) Es mi médico regular; 2) Es mi médico primario de cuidado o grupo médico de multiespecialidades; 3) Tiene una licencia de aprobación del Business & Professions Code; 4) Me ha proporcionado tratamiento médico anteriormente; 5) Tiene y mantiene mi historial médico; 6) Acepta ser mi médico designado.

Ó, deseo que me atienda mi **quiropráctico o acupunturista personal,** quien es el que me ha atendido anteriormente y tiene mi historial. Estoy por entendido que identificar a un quiropráctico o acupunturista solamente es permitido cuando la medical provider network (MPN) no es aplicable. Si la MPN no aplica, mi quiropráctico o acupunturista personal podrá ofrecerme tratamiento durante los primeros 30 días del control médico del empleador, pero un doctor asignado por mi empleador deberá examinarme primero antes de solicitar que me cambien a mi quiropráctico o acupunturista personal.

INFORMACIÓN DEL EMPLEADO:

NOMBRE

DIRECCIÓN

CIUDAD ESTADO CÓDIGO POSTAL

INFORMACIÓN DE SU DOCTOR:

NOMBRE DEL DOCTOR Y/O EL NOMBRE DE GRUPO DE MÉDICOS DE MULTIESPECIALIDADES INTEGRADAS DE SU DOCTOR PERSONAL

DIRECCIÓN

CIUDAD ESTADO CÓDIGO POSTAL

TELÉFONO

FIRMA DEL DOCTOR

FIRMA DE EMPLEADO FECHA

State of California-Health & Welfare Agency-
Department of Social Services

IN-HOME SUPPORTIVE SERVICES — PROVIDER ELIGIBILITY UPDATE

A

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

B

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

C

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

D

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

E

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

F

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

G

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

H

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

A

PROVIDER NUMBER
(2)

B

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

C

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

D

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

E

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

F

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

G

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

H

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

I

COUNTY VALIDATION

AUTHORIZATION	DATE	REMARKS

J

VALIDATION	DATE	REMARKS

SOC 311 1O/85

IN-HOME SUPPORTIVE SERVICES PROGRAM
DIRECT DEPOSIT
ENROLLMENT/CHANGE/CANCELLATION FORM

To elect, change or cancel Direct Deposit, please read the attached instructions and complete all of the information requested.

A separate form must be completed for each type of enrollment action.

PLEASE TYPE OR PRINT CLEARLY USING A BALL POINT PEN.

TYPE OF ACTION

1. ☐ NEW
2. ☐ CHANGE
3. ☐ CANCEL

(TO BE COMPLETED BY THE RECIPIENT/GUARDIAN/CONSERVATOR)

A. RECIPIENT NUMBER ☐☐☐☐☐☐☐☐☐☐			
B. NAME OF PAYEE (LAST, FIRST, MIDDLE)			TELEPHONE # ( )
ADDRESS (STREET, ROUTE, P.O. BOX)	CITY	STATE	ZIP CODE
C. NAME OF GUARDIAN/CONSERVATOR (LAST, FIRST, MIDDLE)			TELEPHONE # ( )
ADDRESS (STREET, ROUTE, P.O. BOX)	CITY	STATE	ZIP CODE
D. PAYEE SOCIAL SECURITY # ☐☐☐☐☐☐☐☐☐	E. TYPE OF DEPOSITOR ACCOUNT (CHECK ONE) ☐ Checking ☐ Savings		
F. NAME AND ADDRESS OF FINANCIAL INSTITUTION	G. ROUTING # ☐☐☐☐☐☐☐☐☐		
H. DEPOSITOR ACCOUNT # ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐			
I. BRANCH NAME & NUMBER			

J. CHECK APPROPRIATE BOX

☐ I hereby authorize the County Welfare office to directly deposit my monthly advance payments.

☐ I hereby authorize the County Welfare office to change my Direct Deposit.

☐ I hereby cancel my Direct Deposit authorization.

K. SIGNATURE OF PAYEE/GUARDIAN/CONSERVATOR	DATE

White - County copy Yellow - Payee copy

STATE OF CALIFORNIA
IHSS PROGRAM

Dear IHSS Recipient:

As an alternative to receiving your monthly In-Home Supportive Services (IHSS) advance pay warrant by mail, the State Department of Social Services (SDSS) is offering you the option of having your advance payment electronically transferred to a financial institution (Bank, Savings and Loan, or Credit Union) of your choice. Direct Deposit through Electronic Fund Transfer (EFT) is limited to those financial institutions by law. Direct Deposit is optional. If you choose to continue receiving your advance pay by mail, you do not need to complete the attached form or take any action.

WHAT IS DIRECT DEPOSIT THROUGH EFT?

With Direct Deposit through EFT, your advance payment is electronically transferred to the financial institution of your choice. You will not receive a warrant through the mail. Instead, every month you will receive a deposit stub, by mail from the State Controller's Office, with information about your direct deposit and tax deductions. By the time you receive the deposit stub, your money will already be waiting in your account. This will save you a trip to the bank.

WHO IS ELIGIBLE FOR DIRECT DEPOSIT?

You are eligible for Direct Deposit if you have been an IHSS recipient for one year, receiving your payment in advance and you hire and pay your service providers.

ENROLLMENT INSTRUCTIONS:

*** PLEASE READ CAREFULLY ***

WHEN TO USE THE DIRECT DEPOSIT ENROLLMENT FORM SOC 404.

To enroll in Direct Deposit, complete the Type of Action section and, sections A through K on the attached form (SOC 404).

1. To sign up as a new enrollee.
2. To change Direct Deposit from checking to savings or vice versa.
3. To change Direct Deposit from one financial institution to another.
4. To change depositor account number within a financial institution.
5. To cancel Direct Deposit.

WHEN WILL MY FIRST DIRECT DEPOSIT TRANSACTION BE CREDITED TO MY ACCOUNT?

Your first transaction may occur from 60 to 90 days after your request is received by your County Welfare Office. The posting date of your deposit is the first day of the month, unless it is a weekend or holiday, then it is the first working day following the weekend or holiday.

IF THERE ARE ANY PROBLEMS WITH THE DIRECT DEPOSIT INFORMATION, IT CAN DELAY RECEIVING YOUR MONEY BY AS MUCH AS 14 DAYS.

INSTRUCTIONS CONTINUED ON BACK

ENROLLMENT INSTRUCTIONS.

1. To enroll in Direct Deposit, complete the Type of Action section and, sections A through K on the attached form (SOC 404).

2. A separate form must be completed for each type of action requested.

Example 1

FINANCIAL INSTITUTION CHECK NO. 4444
HOMETOWN, USA

PAY TO THE ORDER OF _____

I:112145678 I: 5765432109812 4444

Routing No. Dep. Acct. No. Ck. No.

Example 2

FINANCIAL INSTITUTION CHECK NO. 4444
HOMETOWN, USA

PAY TO THE ORDER OF _____

I:112145678 I: 4444 8765432109812

Routing No. Ck. No. Dep. Acct. No.

3. Please verify your depositor account number and routing number with your financial institution.

4. Attach your voided personal check to the upper left portion of the back of the white copy of the enrollment form if you are depositing your funds into your checking account. This will aid in verifying your depositor account number and routing number.

5. For savings account - secure your routing number and depositor number from your financial institution.

SEND THE WHITE COPY OF THE COMPLETED ENROLLMENT FORM TO YOUR COUNTY WELFARE OFFICE AND RETAIN THE YELLOW COPY FOR YOUR RECORDS.

CHANGING FINANCIAL INSTITUTIONS OR DEPOSITOR ACCOUNTS.

Your Direct Deposit will continue to be deposited into your designated account at your financial institution until the County Welfare Office is notified that you wish to redesignate your account and/or your financial institution. To redesignate, complete and submit a new enrollment form with the new information.

DO NOT CLOSE YOUR OLD ACCOUNT UNTIL YOUR FIRST PAYMENT IS DEPOSITED INTO YOUR NEWLY DESIGNATED ACCOUNT AND/OR FINANCIAL INSTITUTION.

CANCELLATION.

The agreement represented by this authorization remains in effect until cancelled by you by written notice to your County Welfare Office. In the event of your death or legal incapacity, it is the responsibility of your estate to notify your County Welfare Office by written notice. It is your responsibility or the responsibility of your estate to notify the receiving financial institution that the authorization has been cancelled. If you become ineligible for advance payment, your Direct Deposit will be cancelled immediately.

IHSS/CMIPS ELECTIVE STATE DISABILITY INSURANCE (SDI) FORM

This form is for elective State Disability Insurance Coverage (Unemployment Insurance Code Section 702.5) and is only for family member providers, who receive their paychecks from the State Controller's Office. **An eligible family member is the recipient's spouse, parent, or a child (includes adopted but not a stepchild or fosterchild) under the age of 18.** This Disability Insurance is not compulsory, and, by electing to be covered, the recipient and his/her family member provider agree to have State Disability Insurance premiums deducted from the family member provider's paychecks. Do not complete this form unless both the recipient/employer and the provider/employee wish to have the provider's services voluntarily covered for Disability Insurance under the provisions of Section 702.5 of the Code.

TO BE COMPLETED AND SIGNED BY THE RECIPIENT/EMPLOYER

RECIPIENT NAME		SOCIAL SECURITY NUMBER	TELEPHONE NUMBER ( )
STREET ADDRESS	CITY	STATE	ZIP CODE

I, the undersigned, certify that the statements made in this application are true and correct to my best knowledge and belief. I hereby elect and make application to have the exempt family services considered as employment subject to the Unemployment Insurance Code for disability insurance only. **THE ELECTIVE AGREEMENT IS TO BE IN EFFECT FOR AT LEAST TWO COMPLETE CALENDAR YEARS OR UNTIL TERMINATION OF THE PROVIDER SERVICES.** The elective agreement may be terminated by filing a request for termination by January 31 of any year following two complete years of elective coverage.

RECIPIENT/EMPLOYER SIGNATURE	DATE

TO BE COMPLETED AND SIGNED BY THE PROVIDER/FAMILY MEMBER

PROVIDER NAME		SOCIAL SECURITY NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE NUMBER ( )	RELATIONSHIP TO RECIPIENT *(IF CHILD PLEASE CIRCLE)* NATURAL ADOPTED (STEPCHILD OR FOSTERCHILD NOT ELIGIBLE)	DATE OF BIRTH

1. Is the employment intended to be continuing and not intermittent or seasonal in nature? ..... ☐ **YES** ☐ **NO**
2. Are you able to perform normal and customary provider services with IHSS? ..... ☐ **YES** ☐ **NO**

Deductions for elective SDI will begin with your next warrant.

I elect to be covered by State Disability Insurance and agree to have the contributions for this insurance deducted from my paychecks.

SIGNATURE OF PROVIDER	DATE

COUNTY USE ONLY

RECIPIENT CASE NUMBER
COMMENTS

Note: If your application is approved, the elective coverage agreement will be subject to all of the requirements and conditions of UI Code Sections 631, 702.5, 704 and 707.

ELIGIBILITY FOR DISABILITY INSURANCE BENEFITS UNDER THE CODE DOES NOT BEGIN WITH THE COMMENCEMENT DATE OF COVERAGE. GENERALLY, A MINIMUM OF 7 MONTHS MUST ELAPSE FROM THE COMMENCEMENT DATE OF COVERAGE BEFORE A VALID CLAIM MAY BE FILED BASED SOLELY ON WAGES REPORTABLE UNDER YOUR ELECTION.

Also note: Domestic services are not subject to Personal Income Tax Withholding, however, if a recipient and provider voluntarily agree, income tax can be withheld.

Wages and Contributions - Section 702.5: Contributions to be paid for 'Family Employment' elective coverage are to be based upon actual wages paid to covered family members for services performed up to a maximum wage limitation for the year for each family member. There is no provision in this section to permit the contributions to be based on other than actual wages paid. The amount of any disability benefits paid will also be determined on the basis of wages paid.

Social Security Number Disclosure: The disclosure of your Social Security Account Number is mandatory under the Federal Tax Reform Act of 1976. The number will be used for identification purposes and will be available only to authorized personnel within the Employment Development Department and other government agencies as permitted in Sections 322 and 1095 of the California Unemployment Insurance Code.

TERMINATION OF ELECTIVE SDI

Only the Recipient/Employer can apply to have elective SDI coverage stopped for his/her provider.

Elective SDI coverage can only be terminated during January after two complete years of elective coverage or upon terminating employment.

I request termination of elective SDI coverage for my provider.

SIGNATURE OF RECIPIENT	DATE

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
IN-HOME SUPPORTIVE SERVICES PROGRAM

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

Distribution:

White	-	State Compensation Insurance Fund
Yellow	-	Employer's Copy
Pink	-	Employee's Copy
Goldenrod	-	Employee's Temporary Receipt

IN-HOME SUPPORTIVE SERVICES (IHSS)
EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS
NOTICE OF POTENTIAL ELIGIBILITY FOR BENEFITS

If you are injured or become ill because of your job, you may be entitled to one or more of the following benefits provided for you as an Individual Provider of IHSS, depending upon your individual situation: medical treatment, compensation for lost time related to this injury, compensation for a permanent impairment, vocational rehabilitation, and/or death benefits. Compensation is based on a percentage of your earnings. If you are hospitalized or off work for more than 3 days as a result of this injury, you will receive your first payment of compensation or a notice within 14 days of the county's IHSS worker's knowledge of this injury. Along with your first payment, you will also receive a pamphlet describing more fully compensation benefits and procedures.

Failure to file this claim will make it impossible for you to receive any late payment penalty that may be due and will also preclude your right to pursue further legal remedies.

If you need assistance in completing this form or have any questions regarding your work injury, you may contact the State of California Office of Benefit Assistance and Enforcement by calling 1-800-736-7401. This service is provided to you at no cost. You also may consult an attorney.

ANY PERSON WHO MAKES, OR CAUSES TO BE MADE, ANY KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR REPRESENTATION FOR THE PURPOSE OF OBTAINING OR DENYING WORKERS' COMPENSATION BENEFITS OR PAYMENTS IS GUILTY OF A FELONY.

PART I - PROVIDER/EMPLOYEE: *Complete the "Employee" section and give the form to the county IHSS worker. Keep the copy marked "Employee's Temporary Receipt" until you receive the dated copy from the county.*

NAME OF EMPLOYEE	DATE OF INJURY OR ILLNESS / /	TIME OF DAY ☐ A.M. ☐ P.M.
HOME ADDRESS (NUMBER, STREET, CITY, ZIP CODE)		
WHERE DID ACCIDENT OR EXPOSURE OCCUR (NUMBER, STREET, CITY, ZIP CODE)		
DESCRIBE THE INJURY OR ILLNESS AND HOW IT OCCURRED		
WHAT SPECIFIC PART OF YOUR BODY WAS INJURED?		
WHAT IS YOUR RELATIONSHIP TO THE IHSS RECIPIENT/EMPLOYER?		
SIGNATURE OF EMPLOYEE	SOCIAL SECURITY NO: – –	

I gave this form to the county IHSS worker on (date) _____, 20____.

PART 2 – *COUNTY IHSS WORKER: COMPLETE THIS SECTION AND PROMPTLY GIVE THE EMPLOYEE A COPY AS A RECEIPT. SIGNING OF THIS FORM DOES NOT NECESSARILY CONSTITUTE ACCEPTANCE OF A CLAIM.*

NAME OF EMPLOYER	IHSS NO.	TELEPHONE
DATE OF KNOWLEDGE OF INJURY / /	DATE CLAIM FORM WAS PROVIDED TO EMPLOYEE / /	DATE CLAIM FORM WAS RECEIVED FROM EMPLOYEE / /
SIGNATURE OF IHSS WORKER		SSW NO.

STATE
COMPENSATION
INSURANCE
FUND

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

EMPLOYER: YOU ARE REQUIRED BY LAW TO POST THE INFORMATION CONTAINED ON THIS NOTICE IN A CONSPICUOUS LOCATION FREQUENTED BY EMPLOYEES AND WHERE SUCH NOTICE MAY BE EASILY READ BY EMPLOYEES DURING THE COURSE OF THE WORK DAY.

NOTICE TO EMPLOYEES

DEPARTMENT OF SOCIAL SERVICES IN-HOME SUPPORTIVE SERVICES PROGRAM

Our Workers' Compensation Insurer is: **STATE COMPENSATION INSURANCE FUND**

If a job injury occurs...

If you become injured or ill because of your job, you will be entitled to automatic benefits under the California Workers' Compensation Law. These benefits include:

Medical Care–All authorized medical expenses are fully covered. If you need medical care, you will be referred to a local doctor. Should you still need care 30 days after reporting the injury, you may be treated by a physician of your own choice. (You may be treated by your own personal physician immediately following your injury if you have notified your employer in writing before the injury occurs of the name and address of your personal physician.) For further information, please contact your Employer's County Social Services Worker.

Disability Income–If hospitalized, or unable to work for more than three days, you will receive income equal to two-thirds of your average weekly pay, up to a legal maximum per week. If you receive a permanent disability, additional payments will be provided.

Rehabilitation–If your injury or illness prevents you from returning to your same job, you may be eligible for vocational rehabilitation and retraining.

Death Benefits–Should the injury cause death, a benefit will be paid to dependents.

***Important**–Always immediately notify your Employer's County Social Services Worker of any work-related injury or illness. If you have any questions or would like more details about workers' compensation benefits, please call the Office of Benefit Assistance and Enforcement at 1-800-736-7401.*

When a job injury occurs...

Be sure that:

Necessary first aid and appropriate emergency treatment is provided immediately as required by the nature of the injury (even if the employee has previously notified the employer that he wishes to be treated by his own personal physician).

The injured employee is taken to a doctor or a hospital, as necessary.

The accident is reported immediately! Any delay in reporting may delay workers' compensation benefits.

Emergency Phone Numbers:

Social Services Worker (name and telephone)

Hospital (name and telephone)

Ambulance (name and telephone)

Fire (telephone) **Police** (telephone)

Concerning off-duty recreational, social or athletic activity.

Your employer or its insurance carrier may not be liable for the payment of workers' compensation benefits for any injury which arises out of an employee's voluntary participation in any off-duty recreational, social, or athletic activity which is not a part of the employee's work-related duties.

This notice is in compliance with Section 3550 of the Labor code which states in part that every employer subject to the compensation provision of the code shall post, and keep posted, in a conspicuous location a notice which shall state the name of the current compensation insurance carrier of such employer. In addition, this posting notice follows State administrative guidelines under the "employee information" law for providing information to employees about workers' compensation benefits.

SOC 413 (10/90)

Fig. XIII-G- 2 – SOC 413

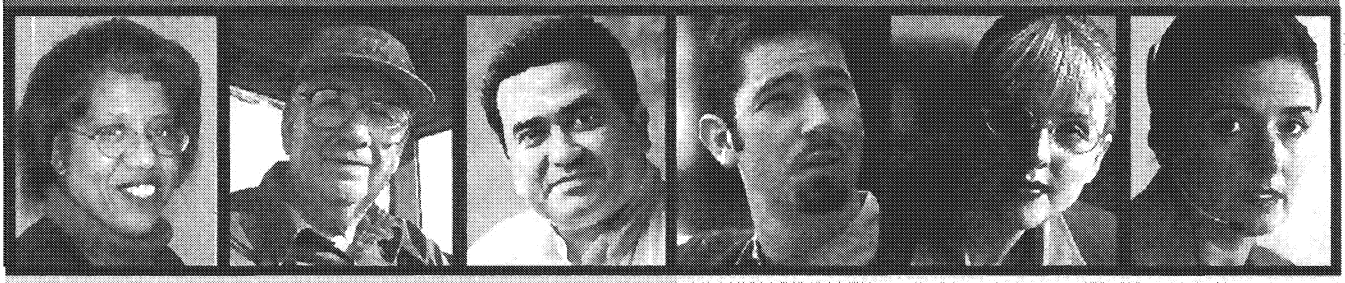
new employee's guide to WORKERS' compensation

Helpful information you should know if you are injured on the job or become ill due to your job.

guía para nuevos empleados SOBRE LA compensación A LOS TRABAJADORES

Información útil en caso de que sufra alguna lesión en el trabajo o se enferme a causa de su trabajo.

STATE COMPENSATION INSURANCE FUND



Questions & Answers

What is workers' compensation?

At no cost to you, it is insurance that the law requires your employer to carry to help you if you are injured on the job or if you become ill due to your job.

What is a workers' compensation injury or illness?

An injury or illness that occurs due to employment is considered a workers' compensation injury or illness. Under workers' compensation law, you will receive help if you are injured, no matter who was at fault.

Workers' compensation covers various types of events, injuries, and illnesses. You could get hurt by one event at work, such as hurting your back in a fall, or by repeated exposures at work, such as hurting your wrist from doing the same motion over and over.

What is State Compensation Insurance Fund?

We are the insurance carrier your employer has chosen to provide its workers' compensation coverage. We have more than 90 years of experience providing workers' compensation throughout California.

Is workers' compensation the same as State Disability Insurance?

No. Workers' compensation is only for injuries or illnesses that occur due to employment. State Disability Insurance (SDI) is for injuries or illnesses that are not work-related, and it is a benefit that the Employment Development Department provides.

Preguntas y Respuestas

¿Qué es la compensación a los trabajadores?

Es un seguro que su empleador debe contratar, por ley y sin ningún costo para usted, para ayudarlo en caso de que sufra alguna lesión en el trabajo o se enferme a causa de su trabajo.

¿Qué es una enfermedad o lesión susceptible de compensación a los trabajadores?

Toda lesión o enfermedad causada por el trabajo es considerada lesión o enfermedad susceptible de compensación a los trabajadores. De acuerdo con la legislación vigente en materia de compensación a los trabajadores, usted recibirá ayuda si sufre una lesión, independientemente de quién sea el culpable. La compensación a los trabajadores cubre diferentes tipos de acontecimientos, lesiones y enfermedades. En el trabajo, usted puede lesionarse por un acontecimiento, (por ejemplo, lastimarse la espalda por una caída), o bien, por la reiteración de una determinada actividad, (por ejemplo, lastimarse la muñeca por la repetición constante de un movimiento.

¿Qué es State Compensation Insurance Fund?

Somos la compañía de seguros que ha elegido su empleador para suministrar la cobertura de compensación a los trabajadores. Contamos con más de 90 años de experiencia en el suministro de seguros por accidentes o enfermedades laborales en el estado de California.

¿Es la compensación a los trabajadores lo mismo que el Seguro Estatal por Incapacidad?

No. La compensación a los trabajadores es sólo para lesiones o enfermedades que ocurren debido al trabajo. El Seguro Estatal por Incapacidad (SDI) cubre lesiones o enfermedades que no están relacionadas con el trabajo. Es un beneficio que brinda el Departamento de Desarrollo del Empleo.

How does this coverage affect my own health insurance?

Workers' compensation is separate from personal health-care insurance. Workers' compensation insurance covers work-related injuries and illnesses only. There is no deductible—the insurance carrier pays all approved medical bills. It is important to let the treating doctor know if your injury is work-related.

How do I file a claim?

If you are injured on the job, as soon as you can, tell your supervisor that you have been hurt. Except for first-aid injuries, your employer will provide you with a claim form on which you can describe your injury, as well as how, when, and where it occurred. Return the completed form to your employer, who will send it to us. We will then get in touch with you to explain the benefits to which you may be entitled.

What are my benefits and rights?

Within one day after an employee files a claim form, the law requires the employer to authorize medical treatment as required and limited by the law, until the claim is accepted or rejected, up to a limit of $10,000 in total. All medical treatment is provided in accordance with the medical treatment utilization schedule.

If State Fund accepts your claim, State Fund will pay all approved medical care that is reasonable, necessary, and supported by evidence-based treatment guidelines. This care may include doctors, hospital services, physical therapy, lab tests, x-rays, medicines, and related reasonable transportation expenses. For injuries on or after January 1, 2004, there are limits on the number of chiropractic, occupational therapy, and physical therapy visits.

State Fund pays for all authorized treatment, so you should not receive any bills. The law states that you are not responsible for copayments or balance-due bills after we have paid the provider. If you receive any bills, or a medical provider or pharmacy demands payment up-front, contact your claims representative right away to direct you elsewhere.

We will also pay a portion of your lost wages if you cannot work due to the injury. This benefit is called temporary disability. If your injury or illness results in a permanent impairment that diminishes your future earning capacity, we will also pay you permanent disability benefits. In the event of a work-related death, we will pay death benefits to your qualified surviving dependents.

As of January 1, 2004, the Labor Code allows State Fund to review medical-treatment requests from your physician through a utilization review (UR) process. This review process involves doctors and other health consultants reviewing your medical-treatment needs by following medical-treatment guidelines approved by the administrative director of the Division of Workers' Compensation (DWC). There are time limits to approve, modify, delay, or deny treatment requests from your physician.

How is temporary disability calculated?

The weekly temporary disability rate is two-thirds of your average weekly earnings, subject to minimum and maximum amounts that are determined by law. The minimum and

¿De qué manera afecta esta cobertura al seguro de salud?

La compensación a los trabajadores es independiente del seguro de salud personal. El seguro de compensación a los trabajadores sólo cubre lesiones y enfermedades relacionadas con el trabajo. No existe deducible, ya que la compañía de seguros paga todas las facturas médicas aprobadas. Es importante comunicar al médico tratante que su lesión está relacionada con el trabajo.

¿Cómo presento un reclamo?

Si se lesiona en el trabajo, comuníquele a su supervisor tan pronto como pueda que ha sufrido una lesión. Excepto en lesiones de primeros auxilios, su empleador le entregará un formulario de reclamos, en el que deberá describir su lesión y aclarar cómo, cuándo y dónde se produjo. Una vez completado el formulario, devuélvalo a su empleador para que nos lo envíe. De este modo, nos pondremos en contacto con usted para explicarle los beneficios a los que puede acceder.

¿Cuáles son mis derechos y beneficios?

Hasta tanto se acepte o rechace el reclamo, la legislación vigente obliga al empleador a autorizar tratamiento médico por un valor máximo de $10,000 en total dentro de las 24 horas posteriores a la presentación del formulario de reclamos, conforme a las disposiciones y limitaciones de la legislación. Todo tratamiento médico se realiza conforme a su correspondiente programa de utilización.

Si State Fund acepta su reclamo, pagará toda la atención médica aprobada que resulte razonable y necesaria y que esté sustentada por las pautas de tratamiento basadas en las pruebas. Esta atención puede incluir los gastos para médicos, servicios hospitalarios, terapia física, pruebas de laboratorios, radiografías, medicamentos y transporte relacionado. En el caso de lesiones posteriores al 1ro de enero de 2004, existen restricciones en la cantidad de sesiones de terapia ocupacional, física y quiropráctica.

State Fund pagará todo el tratamiento autorizado para que usted no reciba ninguna factura. La ley establece que usted no es responsable de las facturas con saldos pendientes o copagos después de que hayamos pagado al proveedor. Si recibe alguna factura o el proveedor de servicio de salud o de la farmacia le exige pago por adelantado, póngase en contacto de inmediato con el representante de reclamos para que lo derive a otro lugar.

También pagaremos parte del salario perdido si no puede trabajar debido a la lesión. Este beneficio se denomina discapacidad temporal (TD). Si su lesión o enfermedad ocasionara un problema permanente que redujera su capacidad de trabajo en el futuro, también le pagaremos beneficios por discapacidad permanente. Ante una muerte relacionada con el trabajo, pagaremos los beneficios garantizados en caso de muerte a las personas a su cargo que cumplan con los requisitos correspondientes.

A partir del 1ro de enero de 2004, el Código Laboral le permite a State Fund de revisar cada solicitud de tratamiento de su médico mediante el proceso denominado revisión de utilización (UR). Este proceso de revisión involucra a médicos y otros especialistas de la salud, que examinarán su necesidad de recibir tratamiento médico en función de pautas para tratamientos médicos aprobadas por el director administrativo del Division of Workers' Compensation (DWC). Existen plazos para aprobar, modificar, retrasar o rechazar las solicitudes de tratamiento de su médico.

¿Cómo se calcula la discapacidad temporal (TD)?

El coeficiente semanal de discapacidad temporal es dos tercios de sus ingresos medios semanales y está sujeto a cantidades

maximum amounts that are in effect depend upon your date of injury, as shown on the following table:

TD Rates	2002	2003	2004	2005	2006	2007
Minimum	Actual Wages	$126	$126	$126	$126	$132.25
Maximum	$490	$602	$728	$840	$840	$881.66

We recalculate temporary disability payments made two or more years after the injury to reflect the rates in effect at the time of payment.

When does temporary disability start and stop?

If you are unable to work for more than 3 calendar days, we will pay you temporary disability. This 3-day "waiting period" will qualify for payment as of the fourth day of medically authorized lost time from work when you are unable to work for more than 14 calendar days, or if you are hospitalized as an inpatient. You will receive temporary disability (TD) payments every two weeks during the time you qualify for this benefit. Generally, temporary disability stops when you return to work, or when the treating physician releases you for work or says that your injury has reached a point of maximum improvement. TD payments will not be extended beyond 104 compensable weeks within two years after the initial TD payment. (Exempt are certain injuries that typically take longer to heal; they are subject to a cap of 240 weeks within a five-year period.) After the termination of the 104 weeks of TD payments, a timely Employment Development Department filing may result in your qualifying for additional state disability benefits.

How is permanent disability calculated and paid?

Your examining physician will report on any permanent impairment that may be considered a permanent disability. Under workers' compensation law, a permanent disability rating involves the use of a specialized formula. This formula considers your age and occupation at the time of your injury or illness, diminished future earning capacity, plus any permanent impairments that the examining physician may indicate. The permanent disability rating yields a specific dollar amount. The exact amount depends on the date of injury, the percentage of disability, and your average weekly earnings at the time of injury. Once permanent disability payments begin, you receive payments every two weeks at your permanent disability rate. This rate is equal to two-thirds of your average weekly wages at the time of injury, subject to the established minimum and maximum rates. The following table lists the maximum permanent disability payments for each percentage range.

Maximum Permanent Disability Payments

Rating	07/1/96-12/31/02	2003	2004	2005	2006-2007
Up to 14.75%	$140	$185	$200	$220	$230
15% to 24.75%	$160	$185	$200	$220	$230
25% to 69.75%	$170	$185	$200	$220	$230
70% to 99.75%	$230	$230	$250	$270	$270
Minimum per week:	$ 70	$100	$105	$105	$130

mínimas y máximas determinadas por la ley. Las cantidades mínimas y máximas en vigencia dependen de la fecha en que ocurrió la lesión, como se muestra en la tabla siguente:

Tasas de TD	2002	2003	2004	2005	2006	2007
Mínimo	Salario Actual	$126	$126	$126	$126	$132.25
Máximo	$490	$602	$728	$840	$840	$881.66

Nosotros volvemos a calcular los pagos por discapacidad temporal realizados en un período mínimo de dos años a partir de la lesión para que reflejen los coeficientes en vigencia en el momento del pago.

¿Cuándo comienza y cuándo finaliza la discapacidad temporal?

Si está imposibilitado de trabajar durante más de 3 días consecutivos, le pagaremos por discapacidad temporal. Este "período de espera" de tres días le permitirá recibir el pago a partir del cuarto día de tiempo laboral perdido con autorización médica, si no puede trabajar durante más de 14 días consecutivos o si se lo debe hospitalizar. Recibirá pagos por discapacidad temporal cada dos semanas mientras reúna los requisitos para recibir este beneficio. Generalmente, la discapacidad temporal termina cuando regresa al trabajo o cuando el médico tratante permite que vuelva a trabajar o señala que su lesión ha alcanzado el punto de mejoramiento máximo. Los pagos por TD no se extenderán más allá de las 104 semanas indemnizables dentro de los dos años posteriores al pago inicial por TD. (Quedan exceptuadas ciertas lesiones que demoran más tiempo en curarse. El límite máximo en estos casos es de 240 semanas dentro de un período de cinco años.) Luego del término de las 104 semanas de pagos TD, puede que oportunamente resulte un archivo del Departamento de Desarrollo de Empleo de su calificación para beneficios adicionales estatales de discapacidad.

¿Cómo se calcula y se paga la discapacidad permanente?

El médico que lo atiende informará todo problema permanente que pudiera considerarse discapacidad permanente. De acuerdo con la legislación vigente en materia de indemnizaciones por accidentes o enfermedades laborales, el cálculo de una discapacidad permanente requiere el uso de una fórmula especializada. Esta fórmula considera la edad y ocupación en el momento de la lesión o enfermedad y la reducción de la capacidad de trabajo en el futuro, además de todos los problemas permanentes que podría indicar el médico que lo revise. El cálculo de la discapacidad permanente da como resultado una cantidad específica de dólares. La cantidad exacta depende de la fecha de la lesión, el porcentaje de discapacidad y sus ingresos semanales medios en el momento de la lesión. Una vez iniciados los pagos, los recibirá cada dos semanas de acuerdo con su tasa de discapacidad permanente. Esta tasa equivale a dos tercios de su salario medio semanal en el momento de la lesión y está sujeto a los coeficientes mínimos y máximos establecidos. La siguiente tabla señala los pagos máximos por discapacidad permanente para cada rango de porcentajes.

Pago Máximo Por Discapacidad Permanente

Clasificación	Tasas 01/7/96-31/12/02	2003	2004	2005	2006-2007
Hasta 14.75%	$140	$185	$200	$220	$230
De 15% a 24.75%	$160	$185	$200	$220	$230
De 25% a 69.75%	$170	$185	$200	$220	$230
De 70% a 99.75%	$230	$230	$250	$270	$270
Mínimo por semana:	$ 70	$100	$105	$105	$130

When does permanent disability start and stop?

Generally, if we accept your claim and your treating physician has determined that you have permanent disability, payments begin within 14 days after the termination of temporary disability. If we know the extent of your permanent disability, we will continue the payments every two weeks until we have paid the full benefit. If we do not know the extent of your permanent disability, payments will continue every two weeks until we have paid a reasonable estimate of your permanent disability indemnity due.

How are death benefits calculated and paid?

The total death benefit is contingent on the number of surviving partial and total dependents at the time of injury or illness resulting in death. Once we determine the dependency, we pay the death benefit in installments at the decedent's temporary disability rate. However, the rate must be no less than $224 per week until we have paid the total death benefit, or, if dependency involves a minor child, until the minor child is 18 years old. For injuries on or after January 1, 2003, benefits will be paid to a dependent child for life when physically or mentally incapacitated from earning. The next table shows the distribution of maximum death benefits.

Death Benefit Maximums

	07/01/96-12/31/05	2006 - 2007
Single total dependent	$125,000	$250,000
No total dependents and one or more partial dependents	$125,000	$250,000
Single total dependent and one or more partial dependents	$145,000	$290,000
Two total dependents	$145,000	$290,000
Three or more total dependents	$160,000	$320,000

What is the role and function of the primary treating physician?

Your treating doctor will decide what type of medical care you'll get for your injury or illness, determine when you can return to work, help identify the kinds of work you can do safely while recovering, refer you to specialists, if necessary, and write medical reports that will affect the benefits you receive.

Where do I get medical treatment?

If your injury or illness is due to employment, the State Fund Medical Provider Network will provide authorized medical treatment.

What is the State Fund Medical Provider Network?

State Fund's Medical Provider Network (MPN) is made up of a group of physicians and other medical service providers within the state of California, some who primarily treat occupational injuries and other providers who specialize in general areas of medicine. If necessary, the MPN will provide specialists to treat your injury or illness.

If your injury or illness is due to employment, the State Fund MPN physicians and other medical providers will provide

¿Cuándo comienza y cuándo finaliza la discapacidad permanente?

Generalmente, si aceptamos su reclamo y su médico tratante ha determinado que usted padece de discapacidad permanente, los pagos comienzan dentro de los 14 días posteriores a la terminación de la discapacidad temporal. Si conocemos la duración de su discapacidad permanente, continuaremos los pagos cada dos semanas hasta que hayamos abonado la totalidad del beneficio. Si no conocemos la duración de su discapacidad permanente, los pagos continuarán cada dos semanas hasta que hayamos pagado una tasa razonable en función de una valoración de la indemnización por discapacidad permanente.

¿Cómo se calculan y se pagan los beneficios en caso de muerte?

El beneficio total garantizado en caso de muerte está supeditado a la cantidad de personas total o parcialmente dependientes de usted en el momento de la lesión o enfermedad que provoca la muerte. Una vez que determinemos quiénes son dependientes, pagaremos en plazos el beneficio en caso de muerte, de acuerdo con el coeficiente de discapacidad temporal del difunto. Sin embargo, la cantidad no será inferior a $224 por semana hasta que hayamos pagado el beneficio total en caso de muerte o, si la dependencia involucrara a un menor, hasta que haya cumplido los 18 años de edad. En el caso de lesiones posteriores al 1ro de enero de 2003, el niño dependiente recibirá los beneficios de por vida si tiene una discapacidad física o mental para trabajar en forma remunerada. La tabla siguiente muestra la distribución de los beneficios máximos garantizados en caso de muerte.

Beneficios Máximos En Caso De Muerte

	01/07/96-31/12/05	2006 - 2007
Una persona totalmente dependiente	$125,000	$250,000
Sin personas totalmente dependientes y una o más personas parcialmente dependientes	$125,000	$250,000
Una persona totalmente dependiente y una o más personas parcialmente dependientes	$145,000	$290,000
Dos personas totalmente dependientes	$145,000	$290,000
Tres o más personas totalmente dependientes	$160,000	$320,000

¿Cuál es la función del médico tratante primario?

Su médico tratante decidirá que tipo de atención médica recibirá por su lesión o enfermedad, determinará cuándo podrá regresar al trabajo, ayudará a identificar las clases de trabajo que usted puede realizar sin riesgos mientras se recupera, lo referirá a especialistas (en caso de ser necesario) y redactará informes médicos que condicionarán los beneficios que recibirá.

¿Dónde obtengo tratamiento médico?

Si su lesión o enfermedad se debe al trabajo, la State Fund Medical Provider Network le proporcionará tratamiento médico autorizado.

¿Qué es la State Fund Medical Provider Network?

La State Fund Medical Provider Network (MPN) está compuesta por un grupo de médicos y otros proveedores de servicios médicos en el estado de California, unos quiénes principalmente

authorized medical treatment. These medical providers will provide quality medical treatment based on the utilization schedule developed by the administrative director of the DWC.

To meet medical access standards, an MPN must have at least three physicians of each specialty expected to treat common injuries experienced by injured employees on the basis of the type of occupation or industry in which the employee is employed. An MPN must have a primary treating physician and a hospital for emergency health-care services or a provider of all emergency health-care services within 30 minutes or 15 miles of each covered employee's residence or workplace. An MPN must have providers of occupational health services and specialists within 60 minutes or 30 miles of a covered employee's residence or workplace.

How do I get medical treatment?

After you file a claim, your employer will refer you to an MPN facility for initial treatment within 3 business days for non-emergency services.

If you are temporarily working outside the geographical service area of the Medical Provider Network, and you are injured on the job, you should seek emergency treatment at the nearest emergency room. If you are injured on the job, but it is not an emergency, you should notify your adjuster, State Fund's Claims Reporting Center, or your primary treating physician. You must contact State Fund or your employer if additional treatment is needed, and continue authorized treatment with an available MPN physician.

How do I get emergency medical treatment?

If it's a medical emergency, call 911 or go to an emergency room right away. Your employer may advise you where to go for treatment. Tell the health-care provider who treats you that your injury or illness is job-related, and, if possible, give your employer's workers' compensation carrier information.

Can I change my doctor?

Yes, after the initial medical evaluation with an MPN doctor, you have the right to choose another primary treating physician or subsequent physician from the MPN.

How do I choose a doctor?

You may obtain a regional-area listing of MPN doctors by going to MEDfinder MPN at www.scif.com. You may also obtain a regional-area listing by telephoning or sending a written request to your claims adjuster, if one has been assigned to you, or by calling State Fund's Claims Reporting Center at (888) 222-3211. If you wish to obtain a complete hard-copy list of all MPN providers, contact the State Fund MPN by sending an e-mail to scifmpn@scif.com, or by calling (866) 436-0204, or by sending a written request to:

State Compensation Insurance Fund
Attention: State Fund Medical Provider Network
900 Corporate Center Dr.
Monterey Park, CA 91754

After you receive a regional-area listing of MPN doctors, you may select a treating doctor (or any subsequent doctor) on the basis of the physician's specialty or recognized expertise in treating your particular injury or condition.

tratan lesiones ocupacionales, así como otros proveedores especialistas en áreas generales de medicina. Si es necesario, la MPN proporcionará especialistas para tratar su lesión o enfermedad.

Si su lesión o enfermedad se debe al empleo, los médicos y otros proveedores de la MPN le brindarán tratamiento médico autorizado. Estos proveedores médicos proporcionarán tratamiento médico de calidad basado en el programa de utilización desarrollado por el director administrativo de la Division of Workers' Compensation (DWC).

Para cumplir los estándares de acceso médico, una MPN debe contar con un mínimo de tres médicos de cada especialidad esperada para tratar lesiones comunes experimentadas por empleados, con base en el tipo de ocupación o industria en la cual trabaja el empleado. Una MPN debe contar con un médico de atención primaria y un hospital para servicios de atención médica de emergencia, o un proveedor de todos los servicios de atención médica de emergencia a una distancia no mayor de 30 minutos o 15 millas de la residencia o lugar de trabajo de cada empleado cubierto. Una MPN debe tener proveedores de servicios y especialistas de salud ocupacional a una distancia no mayor de 60 minutos o 30 millas de la residencia o lugar de trabajo de cada empleado cubierto.

¿Cómo obtengo tratamiento médico?

Si no se trata de una emergencia, luego de que presente el reclamo, su empleador lo enviará a un centro de la MPN para el tratamiento inicial, dentro de los 3 días hábiles siguientes. Si está trabajando temporalmente fuera del área geográfica de servicios de la Medical Provider Network y se lesiona en su trabajo, debe solicitar tratamiento de urgencia en la sala de emergencias más cercana. Si usted necesita tratamiento médico no de emergencia, debe comunicarse con su ajustador de reclamos, el Centro de Atención de Reclamos las 24 horas de State Fund, o su médico de atención primaria. Si es necesario un tratamiento adicional y continuar el tratamiento autorizado con un médico disponible de la MPN, deberá ponerse en contacto con State Fund o con su empleador.

¿Cómo obtengo tratamiento médico de emergencia?

En caso de emergencia médica, llame al 911 o diríjase a una sala de emergencias de inmediato. Su empleador puede sugerirle dónde acudir para recibir tratamiento. Comuníquele al médico que lo atienda que su lesión o enfermedad está relacionada con el trabajo y, si es posible, dele información acerca de la compañía de seguros a cargo de la compensación a los trabajadores de su empleador.

¿Puedo cambiar mi doctor?

Sí; después de la evaluación médica inicial con un doctor de la MPN, usted tiene el derecho a elegir a otro médico de atención primaria o médico subsecuente de la MPN.

¿Cómo elijo un doctor?

Usted puede obtener una lista regional de médicos de la red MPN mediante el buscador MEDfinder MPN en www.scif.com. También puede obtener una lista regional llamando por teléfono o enviando una petición por escrito a su ajustador de reclamos, si se le ha asignado uno, o llamando al Centro de Atención de Reclamos las 24 horas de State Fund al (888) 222-3211. Si usted desea obtener una copia de la lista completa de todos los proveedores de la MPN, comuníquese con la MPN de State Fund

If there are less than three primary treating physicians within 15 miles of your location in a specialty appropriate to treat your injury, you may choose your own doctor or provider outside the MPN network. For assistance you may contact your adjuster, if one has been assigned to you, or the State Fund Claims Reporting Center.

Am I able to predesignate a personal physician?

Yes, provided that you have predesignated the doctor or a multispecialty medical group of licensed doctors of medicine or osteopathy (MDs or DOs) that provides comprehensive medical services primarily for nonoccupational injuries and illness before you are injured and your employer offers group health coverage (HMO/PPO/HCO). Your predesignated physician must meet the following requirements:

- Must be your regular physician.
- Must be your primary care physician or your physician's integrated multispecialty medical group
- Must be licensed per Business & Professions Code.
- Must have previously provided your treatment.
- Retains your medical records, including medical history.
- Agrees to be your predesignated physician.

To predesignate, you must give your employer the name and address of your physician or your physician's integrated multispecialty medical group *in writing*, before you are injured.

If you do not predesignate, your employer will arrange your initial treatment with a physician within the MPN. After this initial treatment, you will be able to choose your physician within the MPN.

Can I predesignate a personal chiropractor or acupuncturist?

No. But, if the MPN is not applicable and you have identified a personal chiropractor or acupuncturist in writing prior to the date of your injury, you may request a change from the employer's physician to your personal chiropractor or acupuncturist. This request for a change of physician may be made at any time after the initial treatment provided by your employer.

What do I do if I disagree with my doctor's diagnosis or treatment?

It is your responsibility to advise your adjuster of the dispute and request a second opinion. You will need to select a doctor or specialist from the list of MPN providers. You need to make an appointment with the selected doctor within 60 days. If you do not make the appointment within the 60-day period, you will not be allowed to have a second opinion with regard to this disputed diagnosis or treatment by this treating physician. (For more details on this MPN process, see *Employee's Guide to the State Fund Medical Provider Network*, form 13176.)

How can I return to work as soon as possible?

To help you return to work as soon as possible, you should actively communicate with your treating doctor, claims representative, and employer about the kinds of work you can do while recovering. They may coordinate efforts to

enviando un correo electrónico a scifmpn@scif.com, llamando al (866) 436-0204, o enviando una petición por escrito a:

State Compensation Insurance Fund
Attention: State Fund Medical Provider Network
900 Corporate Center Dr.
Monterey Park, CA 91754

Después de que reciba una lista de los doctores de la MPN en el área regional, usted puede seleccionar a un doctor que brinde tratamiento (o a cualquier doctor subsecuente) basado en la especialidad de éste o su experiencia reconocida en el tratamiento de su lesión o enfermedad particular.

Si existen menos de tres médicos de atención primaria dentro de un radio de 15 millas de donde usted se encuentre, que tengan la especialidad que usted selecciona, es posible que se le permita elegir a su propio medico o proveedor fuera de la red MPN. Comuníquese con su ajustador de reclamos, si es que se le ha asignado uno, o al Centro de Atención de Reclamos las 24 horas de State Fund para obtener ayuda.

¿Puedo previamente designar un médico personal?

Sí, siempre que previamente designe al médico o a un grupo médico de multiespecialidades de doctores titulados en medicina u osteopatía (MDs or DOs) que provean un servicio médico completo principalmente a lesiones que no sean adquiridas en el trabajo y enfermedades que se hayan presentado antes de la lesión, y su empleador le ofrezca cobertura médica de grupo (HMO/PPO/HCO). El médico designado por usted debe cumplir con los siguientes requisitos:

- Debe ser su médico de cabecera.
- Debe ser su médico de atención primaria o el grupo médico de multiespecialidades del médico.
- Debe tener licencia conforme al Código de Negocios y Profesiones.
- Debe haberlo atendido previamente.
- Conserva sus registros médicos, incluida la historia clínica.
- Está de acuerdo en ser su médico previamente designado.

Para designar previamente, usted debe darle a su empleador el nombre y dirección de su médico personal o su grupo personal de doctores de multiespecialidades médicas *por escrito*, antes de sufrir una lesión.

Si no designa previamente ningún médico, su empleador acordará su tratamiento inicial con un médico de la MPN. Luego de este tratamiento inicial, podrá elegir un médico de la MPN.

¿Puedo previamente designar un quiropráctico o acupunturista personal?

No. Sin embargo, si la MPN no correspondiera por algún motivo y usted hubiera designado por escrito un quiropráctico o acupunturista personal antes de la fecha de su lesión, puede solicitar que se sustituya el médico elegido por su empleador por el quiropráctico o acupunturista personal de su elección. La solicitud para cambiar de médico puede realizarse en cualquier momento después del tratamiento inicial suministrado por su empleador.

return you to modified duty or other work that is medically appropriate. This modified or other duty may be temporary or may be extended depending on the nature of your injury or illness.

May I file a workers' compensation claim if an injury occurs outside of work?

Your employer or your employer's carrier may not be liable for the payment of workers' compensation benefits for an injury resulting from your voluntary participation in any off-duty recreational, social, or athletic activity that is not part of your work-related duties.

Note: Workers' compensation fraud laws make it a felony for anyone to file a false or fraudulent statement or to submit a false report or any other document for the purpose of obtaining or denying workers' compensation benefits. Anyone caught performing these illegal acts will be prosecuted. If convicted, the person can face up to 5 years in prison and/or up to a $150,000 fine.

What if I have a recurrence and require further medical care?

If you need more medical care for your injury after your original treatment has ended, you have one full year after your last treatment to notify us of your request for more medical care.

What if I have to change my line of work because of a workers' compensation injury?

For injuries before January 1, 2004, if you are unable to return to your job due to a workers' compensation injury, you may qualify for vocational rehabilitation benefits. Your rehabilitation plan may be as simple as a modification of your current job to accommodate any limitations you have suffered, or it may involve training for a new job. Our vocational rehabilitation counselors will help you obtain any needed services.

For injuries before January 1, 2004, a represented employee may agree to settle his or her right to future vocational rehabilitation with a one-time payment which cannot be more than $10,000.

For injuries on or after January 1, 2004, if your injury results in permanent disability, and you are unable to return to work within 60 days after the last payment of temporary disability, and your employer does not offer modified or alternative work, a nontransferable voucher for education-related costs is payable to a state-approved school. The voucher can be up to $10,000 depending on the level of your permanent disability. This benefit is called a Supplemental Job Displacement Benefit (SJDB). The following table shows the specific ranges of the benefit.

Supplemental Job Displacement Benefits (SJDB)

Permanent Disability Level	SJDB Voucher Amount
Less than 15%	Up to $4,000
15% to 25%	Up to $6,000
26% to 49%	Up to $8,000
50% to 99%	Up to $10,000

¿Qué debo hacer si no estoy de acuerdo con el diagnóstico o tratamiento de mi médico?

Es su responsabilidad notificar al mediador de la situación y solicitar una segunda opinión. Deberá seleccionar un médico o especialista de la lista de la MPN. Debe fijar una cita con el médico seleccionado dentro de los 60 días. Si no fija la cita en el período de 60 días, no se le permitirá obtener una segunda opinión con respecto a este diagnóstico o tratamiento por este médico tratante en disputa. (Para obtener más detalles sobre este proceso de la MPN, consulte la *Guía del Empleado para la State Fund Medical Provider Network*, formulario 13176).

¿Cómo puedo volver a trabajar lo antes posible?

Para ayudarlo a regresar a su trabajo lo antes posible, se debe comunicar en forma activa con el médico tratante, el representante de reclamos y el empleador para conocer los tipos de trabajo que puede realizar mientras se recupera. Ellos podrán coordinar esfuerzos para que pueda regresar y realizar una tarea modificada o bien pueda encargarse de otro trabajo acorde a su salud. Este trabajo nuevo o modificado podrá ser temporal o extenderse durante cierto tiempo, según la naturaleza de su lesión o enfermedad.

¿Puedo presentar un reclamo de compensación a los trabajadores si la lesión se produce fuera de mi trabajo?

El empleador puede quedar exento del pago de los beneficios de compensación a los trabajadores en el caso de lesiones que se produjeran por la participación voluntaria del empleado en actividades recreativas, sociales o deportivas fuera del horario laboral que no formasen parte de las tareas de su trabajo.

Nota: la legislación en materia de fraude en la compensación a los trabajadores considera delito grave presentar una declaración falsa o fraudulenta o enviar un informe o cualquier documento falso con el propósito de obtener o rechazar beneficios de compensación a los trabajadores. A los culpables de tales ilícitos se les iniciará un procedimiento criminal. En caso de ser declarada culpable, la persona puede enfrentar una condena de hasta 5 años de prisión y/o una multa de hasta $150,000.

¿Qué ocurre si los síntomas reaparecen y necesito continuar con la atención médica?

Si necesita más atención médica por su lesión una vez que ha terminado su tratamiento original, tiene un año entero a partir de su último tratamiento para notificarnos que necesita más atención médica.

¿Qué ocurre si debo modificar mi línea de trabajo debido a la lesión susceptible de compensación a los trabajadores?

En el caso de lesiones anteriores al 1ro de enero de 2004, si no puede regresar a su trabajo debido a la lesión susceptible de compensación a los trabajadores, puede acceder a los beneficios de rehabilitación vocacional. Su plan de rehabilitación puede ser simple, como la modificación de su trabajo actual para adaptarlo a la limitación que haya sufrido, o puede consistir en la capacitación para un nuevo trabajo. Nuestros asesores en rehabilitación vocacional lo ayudarán a obtener todos los servicios que sean necesarios.

En el caso de lesiones anteriores al 1ro de enero de 2004, el empleado representado puede aceptar saldar su derecho a la futura rehabilitación vocacional con un pago único que no superará los $10,000.

What protects me from discrimination for filing a workers' compensation claim?

It is illegal for your employer to punish or fire you for having a work injury or illness, for filing a claim, or for testifying in another person's workers' compensation case. If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state. If you believe you have experienced discrimination because of your injury, you should discuss your rights with an information and assistance officer of the DWC or with an attorney.

What if I have not received the benefits that I think I should have?

If you have not received the benefits you think you should have, ask for an explanation from your State Fund claims representative. Misunderstandings and errors sometimes do occur, but you can resolve most of them by talking with your claims representative. If you are not satisfied with your claims representative's answers, you have several options. You have the right to consult with and be represented by an attorney. You can consult with an information and assistance officer of the DWC. You can also file an Application for Adjudication of Claim with the Workers' Compensation Appeals Board (WCAB) to resolve your claim formally. The information and assistance officer can help you file the Application for Adjudication of Claim.

Are there time limits for filing a claim?

Yes. Generally, the law requires you to provide your employer with notice of your injury within 30 days of the date of injury. In addition, should you disagree with any of our actions, in order to protect your rights you must commence proceedings before the WCAB by filing an Application for Adjudication of Claim within one year of the date of injury, or one year from the last furnishing of indemnity or medical-treatment benefits by your employer or State Fund. It is very important that you act promptly so as not to risk losing your benefits because you waited too long.

En el caso de lesiones posteriores al 1ro de enero de 2004, si la lesión le produce una discapacidad permanente, no puede regresar a su trabajo dentro de los 60 días posteriores al último pago recibido por discapacidad temporal y su empleador no le ofrece un trabajo alternativo o modificado, se le otorgará un vale no transferible para cubrir costos relacionados con su educación, que será pagadero a una escuela con autorización estatal. El vale no podrá superar los $10,000 y dependerá del nivel de discapacidad permanente. Este beneficio se denomina Beneficio Complementario Por Sustitución De Trabajo (SJDB). La siguiente tabla muestra las escalas específicas del beneficio.

Beneficios Complementarios Por Sustitución De Trabajo (SJDB)	
Nivel de discapacidad permanente	**Monto del vale de SJDB**
Inferior al 15%	Hasta $4,000
De 15% a 25%	Hasta $6,000
De 26% a 49%	Hasta $8,000
De 50% a 99%	Hasta $10,000

¿Qué me protege contra la discriminación por presentar un reclamo de compensación a los trabajadores?

Es ilegal que su empleador lo sancione o despida por sufrir una lesión o enfermedad laboral, por presentar un reclamo o por prestar declaración en un caso de compensación a los trabajadores de un tercero. En caso de comprobarse alguna de estas infracciones, podrá recibir los salarios perdidos, la reincorporación al trabajo, beneficios adicionales y los costos y gastos hasta los límites establecidos por el estado. Si considera que ha sido discriminado a causa de su lesión, deberá analizar sus derechos con un funcionario de información y asesoramiento del Division of Workers' Compensation del estado o bien con un abogado.

¿Qué ocurre si no recibo los beneficios que considero que debo recibir?

Si no ha recibido los beneficios que considera que debería recibir, solicite una explicación al representante de reclamos de State Fund. A veces se producen malentendidos y errores, aunque podrá resolver la mayoría de ellos hablando con su representante de reclamos.

Si no queda satisfecho con las respuestas del representante de reclamos, cuenta con diversas opciones. Tiene el derecho de consultar y ser representado por un abogado. Puede consultar a un funcionario de información y asesoramiento de Division of Workers' Compensation. También puede presentar una solicitud de arbitraje de reclamo, denominada Application for Adjudication of Claim, ante el Workers' Compensation Appeals Board (WCAB), para resolver su reclamo formalmente. El funcionario de información y asesoramiento puede ayudarlo a presentar esta solicitud de reclamo.

¿Existe algún límite de tiempo para presentar un reclamo?

Sí. Según la ley, el plazo del que normalmente dispone para notificar la lesión al empleador es de 30 días a partir de la fecha de dicha lesión. Además, en caso de que no esté de acuerdo con alguna de nuestras medidas, para proteger sus derechos debe iniciar una demanda ante el Workers' Compensation Appeals Board presentando una solicitud de arbitraje de reclamo antes de cumplirse un año de la fecha de la lesión o de la última indemnización o beneficio de tratamiento médico que le haya proporcionado su empleador o State Fund. Es muy importante actuar de inmediato para no arriesgarse a perder los beneficios por demorarse demasiado.

DIVISION OF WORKERS' COMPENSATION

INFORMATION AND ASSISTANCE OFFICERS

ANAHEIM	714/738-4038	REDDING	530/225-2047
BAKERSFIELD	661/395-2514	RIVERSIDE	951/782-4347
EUREKA	707/441-5723	SACRAMENTO	916/263-2741
FRESNO	559/445-5355	SALINAS	831/443-3058
GOLETA	805/968-4158	SAN BERNARDINO	909/383-4522
GROVER BEACH	805/481-3380	SAN DIEGO	619/767-2082
LONG BEACH	562/590-5240	SAN FRANCISCO	415/703-5020
LOS ANGELES	213/576-7389	SAN JOSE	408/277-1292
MARINA DEL REY	310/482-3820	SANTA ANA	714/558-4597
OAKLAND	510/622-2861	SANTA ROSA	707/576-2452
OXNARD	805/485-3528	STOCKTON	209/948-7980
POMONA	909/623-8568	VAN NUYS	818/901-5374

(800) 736-7401 (Recorded information only)

DIVISION OF WORKERS' COMPENSATION

FUNCIONARIOS DE INFORMACIÓN Y ASESORAMIENTO

ANAHEIM	714/738-4038	REDDING	530/225-2047
BAKERSFIELD	661/395-2514	RIVERSIDE	951/782-4347
EUREKA	707/441-5723	SACRAMENTO	916/263-2741
FRESNO	559/445-5355	SALINAS	831/443-3058
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OXNARD	805/485-3528	STOCKTON	209/948-7980
POMONA	909/623-8568	VAN NUYS	818/901-5374

(800) 736-7401 (Sólo información grabada)

STATE FUND LOCATIONS

Bakersfield	(661) 664-4000	Sacramento	(916) 924-5100
Eureka	(707) 443-9721	San Bernardino	(909) 384-4500
Fresno	(559) 433-2700	San Diego	(858) 552-7100
Los Angeles	(818) 291-7000	San Jose	(408) 363-7400
Oxnard	(805) 988-5300	Santa Ana	(714) 565-5000
Pleasanton	(925) 523-5200	Santa Rosa	(707) 573-6500
Redding	(530) 223-7000	South Orange	(714) 347-5400
Riverside	(951) 656-8300	Stockton	(209) 476-2600

OFICINAS DEL STATE FUND

Bakersfield	(661) 664-4000	Sacramento	(916) 924-5100
Eureka	(707) 443-9721	San Bernardino	(909) 384-4500
Fresno	(559) 433-2700	San Diego	(858) 552-7100
Los Angeles	(818) 291-7000	San Jose	(408) 363-7400
Oxnard	(805) 988-5300	Santa Ana	(714) 565-5000
Pleasanton	(925) 523-5200	Santa Rosa	(707) 573-6500
Redding	(530) 223-7000	South Orange	(714) 347-5400
Riverside	(951) 656-8300	Stockton	(209) 476-2600

CUSTOMER SERVICE CENTER

Policy Services & Certificates of Insurance
(877) 405-4545 toll-free
(800) 268-3635 toll-free fax

Certificates of Insurance
(866) 266-2071 toll-free fax

24-Hour Claims Reporting Center
(888) 222-3211 toll-free
(800) 371-5905 toll-free fax

Fraud Hot Line
(888) 786-7372 toll-free

CENTRO DE ATENCIÓN AL CLIENTE

Servicios de pólizas y Certificados de seguros
(877) 405-4545 línea gratuita
(800) 268-3635 fax en línea gratuita

Certificados de seguros
(866) 266-2071 fax en línea gratuita

Centro de atención de reclamos las 24 horas
(888) 222-3211 línea gratuita
(800) 371-5905 fax en línea gratuita

Línea de asistencia para fraude
(888) 786-7372 línea gratuita

STATE COMPENSATION INSURANCE FUND
www.scif.com

e13286 (Rev. 03/07)

STATE COMPENSATION INSURANCE FUND

To our policyholders:

California law requires employers to provide a form on which employees may indicate the name of their personal physician or personal chiropractor. The form must be provided to new hires either at the time the employee is hired or by the end of the first pay period.

This form is available from your State Fund representative at no cost to you. Keep a supply on hand. Document personnel records, indicating when this form was provided and when it was returned to you.

PLEASE SEE REVERSE SIDE

After completion by employee, keep original in the employee's personnel file, and provide a copy to your employee.

STATE COMPENSATION INSURANCE FUND

A nuestros asegurados:

La legislación del Estado de California obliga a los empleadores a suministrar un formulario en el que los empleados pueden indicar el nombre de su médico personal o de su acupunturista o quiropráctico personal. El formulario debe entregarse al nuevo empleado en el momento de la contratación o al finalizar el primer período de pago.

Un representante del State Fund le entregará este formulario sin costo alguno. Siempre tenga formularios a la mano. Documente los registros personales, indicando cuándo se le entregó este formulario y cuándo se le ha devuelto.

LEA AL DORSO

Después de que el empleado haya completado el formulario, conserve el original en el archivo personal del empleado y entréguele una copia.

Employee's Predesignation of Personal Physician Form

• In order for an employee to predesignate a personal physician, the employer must offer group health insurance.

• The employee may use the predesignation of personal physician form to name a medical doctor or doctor of osteopathic medicine or the personal physician's integrated multispecialty medical group if all other requirements are met.

• The physician is not required to sign this form, but in lieu of a signature, other documentation of the physician's agreement is required.

For the employee:

If I am injured on the job, I wish to be treated by my personal physician or my personal physician's integrated multispecialty medical group, who meets all the following requirements: (1) is my regular physician; (2) is my primary care physician or integrated multispecialty medical group; (3) is licensed per Business & Professions Code; (4) has previously provided my treatment; (5) retains my records; (6) agrees to be my predesignated physician.

Or, I wish to be treated by my personal chiropractor or acupuncturist, who has treated me before and has my records. I understand my identification of a personal chiropractor or acupuncturist is allowed only if there is no medical provider network (MPN) applicable. If the MPN is not applicable, my personal chiropractor or acupuncturist may treat my injury during the first 30 days of the employer's medical control, but I must first be evaluated by my employer's physician before I may request a change to my personal chiropractor or acupuncturist.

EMPLOYEE'S INFORMATION:

NAME

ADDRESS

CITY STATE ZIP

YOUR DOCTOR'S INFORMATION:

NAME OF DOCTOR AND/OR NAME OF PERSONAL PHYSICIAN'S MULTISPECIALTY MEDICAL GROUP

ADDRESS

CITY STATE ZIP

PHONE

DOCTOR'S SIGNATURE

EMPLOYEE'S SIGNATURE DATE

Formulario de Designación Previa del Médico Personal del Empleado

• Para que un empleado pueda previamente designar su médico personal, el empleador debe ofrecer seguro médico de grupo.

• Si se han cumplido todos los otros requerimientos, el empleado puede utilizar el formulario de designación previa del médico personal para nombrar a un doctor médico o un doctor de medicina osteopática o el grupo de médicos de multiespecialidades integradas de su médico personal.

• No se requiere la firma del médico en este formulario, pero en lugar de una firma, otra documentación del acuerdo del médico es requerida.

Para el empleado:

Si me lesiono en el trabajo, deseo que me atienda mi doctor personal o el grupo de médicos de multiespecialidades integradas de mi doctor personal, quien llena todos los siguientes requisitos: 1) Es mi médico regular; 2) Es mi médico primario de cuidado o grupo médico de multiespecialidades; 3) Tiene una licencia de aprobación del Business & Professions Code; 4) Me ha proporcionado tratamiento médico anteriormente; 5) Tiene y mantiene mi historial médico; 6) Acepta ser mi médico designado.

Ó, deseo que me atienda mi **quiropráctico o acupunturista personal,** quien es el que me ha atendido anteriormente y tiene mi historial. Estoy por entendido que identificar a un quiropráctico o acupunturista solamente es permitido cuando la medical provider network (MPN) no es aplicable. Si la MPN no aplica, mi quiropráctico o acupunturista personal podrá ofrecerme tratamiento durante los primeros 30 días del control médico del empleador, pero un doctor asignado por mi empleador deberá examinarme primero antes de solicitar que me cambien a mi quiropráctico o acupunturista personal.

INFORMACIÓN DEL EMPLEADO:

NOMBRE

DIRECCIÓN

CIUDAD ESTADO CÓDIGO POSTAL

INFORMACIÓN DE SU DOCTOR:

NOMBRE DEL DOCTOR Y/O EL NOMBRE DE GRUPO DE MÉDICOS DE MULTIESPECIALIDADES INTEGRADAS DE SU DOCTOR PERSONAL

DIRECCIÓN

CIUDAD ESTADO CÓDIGO POSTAL

TELÉFONO

FIRMA DEL DOCTOR

FIRMA DE EMPLEADO FECHA

FORM SAMPLES

APS

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

CONFIDENTIAL REPORT - NOT SUBJECT TO PUBLIC DISCLOSURE

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE

DATE COMPLETED:

TO BE COMPLETED BY REPORTING PARTY. PLEASE PRINT OR TYPE. SEE GENERAL INSTRUCTIONS.

A. VICTIM ☐ Check box if victim consents to disclosure of information [Ombudsman use only - WIC 15636(a)]

*NAME (LAST NAME FIRST)	*AGE	DATE OF BIRTH	SSN	GENDER	ETHNICITY	LANGUAGE (✓ CHECK ONE)
				☐ M ☐ F		☐ NON-VERBAL ☐ ENGLISH ☐ OTHER (*SPECIFY*)

*ADDRESS (IF FACILITY, INCLUDE NAME AND NOTIFY OMBUDSMAN)	*CITY	*ZIP CODE	*TELEPHONE
			( )

*PRESENT LOCATION (IF DIFFERENT FROM ABOVE)	*CITY	*ZIP CODE	*TELEPHONE
			( )

☐ ELDERLY (65+) ☐ DEVELOPMENTALLY DISABLED ☐ MENTALLY ILL/DISABLED ☐ PHYSICALLY DISABLED ☐ UNKNOWN/OTHER ☐ LIVES ALONE ☐ LIVES WITH OTHERS

B. SUSPECTED ABUSER ✓ *Check if* ☐ *Self-Neglect*

NAME OF SUSPECTED ABUSER

☐ CARE CUSTODIAN (type)_____ ☐ PARENT ☐ SON/DAUGHTER ☐ OTHER_____

☐ HEALTH PRACTITIONER (type)_____ ☐ SPOUSE ☐ OTHER RELATION_____

ADDRESS	*ZIP CODE	TELEPHONE	GENDER	ETHNICITY	AGE	D.O.B.	HEIGHT	WEIGHT	EYES	HAIR
		( )	☐M ☐F							

C. REPORTING PARTY: *Check appropriate box if reporting party waives confidentiality to:* ☐ ✓ All ☐ ✓ All but victim ☐ ✓ All but perpetrator

*NAME (PRINT)	SIGNATURE	OCCUPATION	AGENCY/NAME OF BUSINESS

RELATION TO VICTIM/HOW KNOWS OF ABUSE	(STREET)	(CITY)	(ZIP CODE)	(E-MAIL ADDRESS)	TELEPHONE
					( )

D. INCIDENT INFORMATION - Address where incident occurred:

*DATE/TIME OF INCIDENT(S)

PLACE OF INCIDENT (✓ CHECK ONE)

☐ OWN HOME ☐ COMMUNITY CARE FACILITY ☐ HOSPITAL/ACUTE CARE HOSPITAL

☐ HOME OF ANOTHER ☐ NURSING FACILITY/SWING BED ☐ OTHER (Specify)

E. REPORTED TYPES OF ABUSE (✓ CHECK ALL THAT APPLY).

1. PERPETRATED BY OTHERS (WIC 15610.07 & 15610.63)

a. PHYSICAL
- ☐ ASSAULT/BATTERY
- ☐ CONSTRAINT OR DEPRIVATION
- ☐ SEXUAL ASSAULT
- ☐ CHEMICAL RESTRAINT
- ☐ OVER OR UNDER MEDICATION

b. ☐ NEGLECT
c. ☐ FINANCIAL
d. ☐ ABANDONMENT
e. ☐ ISOLATION
f. ☐ ABDUCTION
g. ☐ OTHER (Non-Mandated: e.g., deprivation of goods and services: psychological/mental)

2. SELF-NEGLECT (WIC 15610.57(b)(5))

a. ☐ PHYSICAL CARE (e.g., personal hygiene, food, clothing, shelter)
b. ☐ MEDICAL CARE (e.g., physical and mental health needs)
c. ☐ HEALTH and SAFETY HAZARDS
d. ☐ MALNUTRITION/DEHYDRATION
e. ☐ OTHER (Non-Mandated e.g., financial)

ABUSE RESULTED IN (✓ CHECK ALL THAT APPLY) ☐ NO PHYSICAL INJURY ☐ MINOR MEDICAL CARE ☐ HOSPITALIZATION ☐ CARE PROVIDER REQUIRED ☐ DEATH ☐ MENTAL SUFFERING ☐ OTHER (SPECIFY) ☐ UNKNOWN

F. REPORTER'S OBSERVATIONS, BELIEFS, AND STATEMENTS BY VICTIM IF AVAILABLE. DOES ALLEGED PERPETRATOR STILL HAVE ACCESS TO THE VICTIM? PROVIDE ANY KNOWN TIME FRAME (2 days, 1 week, ongoing, etc.). *LIST ANY POTENTIAL DANGER FOR INVESTIGATOR (animals, weapons, communicable diseases, etc.).*

☐ ✓CHECK IF MEDICAL, FINANCIAL, PHOTOGRAPHS OR OTHER SUPPLEMENTAL INFORMATION IS ATTACHED.

G. TARGETED ACCOUNT

ACCOUNT NUMBER (LAST 4 DIGITS):	TYPE OF ACCOUNT: ☐ DEPOSIT ☐ CREDIT ☐ OTHER	TRUST ACCOUNT: ☐ YES ☐ NO
POWER OF ATTORNEY: ☐ YES ☐ NO	DIRECT DEPOSIT: ☐ YES ☐ NO	OTHER ACCOUNTS: ☐ YES ☐ NO

H. OTHER PERSON BELIEVED TO HAVE KNOWLEDGE OF ABUSE. *(family, significant others, neighbors, medical providers and agencies involved, etc.)*

NAME	ADDRESS	TELEPHONE NO.	RELATIONSHIP
		( )	

I. FAMILY MEMBER OR OTHER PERSON RESPONSIBLE FOR VICTIM'S CARE. *(If unknown, list contact person).*

*NAME	IF CONTACT PERSON ONLY ✓ CHECK ☐	*RELATIONSHIP

*ADDRESS	*CITY	*ZIP CODE	*TELEPHONE
			( )

J. TELEPHONE REPORT MADE TO: ☐ Local APS ☐ Local Law Enforcement ☐ Local Ombudsman ☐ Calif. Dept. of Mental Health ☐ Calif. Dept. of Developmental Services

NAME OF OFFICIAL CONTACTED BY PHONE	*TELEPHONE	DATE/TIME
	( )	

K. WRITTEN REPORT Enter information about the agency receiving this report. Do not submit report to California Department of Social Services Adult Programs Bureau.

AGENCY NAME	ADDRESS OR FAX #	☐ Date Mailed: ☐ Date Faxed:

L. RECEIVING AGENCY USE ONLY ☐ Telephone Report ☐ Written Report

1. Report Received by: Date/Time:

2. Assigned ☐ Immediate Response ☐ Ten-day Response ☐ No Initial Face-To-Face Required ☐ Not APS ☐ Not Ombudsman

Approved by: Assigned to (optional):

3. Cross-Reported to: ☐ CDHS, Licensing & Cert.; ☐ CDSS-CCL; ☐ CDA Ombudsman; ☐ Bureau of Medi-Cal Fraud & Elder Abuse; ☐ Mental Health; ☐ Law Enforcement; ☐ Professional Board; ☐ Developmental Services; ☐ APS; ☐ Other (Specify) Date of Cross-Report:

4. APS/Ombudsman/Law Enforcement Case File Number:_____

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE GENERAL INSTRUCTIONS

PURPOSE OF FORM

This form, as adopted by the California Department of Social Services (CDSS), is required under Welfare and Institutions Code (WIC) Sections 15630 and 15658(a)(1). This form documents the information given by the reporting party on the suspected incident of abuse of an elder or dependent adult. **"Elder,"** means any person residing in this state who is 65 years of age or older (WIC Section 15610.27). **"Dependent Adult,"** means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age (WIC Section 15610.23). Dependent adult includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility (defined in the Health and Safety Code Sections 1250, 1250.2, and 1250.3).

COMPLETION OF THE FORM

1. This form may be used by the receiving agency to record information through a telephone report of suspected dependent adult/elder abuse. Complete items with an asterisk (*) when a telephone report of suspected abuse is received as required by statute and the California Department of Social Services.
2. If any item of information is unknown, enter "unknown."
3. Item A: Check box to indicate if the victim waives confidentiality.
4. Item C: Check box if the reporting party waives confidentiality. Please note that mandated reporters are required to disclose their names, however, non-mandated reporters may report anonymously.

REPORTING RESPONSIBILITIES

Mandated reporters (see definition below under "Reporting Party Definitions") shall complete this form for each report of a known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect, (self-neglect), isolation, and abandonment (see definitions in WIC Section 15610) involving an elder or a dependent adult. **The original of this report shall be submitted within two (2) working days of making the telephone report to the responsible agency as identified below:**

- The county Adult Protective Services (APS) agency or the local law enforcement agency (if abuse occurred in a private residence, apartment, hotel or motel, or homeless shelter).
- Long-Term Care Ombudsman (LTCO) program or the local law enforcement agency (if abuse occurred in a nursing home, adult residential facility, adult day program, residential care facility for the elderly, or adult day health care center).
- The California Department of Mental Health or the local law enforcement agency (if abuse occurred in Metropolitan State Hospital, Atascadero State Hospital, Napa State Hospital, or Patton State Hospital).
- The California Department of Developmental Services or the local law enforcement agency (if abuse occurred in Sonoma Developmental Center, Lanterman Developmental Center, Porterville Developmental Center, Fairview Developmental Center, or Agnews Developmental Center).

WHAT TO REPORT

Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment has observed, suspects, or has knowledge of an incident that reasonably appears to be physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect), or is told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, isolation, financial abuse, abduction, or neglect, shall report the known or suspected instance of abuse by telephone immediately or as soon as practicably possible, and by written report sent within two working days to the appropriate agency.

REPORTING PARTY DEFINITIONS

Mandated Reporters (WIC) "15630 (a) Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter."

Care Custodian (WIC) "15610.17 'Care custodian' means an administrator or an employee of any of the following public or private facilities or agencies, or persons providing care or services for elders or dependent adults, including members of the support staff and maintenance staff: (a) Twenty-four-hour health facilities, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code. (b) Clinics. (c) Home health agencies. (d) Agencies providing publicly funded in-home supportive services, nutrition services, or other home and community-based support services. (e) Adult day health care centers and adult day care. (f) Secondary schools that serve 18- to 22-year-old dependent adults and postsecondary educational institutions that serve dependent adults or elders. (g) Independent living centers. (h) Camps. (i) Alzheimer's Disease Day Care Resource Centers. (j) Community care facilities, as defined in Section 1502 of the Health and Safety Code, and residential care facilities for the elderly, as defined in Section 1569.2 of the Health and Safety Code. (k) Respite care facilities. (l) Foster homes. (m) Vocational rehabilitation facilities and work activity centers. (n) Designated area agencies on aging. (o) Regional centers for persons with developmental disabilities. (p) State Department of Social Services and State Department of Health Services licensing divisions. (q) County welfare departments. (r) Offices of patients' rights advocates and clients' rights advocates, including attorneys. (s) The Office of the State Long-Term Care Ombudsman. (t) Offices of public conservators, public guardians, and court investigators. (u) Any protection or advocacy

agency or entity that is designated by the Governor to fulfill the requirements and assurances of the following: (1) The federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, contained in Chapter 144 (commencing with Section 15001) of Title 42 of the United States Code, for protection and advocacy of the rights of persons with developmental disabilities. (2) The Protection and Advocacy for the Mentally Ill Individuals Act of 1986, as amended, contained in Chapter 114 (commencing with Section 10801) of Title 42 of the United States Code, for the protection and advocacy of the rights of persons with mental illness. (v) Humane societies and animal control agencies. (w) Fire departments. (x) Offices of environmental health and building code enforcement. (y) Any other protective, public, sectarian, mental health, or private assistance or advocacy agency or person providing health services or social services to elders or dependent adults."

Health Practitioner (WIC) "15610.37 'Health practitioner' means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, licensed clinical social worker or associate clinical social worker, marriage, family, and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, paramedic, or person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, a marriage, family, and child counselor trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, or an unlicensed marriage, family, and child counselor intern registered under Section 4980.44 of the Business and Professions Code, state or county public health or social service employee who treats an elder or a dependent adult for any condition, or a coroner."

Officers and Employees of Financial Institutions (WIC) "15630.1. (a) As used in this section, "mandated reporter of suspected financial abuse of an elder or dependent adult" means all officers and employees of financial institutions. (b) As used in this section, the term "financial institution" means any of the following: (1) A depository institution, as defined in Section 3(c) of the Federal Deposit Insurance Act (12 U.S.C. Sec. 1813(c)). (2) An institution-affiliated party, as defined in Section 3(u) of the Federal Deposit Insurance Act (12 U.S.C. Sec. 1813(u)). (3) A federal credit union or state credit union, as defined in Section 101 of the Federal Credit Union Act (12 U.S.C. Sec. 1752), including, but not limited to, an institution-affiliated party of a credit union, as defined in Section 206(r) of the Federal Credit Union Act (12 U.S.C. Sec. 1786 (r)). (c)As used in this section, "financial abuse" has the same meaning as in Section 15610.30. (d)(1)Any mandated reporter of suspected financial abuse of an elder or dependent adult who has direct contact with the elder or dependent adult or who reviews or approves the elder or dependent adult's financial documents, records, or transactions, in connection with providing financial services with respect to an elder or dependent adult, and who, within the scope of his or her employment or professional practice, has observed or has knowledge of an incident that is directly related to the transaction or matter that is within that scope of employment or professional practice, that reasonably appears to be financial abuse, or who reasonably suspects that abuse, based solely on the information before him or her at the time of reviewing or approving the document, records, or transaction in the case of mandated reporters who do not have direct contact with the elder or dependent adult, shall report the known or suspected instance of financial abuse by telephone immediately, or as soon as practicably possible, and by written report sent within two working days to the local adult protective services agency or the local law enforcement agency."

MULTIPLE REPORTERS

When two or more mandated reporters are jointly knowledgeable of a suspected instance of abuse of a dependent adult or elder, and when there is agreement among them, the telephone report may be made by one member of the group. Also, a single written report may be completed by that member of the group. Any person of that group, who believes the report was not submitted, shall submit the report.

IDENTITY OF THE REPORTER

The identity of all persons who report under WIC Chapter 11 shall be confidential and disclosed only among APS agencies, local law enforcement agencies, LTCO coordinators, California State Attorney General Bureau of Medi-Cal Fraud and Elder Abuse, licensing agencies or their counsel, Department of Consumer Affairs Investigators (who investigate elder and dependent adult abuse), the county District Attorney, the Probate Court, and the Public Guardian. Confidentiality may be waived by the reporter or by court order.

FAILURE TO REPORT

Failure to report by mandated reporters (as defined under "Reporting Party Definitions") any suspected incidents of physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect) of an elder or a dependent adult is a misdemeanor, punishable by not more than six months in the county jail, or by a fine of not more than $1,000, or by both imprisonment and fine. Any mandated reporter who willfully fails to report abuse of an elder or a dependent adult, where the abuse results in death or great bodily injury, may be punished by up to one year in the county jail, or by a fine of up to $5,000, or by both imprisonment and fine.

Officers or employees of financial institutions (defined under "Reporting Party Definitions") are mandated reporters of financial abuse (effective January 1, 2007). These mandated reporters who fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding $1,000. Individuals who willfully fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding $5,000. These civil penalties shall be paid by the financial institution, which is the employer of the mandated reporter to the party bringing the action.

GENERAL INSTRUCTIONS (Continued)

EXCEPTIONS TO REPORTING

Per WIC Section 15630(b)(3)(A), a mandated reporter who is a physician and surgeon, a registered nurse, or a psychotherapist, as defined in Section 1010 of the Evidence Code, shall not be required to report a suspected incident of abuse where all of the following conditions exist:

(1) The mandated reporter has been told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect).
(2) The mandated reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred.
(3) The elder or the dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia.
(4) In the exercise of clinical judgment, the physician and surgeon, the registered nurse, or the psychotherapist, as defined in Section 1010 of the Evidence Code, reasonably believes that the abuse did not occur.

Per WIC Section 15630(b)(4)(A), in a long-term care facility, a mandated reporter who the California Department of Health Services determines, upon approval by the Bureau of Medi-Cal Fraud and the Office of the State Long-Term Care Ombudsman (OSLTCO), has access to plans of care and has the training and experience to determine whether all the conditions specified below have been met, shall not be required to report the suspected incident of abuse:

(1) The mandated reporter is aware that there is a proper plan of care.
(2) The mandated reporter is aware that the plan of care was properly provided and executed.
(3) A physical, mental, or medical injury occurred as a result of care pursuant to clause (1) or (2).
(4) The mandated reporter reasonably believes that the injury was not the result of abuse.

DISTRIBUTION OF SOC 341 COPIES

Mandated reporter: After making the telephone report to the appropriate agency, the reporter shall send the original and one copy to the agency; keep one copy for the reporter's file.
Receiving agency: Place the original copy in the case file. Send a copy to a cross-reporting agency, if applicable.
DO NOT SEND A COPY TO THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES ADULT PROGRAMS BUREAU.

STATEMENT ACKNOWLEDGING REQUIREMENT TO REPORT SUSPECTED ABUSE OF DEPENDENT ADULTS AND ELDERS

NOTE: RETAIN IN EMPLOYEE/ VOLUNTEER FILE

NAME

POSITION FACILITY

California law REQUIRES certain persons to report known or suspected abuse of dependent adults or elders. As an employee or volunteer at a licensed facility, you are one of those persons - a "mandated reporter."

PERSONS WHO ARE REQUIRED TO REPORT ABUSE

Mandated reporters include care custodians and any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not paid for that responsibility. [Welfare & Institutions Code ("W&I") section 15630(a)] **Care custodians** include administrators or employees of any CDSS licensed facility, including support and maintenance staff, or persons providing care or services for elders or dependent adults. [W&I §§ 15610.17(e)&(j)]

PERSONS WHO ARE THE SUBJECT OF THE REPORT

Elder means any California resident, 65 years or older. [W&I § 15610.27]
Dependent adult means any California resident, aged 18 through 64, who has physical or mental limitations that restrict his/her ability to carry out normal activities or to protect his/her rights including, but not limited, to persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age. [W&I § 15610.23]

WHEN REPORTING ABUSE IS REQUIRED

Any mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be abuse or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting abuse or neglect, or reasonably suspects that abuse, shall report the known or suspected instance of abuse. This must be done BY TELEPHONE IMMEDIATELY or as soon as practically possible, and BY WRITTEN REPORT WITHIN TWO (2) WORKING DAYS. [W&I § 15630(b)]

PENALTY FOR FAILURE TO REPORT ABUSE

Failure to report abuse of an elder or dependent adult is a MISDEMEANOR CRIME, punishable by jail time, fine or both. [W&I § 15630(h)]

CONFIDENTIALITY OF REPORTER AND OF ABUSE REPORTS

The duties of mandated reporters are individual and no supervisor or administrator shall impede or inhibit the reporting duties, and no person making the report shall be subject to any sanction for making the report. However, internal procedures to facilitate reporting, ensure confidentiality, and apprise supervisors and administrators of reports may be established, provided they are not inconsistent with the reporting law. [W&I § 15630(f)]

The reporting person, the report, and the information on the report, shall be kept confidential and may be disclosed ONLY as provided by law. Any violation of confidentiality is a MISDEMEANOR CRIME. [W&I § 15633(a)]

ABUSE THAT MUST BE REPORTED

Abuse of an elder or dependent adult that must be reported includes: 1) physical abuse; 2) neglect; 3) financial abuse; 4) abandonment; 5) isolation; and 6) abduction. [W&I § 15630(b)]

DEFINITIONS OF ABUSE

Physical abuse means any of the following: (1) **assault** (an unlawful attempt, coupled with a present ability, to commit a violent injury on another person); or assault with a deadly weapon; (2) **battery** (willful and unlawful use of force or violence upon another person); (3) **unreasonable physical constraint, or prolonged or continual deprivation of food or water;** (4) **sexual assault** (as defined in the Penal Code); or (5) **use of a physical or chemical restraint or psychotropic medication** for (a) punishment, or (b) a period beyond that for which the medication was ordered, or (c) any purpose not authorized by the physician and surgeon. [W&I § 15610.63]

Neglect means the negligent failure of any person having the care or custody of an elder or dependent adult to exercise that degree of care that a reasonable person in a like position would exercise. [W&I § 15610.57(a)] Neglect Includes, but is not limited to, the following: (a) failure to assist in personal hygiene, or in the provision of food, clothing, or shelter; (b) failure to provide medical care for physical and mental health needs (unless the sole reason is voluntarily relying on treatment by spiritual means through prayer alone in lieu of medical treatment); (c) failure to protect from health and safety hazards; or (d) failure to prevent malnutrition or dehydration. [W&I § 15610.57(b)]

Financial abuse occurs when a person or entity does any of the following: (1) takes, secretes, appropriates, or retains real or personal property of an elder or dependent adult to a wrongful use or with intent to defraud, or both; or (2) assists in any of these acts. [W&I § 15610.30(a)]

Abandonment means the desertion or willful forsaking of an elder or dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody. [W&I § 15610.65]

Isolation means any of the following: (1) acts intentionally committed for the purpose of preventing, and that do serve to prevent, an elder or dependent adult from receiving his or her mail or telephone calls; (2) telling a caller or prospective visitor that an elder or dependent adult is not present or does not wish to talk with the caller, or does not wish to meet with the visitor where the statement is false, is contrary to the express wishes of the elder or dependent adult, whether he or she is competent or not, and is made for the purpose of preventing the elder or dependent adult from having contact with family, friends, or concerned persons (3) false imprisonment (the unlawful violation of the personal liberty of another); or (4) physical restraint for the purpose of preventing the elder or dependent adult from meeting with visitors. [W&I § 15610.43(a)] These acts shall not constitute isolation if they are performed in response to a reasonably perceived threat of danger to property or physical safety. [W&I § 15610.43(c)]

Abduction means the removal from California and the restraint from returning, or the restraint from returning, of any elder or dependent adult who does not have the capacity to consent to the removal or restraint. [W&I § 15610.06]

WHERE TO CALL IN AND SEND THE WRITTEN ABUSE REPORT

If the abuse is alleged to have occurred in a long-term care facility, including a licensed or unlicensed residential facility serving adults or elders or an adult day program, you must report to either local law enforcement or the local long-term care ombudsman. [W&I § 15630(b)(1)(A)] If the abuse is alleged to have occurred anywhere other than a long-term care facility, you must report to either local law enforcement or county adult protective services. [W&I § 15630(b)(1)(C)]

AS AN EMPLOYEE OR VOLUNTEER OF THIS FACILITY, YOU MUST COMPLY WITH THE DEPENDENT ADULT AND ELDER ABUSE REQUIREMENTS, AS STATED ABOVE. IF YOU DO NOT COMPLY, YOU MAY BE SUBJECT TO CRIMINAL PENALTY.

I, _____, have read and understand my responsibility to report known or suspected abuse of dependent adults or elders. I will comply with the reporting requirements.

SIGNATURE	DATE

FOR USE BY FINANCIAL INSTITUTIONS
REPORT OF SUSPECTED DEPENDENT ADULT/ELDER FINANCIAL ABUSE

[CONFIDENTIAL - Not subject to public disclosure]

DATE COMPLETED:

TO BE COMPLETED BY REPORTING PERSON. PLEASE PRINT OR TYPE.

A. VICTIM

NAME (LAST NAME FIRST)	AGE	DATE OF BIRTH	SSN	GENDER ☐ M ☐ F	LANGUAGE (✓ CHECK ONE) ☐ NON-VERBAL ☐ ENGLISH ☐ OTHER (*SPECIFY*)

ADDRESS (IF FACILITY, INCLUDE NAME)	CITY	ZIP CODE	TELEPHONE
			( )

PRESENT LOCATION (IF DIFFERENT FROM ABOVE)	CITY	ZIP CODE	TELEPHONE
			( )

☐ ELDERLY (65+) ☐ DEVELOPMENTALLY DISABLED ☐ MENTALLY ILL/DISABLED ☐ PHYSICALLY DISABLED ☐ UNKNOWN/OTHER

B. INCIDENT INFORMATION - WHERE INCIDENT OCCURRED

PLACE OF INCIDENT (✓ CHECK ONE)

☐ FINANCIAL INSTITUTION ☐ OWN HOME ☐ CARE FACILITY ☐ OTHER (Specify) ☐ UNKNOWN

ADDRESS WHERE INCIDENT(S) OCCURRED	DATE/TIME OF INCIDENT(S)

C. REPORTER'S OBSERVATIONS

(ATTACH ADDITIONAL PAGES IF NECESSARY)

D. TARGETED ACCOUNT

ACCOUNT NUMBER: (LAST 4 DIGITS)	TYPE OF ACCOUNT: ☐ DEPOSIT ☐ CREDIT ☐ OTHER	TRUST ACCOUNT: ☐ YES ☐ NO
POWER OF ATTORNEY: ☐ YES ☐ NO	DIRECT DEPOSIT: ☐ YES ☐ NO	OTHER ACCOUNTS: ☐ YES ☐ NO

E. SUSPECT INFORMATION

NAME OF SUSPECTED ABUSER(S)	ADDRESS	DATE OF BIRTH	AGE (ESTIMATE IF UNKNOWN)

RELATIONSHIP TO VICTIM

☐ CARE CUSTODIAN ☐ PARENT ☐ SON/DAUGHTER ☐ HEALTH PRACTITIONER ☐ SPOUSE ☐ UNKNOWN ☐ OTHER_____

F. OTHER PERSON(S) BELIEVED TO HAVE KNOWLEDGE OF ABUSE - (family, significant others, neighbors, medical providers and agencies involved, etc.)

NAME	ADDRESS	TELEPHONE NUMBER	RELATIONSHIP

G. TELEPHONE AND WRITTEN REPORTS

TELEPHONE REPORT MADE TO: ☐ Local APS ☐ Local Law Enforcement ☐ Local Ombudsman

NAME OF OFFICIAL CONTACTED BY PHONE	TELEPHONE	DATE/TIME
	( )	

REPORTED BY	TITLE	TELEPHONE	DATE/TIME
		( )	

NAME OF FINANCIAL INSTITUTION	ADDRESS

WRITTEN REPORT SENT TO Enter information about the agency receiving a copy of this report. Do not submit report to California Department of Social Services Adult Programs Bureau.

NAME OF AGENCY	ADDRESS OR FAX #	☐ Date Mailed: ☐ Date Faxed:

H. RECEIVING AGENCY USE ONLY ☐ Telephone Report ☐ Written Report

1. Report Received by: Date/Time:
2. Assigned ☐ Immediate Response ☐ Ten-day Response ☐ No Initial Face-To-Face Required ☐ Not APS ☐ Not Ombudsman

Approved by: Assigned to (optional):

3. Cross-Reported to: ☐ CDHS, Licensing & Cert.; ☐ CDSS-CCL; ☐ CDA Ombudsman; ☐ Bureau of Medi-Cal Fraud & Elder Abuse; ☐ Mental Health; ☐ Law Enforcement; ☐ Professional Board; ☐ Developmental Services; ☐ APS; ☐ Other (Specify) Date of Cross-Report:

4. APS/Ombudsman/Law Enforcement Case File Number:_____

Use SOC 341 to report other types of abuse

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER FINANCIAL ABUSE
FINANCIAL INSTITUTIONS ONLY
GENERAL INSTRUCTIONS

PURPOSE OF THE FORM

This form is to be used by officers and employees of financial institutions ("mandated reporter(s)") to report suspected financial abuse suffered by a dependent adult or elder. Other types of dependent adult or elder abuse may be reported using form SOC 341. This form is available on http://www.dss.cahwnet.gov/cdssweb/On-lineFor_298.htm#SOC.

An "elder is any person residing in California who is 65 years of age or older. A "dependent adult" is anyone residing in California who is between the ages of 18 and 64 years, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons whose physical or mental disabilities have diminished because of age. It also includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility.

The oral or written report may be made to the adult protective services agency (APS) in the county where the apparent victim resides, or to a law enforcement agency in the county where the incident occurred. If the mandated reporter knows the apparent victim resides in a long-term care facility, the report must be provided to the local ombudsman or local law enforcement agency. The mandated reporter must first report the incident by telephone, followed by a written report within two working days, using the form. See http://www.dss.cahwnet.gov/pdf/apscolist.pdf for a list of APS offices by county or http://www.aging.state.ca.us/html/programs/ombudsman_contacts.html for county ombudsman offices.

WHAT TO REPORT

Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment has observed, suspects, or has knowledge of an incident that reasonably appears to be financial abuse, or is told by an elder or a dependent adult that he or she has experienced behavior constituting financial abuse, shall report the known or suspected instance of abuse by telephone immediately, or as soon as practicably possible, and by written report sent within two working days to the appropriate agency.

REPORTING PARTY DEFINITIONS

Officers and employees of financial institutions are mandated reporters of suspected financial abuse of an elder or dependent adult residing in California (WIC 15630.1). Financial abuse of an elder or dependent adult generally means the taking of real or personal property of an elder or dependent adult to a wrongful use, or assisting in doing so (WIC 15610.30). A mandated reporter who has direct contact with the elder or dependent adult, or who does not have direct contact but reviews or approves the elder's or dependent adult's financial documents, records, or transactions, and who reasonably believes that financial abuse has occurred, must report the incident by telephone immediately, or as soon as practicably possible, and by written report sent within two working days to the local adult protective services agency or the local law enforcement agency (WIC 15630.1(d)(1)).

IDENTITY OF THE REPORTING PARTY

The identity of all persons reporting suspected financial abuse shall be confidential and only disclosed among APS agencies, local law enforcement agencies, Long-Term Care Ombudsman (LTCO) coordinators, Bureau of Medi-Cal Fraud and Elder Abuse of the Office of the Attorney General, licensing agencies or their counsel, Investigators of the Department of Consumer Affairs who investigate elder and dependent adult abuse, the Office of the District Attorney, the Probate Court, and the Public Guardian, or upon waiver of the confidentiality by the mandated reporter or by court order.

MULTIPLE REPORTERS

When two or more mandated reporters are jointly knowledgeable of a suspected instance of abuse of a dependent adult or elder, and when there is agreement among them, the telephone report may be made by one member of the group. Also, a single written report may be completed by that member of the group. Any person of that group, who believes the report was not submitted, shall submit the report.

GENERAL INSTRUCTIONS (Continued)

FAILURE TO REPORT
Officers or employees of financial institutions (defined under "Reporting Party Definitions") are mandated reporters of financial abuse (effective January 1, 2007). These mandated reporters who fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding $1,000. Individuals who willfully fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding $5,000. These civil penalties shall be paid by the financial institution, which is the employer of the mandated reporter to the party bringing the action.

WRITTEN REPORT
If any item of information is unknown, write "unknown" beside the item.

1. **Part A: Victim** Provide information as indicated to the extent known to you or available from financial institution records. If the apparent victim is residing at a location other than his or her address of record, indicate in "Present Location."

2. **Part B: Incident Information** Please check the appropriate box to indicate where the incident occurred. If the incident occurred at another location, please enter the address of the incident location.

3. **Part C: Reporter's Observations** Complete this part carefully and completely. Please include any of the following, as applicable:
   - Statements made by the apparent victim or the suspect;
   - Changes to banking patterns or practices; unusual account activity, such as large withdrawals or large wire transfers;
   - Abrupt changes to legal or financial documents, such as a power of attorney or trust instrument;
   - Sudden confusion by the apparent victim regarding his or her personal financial matters;
   - Repeated telephone calls to the financial institution by the apparent victim repeatedly asking the same question(s);
   - Establishment of unnecessary credit for the apparent victim himself or herself or another person;
   - Apparent victim's belief that he or she has won a lottery;
   - Observations regarding changes to the apparent victim's appearance or demeanor, etc.; or
   - Other concerns by the financial institution's officer or employee not listed above.

   Please attach additional pages, if necessary.

4. **Part D: Targeted Account** Complete information as indicated regarding the targeted account of the apparent victim. To ensure confidentiality, indicate only the last 4 digits of that account number. When making the report by telephone, the mandated reporter will be asked to provide the full account number. A trust account includes not only a Totten or informal trust arrangement through a deposit account, but also formal trust arrangements through a financial institution's trust department. If the apparent victim has other accounts with the financial institution, check "yes." If more than one account is affected, indicate on separate page.

5. **Part E: Suspect Information** This information is of particular importance to an agency's ability to conduct an investigation. Attach additional pages if more than one suspect is involved.

6. **Part F: Other Persons Believed to Have Knowledge of Abuse** This section is intended to identify any other persons who have knowledge of the incident(s).

7. **Part G: Telephone and written reports** This part shall be completed by the mandated reporter for statistical reporting to financial institutions, and county, state, and federal entities.

8. **Distribution of SOC 342 copies** The mandated reporter shall send the original and one copy to the appropriate agency, after the telephone report is made; keep one copy for the reporter's file. The receiving agency shall place the original copy in the case file and send a copy to the cross-reporting agency, if applicable. DO NOT SEND A COPY TO THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES ADULT PROGRAMS OPERATIONS BUREAU.

CONFIDENTIAL REPORT -
NOT SUBJECT TO PUBLIC DISCLOSURE

INVESTIGATION OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE – Page 1 of 2

TO BE COMPLETED BY APS SOCIAL WORKER

DEPENDENT ADULT/ELDER NAME (LAST NAME FIRST)	APS CASE NO.	SSN

A. APS INVESTIGATION INFORMATION - ADDITIONAL SPACE ON PAGE TWO

1. DATE(S) AND TIME(S) OF INCIDENT(S)	2. DATE(S) AND TIME(S) INVESTIGATED BY APS

3. NAME OF SUSPECTED ABUSER

4. SUMMARY OF ALLEGATIONS

5. DESCRIBE CHARACTERISTICS OF VICTIM'S ENVIRONMENT (LIVING QUARTERS, ADEQUACY OF CARE, FINANCIAL ARRANGEMENTS, ETC.)

6. ABUSE/SELF-NEGLECT INDICATORS OBSERVED OR REPORTED AT TIME OF INVESTIGATION (CIRCLE ALL THAT APPLY)

a. Physical Indicators: Bruises Burns Welts Fractures Dislocations Lacerations Abrasions Skin Irritations Skin disorders Bedsores Friction burns Untreated injuries Untreated medical/dental problem Stomachaches Malnuturition Dehydration Pallor Sunken eyes/cheeks Fleas Lice/nits No food/water Signs of confinement Poor hygiene Unwashed clothing/bedding Inadequate heating Unsanitary conditions Unsafe housing

b. Behavioral Indicators: Fear Denial Trembling Implausible/conflicting stories Regressive behavior Helplessness Non-responsiveness Resignation Agitation Depression Sleeping disturbances Excessive sleeping

c. Sexual Abuse Indicators: Sexually transmitted disease Genital discharge/infection Genital trauma (Bruises, etc.) Difficulty walking/sitting Excessive body consciousness Fecal soiling Inappropriate sexual behavior

d. Financial Indicators: Unusual bank account activity Inappropriate interest by relative/caretaker Isolated Numerous unpaid bills Lack of affordable necessities/amenities Promise of lifelong care Inappropriately executed/exercised Power of Attorney Forged signature Personal belongings/valuables missing Recent will/transfer of property

7. DESCRIBE PHYSICAL EVIDENCE OF ABUSE/SELF-NEGLECT (CLARIFY INDICATORS ABOVE OR INCLUDE ADDITIONAL INFORMATION)

8. DESCRIBE HOW/WHY ABUSE APPEARS TO HAVE BEEN COMMITTED (MAY INCLUDE WEAPONS USED, POSSIBLE MOTIVE, ETC.)

B. STATEMENTS - ADDITIONAL SPACE ON PAGE TWO. A SIGNED STATEMENT (OPTIONAL) MAY BE OBTAINED FROM ANY OF THE PARTIES LISTED BELOW.

9. VICTIM'S STATEMENT (INCLUDE REPORTS OF THREATS, INTIMIDATION, HARASSMENT)

10. ASSESSMENT OF VICTIM'S WILLINGNESS AND ABILITY TO COOPERATE WITH INVESTIGATION AND PROSECUTION

PRINT APS SOCIAL WORKER NUMBER	SIGNATURE OF APS SOCIAL WORKER	DATE

CONFIDENTIAL REPORT -
NOT SUBJECT TO PUBLIC DISCLOSURE

INVESTIGATION OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE – Page 2 of 2

TO BE COMPLETED BY APS SOCIAL WORKER

DEPENDENT ADULT/ELDER NAME (LAST NAME FIRST)	APS CASE NO.	SSN

11. SUSPECTED ABUSER'S STATEMENT

12. STATEMENT(S) OF OTHER PERTINENT PARTIES (INCLUDE ADDRESS/TELEPHONE NUMBER IF NOT ON SOC 341)

13. ARE OTHER AGENCIES INVOLVED IN INVESTIGATION? ☐ YES ☐ NO IF SO, GIVE AGENCY NAME AND NAME AND TELEPHONE NUMBER OF CONTACT PERSON

C. USE THIS SPACE FOR ADDITIONAL INFORMATION OR STATEMENTS - IF CONTINUATION FROM PREVIOUS ITEM, PLEASE SPECIFY ITEM NUMBER.

D. OUTCOME OF APS INVESTIGATION

14. ALLEGATIONS AND FINDINGS

PERPETRATED BY OTHERS:				PERPETRATED BY SELF:			
☐ Physical	☐ Confirmed	☐ Inconclusive	☐ Unfounded	☐ Physical Care	☐ Confirmed	☐ Inconclusive	☐ Unfounded
☐ Sexual	☐ Confirmed	☐ Inconclusive	☐ Unfounded	☐ Medical Care	☐ Confirmed	☐ Inconclusive	☐ Unfounded
☐ Financial	☐ Confirmed	☐ Inconclusive	☐ Unfounded	☐ Health and Safety	☐ Confirmed	☐ Inconclusive	☐ Unfounded
☐ Neglect	☐ Confirmed	☐ Inconclusive	☐ Unfounded	☐ Malnutrition/Dehydration	☐ Confirmed	☐ Inconclusive	☐ Unfounded
☐ Abandonment	☐ Confirmed	☐ Inconclusive	☐ Unfounded	☐ Financial	☐ Confirmed	☐ Inconclusive	☐ Unfounded
☐ Isolation	☐ Confirmed	☐ Inconclusive	☐ Unfounded				
☐ Abduction	☐ Confirmed	☐ Inconclusive	☐ Unfounded				
☐ Psychological	☐ Confirmed	☐ Inconclusive	☐ Unfounded				

15. COMMENTS

PRINT APS SOCIAL WORKER NUMBER	SIGNATURE OF APS SOCIAL WORKER	SIGNATURE OF APS SUPERVISOR

INSTRUCTIONS FOR COMPLETING THE SOC 343
Page 1 of 2

Heading - Give client's name, APS case number and social security number.

Part A - APS Investigation Information

1. Give date(s) and time(s) of incident(s) as reported.

2. Give date(s) and time(s) the incident(s) are actually investigated by APS.

3. Give suspected abuser's name.

4. Give summary of allegations as reported.

5. Describe the pertinent characteristics of the victim's environment including conditions of his/her present living quarters, the adequacy of care being provided, what types of financial arrangements the victim has, etc.

6. Circle all the abuse/self-neglect indicators that are observed or reported by the victim at the time of the APS investigation.

7. Describe the physical evidence of abuse/self-neglect observed or reported by the victim at the time of the APS investigation. This section may be used to clarify the indicators reported under A6 above.

8. Describe how or why the abuse appears to have been committed. This requires a subjective determination by the APS worker performing the investigation.

Part B - Statements

9. Summarize the victim's statement as given to the APS worker performing the investigation.

10. Give an assessment of the victim's willingness and ability to cooperate with an investigation and prosecution. This requires a subjective determination by the APS worker doing the investigation.

Footing - Give APS social worker number, APS social worker signature, and date the SOC 343 was completed.

INSTRUCTIONS FOR COMPLETING THE SOC 343
Page 2 of 2

Heading - Give client's name, APS case number and social security number.

Part B - Statements (continued)

11. Summarize the suspected abuser's statement.

12. Summarize the statements of any other pertinent parties, identifying the person by name, address and telephone number if this information is not already included on the SOC 341.

13. Indicate if other agencies are involved in the investigation. If so, give the agency name and telephone number of a contact person.

Part C - Additional Space

Use this additional space to continue any items under parts A or B.

Part D - Outcome of APS Investigation

14. Indicate allegations and findings.

15. Use this space for additional comments.

Footing - Give APS social worker number, APS social worker signature, and APS supervisor signature.

FORM SAMPLES

CPS

Print

SUSPECTED CHILD ABUSE REPORT

Reset Form

To Be Completed by **Mandated Child Abuse Reporters**
Pursuant to Penal Code Section 11166

PLEASE PRINT OR TYPE

CASE NAME: _____

CASE NUMBER: _____

A. REPORTING PARTY

NAME OF MANDATED REPORTER	TITLE	MANDATED REPORTER CATEGORY
REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS — Street / City / Zip		DID MANDATED REPORTER WITNESS THE INCIDENT? ☐ YES ☐ NO
REPORTER'S TELEPHONE (DAYTIME) ( )	SIGNATURE	TODAY'S DATE

B. REPORT NOTIFICATION

☐ LAW ENFORCEMENT ☐ COUNTY PROBATION ☐ COUNTY WELFARE / CPS (Child Protective Services)	AGENCY	
ADDRESS — Street / City / Zip		DATE/TIME OF PHONE CALL
OFFICIAL CONTACTED - TITLE		TELEPHONE ( )

C. VICTIM
One report per victim

NAME (LAST, FIRST, MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS — Street / City / Zip		TELEPHONE ( )	
PRESENT LOCATION OF VICTIM	SCHOOL	CLASS	GRADE
PHYSICALLY DISABLED? ☐ YES ☐ NO	DEVELOPMENTALLY DISABLED? ☐ YES ☐ NO	OTHER DISABILITY (SPECIFY)	PRIMARY LANGUAGE SPOKEN IN HOME
IN FOSTER CARE? ☐ YES ☐ NO	IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: ☐ DAY CARE ☐ CHILD CARE CENTER ☐ FOSTER FAMILY HOME ☐ FAMILY FRIEND ☐ GROUP HOME OR INSTITUTION ☐ RELATIVE'S HOME		TYPE OF ABUSE *(CHECK ONE OR MORE)* ☐ PHYSICAL ☐ MENTAL ☐ SEXUAL ☐ NEGLECT ☐ OTHER (SPECIFY)
RELATIONSHIP TO SUSPECT	PHOTOS TAKEN? ☐ YES ☐ NO		DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? ☐ YES ☐ NO ☐ UNK

D. INVOLVED PARTIES

VICTIM'S SIBLINGS

NAME	BIRTHDATE	SEX	ETHNICITY	NAME	BIRTHDATE	SEX	ETHNICITY
1.				3.			
2.				4.			

VICTIM'S PARENTS/GUARDIANS

NAME (LAST, FIRST, MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS — Street / City / Zip	HOME PHONE ( )	BUSINESS PHONE ( )	
NAME (LAST, FIRST, MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS — Street / City / Zip	HOME PHONE ( )	BUSINESS PHONE ( )	

SUSPECT

SUSPECT'S NAME (LAST, FIRST, MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS — Street / City / Zip	TELEPHONE ( )		
OTHER RELEVANT INFORMATION			

E. INCIDENT INFORMATION

IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX ☐ *IF MULTIPLE VICTIMS, INDICATE NUMBER:* _____

DATE / TIME OF INCIDENT	PLACE OF INCIDENT

NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)

SS 8572 (Rev. 12/02)

DEFINITIONS AND INSTRUCTIONS ON REVERSE

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS 8583 if (1) an active investigation was conducted and (2) the incident was determined not to be unfounded.

WHITE COPY-Police or Sheriff's Department; BLUE COPY-County Welfare or Probation Department; GREEN COPY- District Attorney's Office; YELLOW COPY-Reporting Party

10-116 NOTICE OF ACTION 10-116

.1 A written notice of action, containing information about the right to request a hearing, shall be provided to the applicant or client when an:

.11 Application is denied.

.12 Approval action is taken which includes a service fee or an hourly or other limitation.

.13 Existing authorization is adversely altered, discontinued or reduced, or a service fee is changed.

.2 An oral approval may be used if a fee is not involved, or the approval does not involve limitation on the payment or hours of services authorized.

.3 Timeliness: Notices shall be mailed or otherwise provided in a timely manner.

.31 An approval or denial notice shall be provided within 30 days of the date the application is signed.

.32 A notice of action reducing or discontinuing a service payment shall be mailed or released at least ten days in advance of the effective date of the intended action. The ten-day count does not include the day of mailing or the effective day of the action.

.4 Scope/Adequacy

.41 An approval notice shall inform the applicant of the effective date.

.42 A notice which denies, reduces, discontinues or suspends a service, or which increases a fee, shall include the information concerning the recipient's circumstances which has been used to make the determination and shall cite the regulations which support the action.

.43 Notice which alter an existing service authorization shall indicate the circumstances under which the service will continue during the hearing process, if a hearing is requested.

.44 All written notices of action shall contain information about the right to request a hearing, and shall meet the requirements for standardized notice formats, including the procedure for exercising that right.

10-116 NOTICE OF ACTION (Continued) **10-116**

.5 Exceptions

.51 Notice is not required for information and referral service.

.52 The agency may dispense with timely notice but shall send an adequate notice not later than the effective date of the action when:

.521 The agency has factual information confirming the death of the recipient.

.522 The agency receives a signed statement from the recipient that the recipient no longer wishes the service.

.523 A limited term services authorization ends, providing the recipient had been informed in writing at the time of approval that the allowance would terminate on a specified date.

.524 The agency receives a signed statement from the recipient, in response to a prior notice from the agency that a service fee has been increased, that the recipient will not pay the new fee or no longer wishes the service at the new fee.

.525 The agency receives information that a recipient has been admitted or committed to an institution in which continued services of the Primary would not qualify for federal financial participation.

.526 A notice to the last address of record has been returned undelivered and a new address is not known.

.527 The agency receives definitive information that the client has been accepted for the same service in another jurisdiction.

.528 The agency receives a signed statement from the recipient that the recipient will not supply essential eligibility information previously requested in writing by the agency. The original request for information shall clearly state that service will be mandatorily withheld if the essential information is not received by the specified date. A timely notice shall be sent if the requested information is not received on the specified date.

Notice of Action Messages NA 690

The Notice of Action (NOA) is used communicate case status, authorization or changes to an IHSS recipient case. IHSS Notices of Action are printed in English or Spanish. The Spanish version is produced when the primary language of the recipient is indicated as Spanish (Field F5 – 1 Spanish). A copy of a blank Spanish NOA can be obtained from the CDSS IHSS/CMIPS Unit upon request.

The following message are either system generated by specific case actions and entries or manually entered by county staff and are used to communicate with the recipient actions associated with the IHSS case.

The Notice of Action field descriptions

Field: **IN-HOME SUPPORTIVE SERVICES NOTICE OF ACTION**
Description: The **TYPE OF ACTION** prints, centered, at the top of the form to the right of the header. The message corresponding with the TYPE OF ACTION prints above the HOW/WAS area field E. TYPE of ACTION messages are system generated from SOC 293, Field F1, STATUS and other actions taken on a recipient case.

Type of Action	Message
APPROVAL	YOUR APPLICATION FOR IN-HOME SERVICES DATED MM/DD/YYYY HAS BEEN APPROVED EFFECTIVE MM/DD/YYYY. YOU ARE AUTHORIZED TO RECEIVE SERVICES LISTED BELOW.
DENIAL	YOUR APPLICATION FOR IN-HOME SERVICES DATED MM/DD/YYYY HAS BEEN DENIED.
DISCONTINUANCE	YOUR ELIGIBILITY FOR IN-HOME SERVICES WILL BE DISCONTINUED EFFECTIVE MM/DD/YYYY.
LEAVE	YOUR IN-HOME SERVICES HAVE BEEN TEMPORARILY SUSPENDED EFFECTIVE MM/DD/YYYY.
PROVISIONAL APPROVAL	YOUR APPLICATION FOR IN-HOME SERVICES DATED MM/DD/YYYY HAS BEEN PROVISIONALLY APPROVED EFFECTIVE MM/DD/YYYY. YOU ARE AUTHORIZED TO RECEIVE SERVICES LISTED BELOW.
REASSESSMENT CHANGE	YOUR AUTHORIZATION FOR IN-HOME SERVICES HAS BEEN CHANGED EFFECTIVE MM/DD/YYYY.
REASSESSMENT NO CHANGE	UPON REASSESSMENT WE FIND THERE IS NO CHANGE FROM YOUR PREVIOUS AUTHORIZATION FOR IN-HOME SERVICES EFFECTIVE MM/DD/YYYY.

Field: ADDRESS
Description: The following address fields print on at the top section of the NOA:

- The Recipients IHSS District Office
- The State Hearing Office
- The Recipient or Guardian/conservator's mailing address

Field: CASE NUMBER
Description: The recipient IHSS case number

Field: DATE MAILED
Description: The date the NOA was mailed. This date is system generated if the NOA meets the "Due Process" criteria which requires notification of the recipient within 13 days. The thirteen days are counted from the day of data entry.
If a NOA does not meet the DUE PROCESS criteria, this field will be hand written by the Service Worker, the date the NOA was mailed.

To the right of the date the Medi-Cal Secondary Aid Code will be indicated. This indication (2L, 2M or 2N) assists County Staff in knowing the appropriate NOA 350 insert to include in the mailing.

Field: TYPE OF ACTION MESSAGE
Description: Additional message associated with the TYPE OF ACTION previously indicated at the top center of the NOA.

Field F: THE SHARE OF COST – NOW/WAS
Description: The monies currently (NOW) and previously (WAS) associated with Share of Cost calculations. These fields will appear blank if there is no SOC associated with the recipient case.

Field: THE SERVICES – NOW/WAS
Description: Indicates the hours currently (NOW) and previously (WAS) assessed for services.

Field: ADVANCE PAYMENT NOTIFICATION
Description: A notice of eligibility for advance payment to severely impaired recipients. The box in the lower left section of the document will be checked.

Field: NOA MESSAGES
Description: Verbiage associated with automated and manual NOA code reasons associated to action messages. ***(See NOA Codes below.)***

Field: DISTRICT OFFICE
Description: The District Office within the county responsible for the recipient case.

Field: SERVICE WORKER
Description: The name (Last Name, First Name) of the Service Worker responsible for the recipient case.

Field: SW#
Description: A numeric value associated with the Service Worker.

Field: TELEPHONE
Description: The telephone number of the Service Worker associated to the recipient case.

Field: RIGHT TO REQUEST A STATE HEARING – Reverse side of NOA
Description: The Right to Request a State Hearing definition is printed on the back side of the NOA Form

Due Process

- CMIPS has an automated "Due-Process" notification. The DATE MAILED field on a NOA will only be printed on the Notice if there is a thirteen day lead time. The thirteen days are counted from the day of data entry.
- Whenever a date is not printed in the Date Mailed section, the County Social Worker is responsible for entering the date mailed.

Notice of Action Codes

Notice of Action messages are automated, system generated, or manually generated by an end user. Automated messages are triggered from entries on the RELA, RELB and RELC screens. Manual messages are necessary because data, not entered in CMIPS affects the action(s) taken on a recipient case. Familiarity with the various messages will assist when a manually generated message must be initiated.

Refer to Section V-A SOC 293 Field by Field Description and Section V-B SOC 293- Special Instructions – *Field ZZ1 – ZZ2 for detailed instructions to print NOA messages.*

The Notice of Action messages, listed in this document, are numbered sequentially, but some sequence numbers have been skipped allowing for future assignments.

- Automated Notice of Action codes are numbered 300 through 399. These codes do not need to be keyed in Field ZZ2, Reason Code.
- Manual Notice of Action codes are numbered 400 through 600. They are entered on the SOC 293 in Field ZZ2, RSN. CD, then entered into CMIPS. Up to four codes may be entered. Manually generated codes 550 through 600 are designated as "boiler plate" messages. When used, after the NOA is printed, it is returned to the County Social Worker to fill in the blanks. Therefore, field ZZ1 must always be coded as a C – County.
- Notice of Action codes numbered 600 through 799 is reserved for future use.
- Notice of Action codes numbered 800 through 998 has been reserved for special circumstances such as litigation or mass mailings.
- Code 999 is used when the county adjusts hours rather than accepting the system generated prorated hours in a prorated month; for example, approve payment for total authorized hours in the otherwise prorated month. ***Refer to Section V-B, Special Instructions, Reason Code 999.***

All Notice of Action messages incorporated into CMIPS have been reviewed and approved by CDSS. If an additional Notice of Action message is needed, please contact CDSS. Do not use the existing messages inappropriately.

Pound signs (#) in the following list of messages represent values that are supplied by the system. Items in italics are separate notes to the reader and are not part of the actual NOA messages.

Automated Messages

Eligibility Status

301 Application provisionally approved pending disability determination. MPP 30-759.31

302 Application provisionally approved pending a determination of blindness. MPP 759.32

305 Your eligibility was determined under Substantial Gainful Activity Rules. MPP 30-755.114

308 Your hours of service are increased because you receive services in the Personal Care Services Program. MPP 30-780, MPP 30-700; W&IC 14132.95(g)

309 Your hours of service are decreased because you are no longer eligible for the Personal Care Services Program. The IHSS maximum for the non-severely impaired is 195 hours a month. MPP 30-765; W&IC 12303.4(a)(1) & (2), 12303.4(b)(1) & (2)

310 Effective MMDDYYYY your eligibility has been transferred from the IHSS Plus Waiver Program to Personal Care Services Program. You may be eligible to receive additional hours of service per month depending on your assessed need.

311 Effective MMDDYYYY your eligibility has been transferred from the IHSS Plus Waiver Program to the IHSS – Residual Program.

312 Effective MMDDYYYY, your eligibility has been transferred from the Personal Care Services Program to IHSS Plus Waiver Program.

313 Effective MMDDYYYY your eligibility has been transferred from the Personal Care Services Program to the IHSS – Residual Program.

314 Effective MMDDYYYY your eligibility has been transferred from the IHSS - Residual Program to In-Home Services Plus Waiver Program.

315 Effective MMDDYYYY your eligibility has been transferred from the IHSS - Residual Program to Personal Care Services Program. You may be eligible to receive additional hours of service per month depending on your assessed need.

316 Effective MMDDYYYY you have been approved to participate in the IHSS Plus Waiver Program because you receive advance pay or restaurant meal allowance, or you receive services from your spouse or you are under the age of 18 and receive services from a parent.

317 Effective MMDDYYYY you have been approved to participate in the Personal Care Services Program. You may be eligible to receive additional hours of service per month depending on your assessed need.

318 Effective MMDDYYYY you have been approved to participate in the IHSS - Residual Program.

319 Effective MMDDYYYY, you have been provisionally approved for the IHSS – Residual program pending your Medi-Cal Eligibility Determination. If the Medi-Cal Eligibility Determination indicates you are eligible for other programs you will receive an additional Notice of Action.

Living Arrangements

320 You are the only person counted in your household. MPP 30-763

321 There are ## *(from field G2)* people living in your household included in determining your share of services. MPP 30-763

322 You are eligible to receive only the above services because you are a minor child living with your parent provider. MPP 30-763

Advance Payment – Direct Deposit

331 You can no longer get an advance payment to pay your service provider. This is because you no longer meet the criteria of 20 hours or more per week of starred (* and **) services. MPP 30-769.731

335 You receive payment in advance. Ask your Social Service Worker about direct deposit to your bank. W&IC 12304.3

336 Your application request for direct deposit has been processed. W&IC 12304.3

337 You are no longer eligible for an advance payment; therefore your direct deposit payment option has been canceled. W&IC 12304.3

338 You have requested a cancellation of your advance pay/direct deposit option. W&IC 12304.3

339 Your State Hearing request for direct deposit has been processed. W&IC 12304.3

Restaurant Meal Allowance

340 You have chosen to receive a Restaurant Meal Allowance instead of Meal Preparation Services. MPP 30-757.134

341 You will no longer receive a Restaurant Meal Allowance because you have chosen to receive Meal Preparation Services. MPP 30-757.134

342 Your Restaurant Meal Allowance is increased due to an increase to the state maximum payment. MPP 30-757.134

Share of Cost

345 Your Share of Cost is $####.##. Please see attached form for information specific to your case.

348 A State Law decreased the SSI/SSP benefit levels. Your share of cost of $ ####.## now exceeds the assessed IHSS cost of ####.## Hours X $ ###.## per hour plus the restaurant meal allowance of $ ### which equals $ #####.##. Since your excess income exceeds the cost of IHSS, your services are discontinued. W&IC 12000.015, W&IC 12304.5

349 The change in your IHSS Share of Cost shown above is effective ##/##/## because of cost of living adjustments to the Social Security payments available to you which are $ #####.##, $ #####.##, $ #####.##. If the Social Security amount you receive is different than reported here, contact your service worker within ten calendar days. MPP 30-755.233

352 You no longer have a share of cost because you receive SSI/SSP. Your Medi-Cal card will continue through SSI/SSP. MPP 30-755.111

353 The change in your IHSS Share of Cost shown above is effective ##/##/## because of Cost of Living Adjustments to SSI/SSP benefit levels and to the social security payments available to you which are $ #####.##, $ #####.##, $ #####.##. If the social security amount you receive is different than reported here, contact your service worker within ten calendar days. MPP 30-755.233

354 The change in your share of cost shown above is effective ##/##/##. MPP 30-755.233 Please see attached form for information specific to your case.

Overpayments/Underpayments

356 You have a monthly overpayment adjustment of $ ###.##. MPP 30-768

Proration, Time Limited Authorizations, Presumptive Eligibility & Refused Services

360 Heavy cleaning services are authorized one time only during the month of ##/##/## *(MN02 or ZZ3)*. MPP 30-757.121

361 Removal of Grass, Weeds and Rubbish services are authorized one time only during the month of ##/##/## *(ZZ3)*. MPP 30-757.161

362 You have been receiving IHSS on a provisional basis. Your eligibility has been established because disability has been determined. MPP 30-755

363 You have been receiving IHSS on a provisional basis. Your eligibility has been established because blindness has been determined. MPP 30-755

364 Your services are prorated in the amount of ###.# *(MN05)* authorized hours ##/##/## *(MN02)* through ##/##/## *(MN03)*. Beginning the next month you are authorized to receive the services listed above. MPP 30-759.4 and .5

365 Your services are prorated in the amount of ###.# *(M5)* authorized hours ##/##/## *(M2)* through ##/##/## *(M3)*. MPP 30-759.4 and 5

366 Due to a mid-month reassessment, your total services for ##/## *(ZZ3)* are prorated in the amount of ###.# *(N5)* authorized hours. Beginning the next month you are authorized to receive the service hours listed above. MPP 30-759.4 and .5

368 You have refused your service need for _____, _____,_____, _____. MPP 30-761.2

369 You have refused some help in _____, _____, _____. MPP 30-761.2

Income, Resources, Other Eligibility Factors

370 Your services assessment included consideration of Alternative Resources for _____, _____, _____. MPP 30-763.6

371 Alternative Resources available to you for _____, ____, ____, have been reduced. MPP 30-763.6

372 No change. MPP 30-761.21

373 Your share of cost of $ #####.## *(K3)* exceeds the assessed IHSS – Residual cost of ####.# *(aa6)* hours X $ ###.## *(L1&L2)* per hour which equals $ #####.##. W&IC 12304.5, MPP 30-753(b)(2), MPP 30-764.12 and MPP 30-775

374 Alternative Resources available to you for ____, ____, ____, have been increased. MPP 30-763.6

375 You have been found in need of additional hours of service. MPP 30-763.1

376 Your In-Home Service hours have been reduced. MPP 30-763

377 All of your In-Home Service needs are met by alternative resources available to you for ____, ____, ____. MPP 30-763.6

379 Your share of cost of $ ####.## *(K3)* exceeds the assessed IHSS - Residual cost of ####.# hours X $###.## per hour plus the restaurant meal allowance of $ ### which equals $ #####.##. W&IC 12304.5, MPP 30-753(b)(2), MPP 30-764.12, MPP 30-755 and MPP 30-757.134

State Maximums

386 The statutory maximum number of hours of ###.## decreases the number of your authorized hours to ###.##. Therefore, you have an Unmet Need of ###.## service hours. W&IC 12303.4

387 The statutory maximum number of In-Home Service hours is ###.##. Therefore, you have an Unmet Need of ###.## service hours. W&IC 12303.4

Worker Generated Messages

The following NOA messages must be generated by a worker since all of the data is not on a data entry form.

Recipient Request

400 You have requested withdrawal of your application for service. MPP 30-009.213
NOTE TO WORKER: *When using this code, enter status D in Field F1 to clear the recipient file. The code will override denial/termination messages.*

401 You have requested a reduction of service hours. MPP 30-009.213

402 You have requested a change from arrears to advance payment to pay your own provider. MPP-30-769.731

403 You have requested a change from advance to arrears payment. MPP 30-769.731

404 Your services were erroneously discontinued and have been restored. *(No new application date is required.)* MPP 30-755.1

405 Your authorization for all services is time limited and will end on ##/##/##. MPP 30-759.5

406 Emergency services above are authorized subject to a complete needs assessment. MPP 30-759.8

407 You have requested termination of all service hours. MPP 30-009.213

408 Your request for services was erroneously denied and In-Home Services have been approved. *(No new application date is required.)* MPP 30-755.1

409 Because you have elected to terminate your participation in the In-Home Supportive Services Plus Waiver Program, your In-Home Services will be terminated effective MMDDYYYY.

Electronic Funds Transfer

415 Your application for Direct Deposit by Electronic Funds Transfer of your advance payment has been denied because you have not been a recipient of IHSS for at least one year and/or you are not eligible for advance pay. W&IC 12304.3

Residence

421 You are residing in a community care facility. MPP 30-701

422 You are residing in the home of relatives and receiving a board and care payment. MPP 30-701 and MPP 46-140.11(b)

424 You are an alien not lawfully admitted for permanent residence in the U.S. MPP 30-770.4

425 You do not have California State residence. MPP 30-770.4

426 You have been out of the country for a full calendar month or for 30 days in a row. MPP30-770.46

427 You are not living in your own home. MPP 30-701

428 Whereabouts unknown. MPP 30-755.21

429 You are residing in a hospital. MPP 30-701

430 You are residing in an intermediate care facility. MPP 30-701

431 You are residing in a skilled nursing facility. MPP 30-701

Income, Resources and Other Eligibility Factors

440 You are not 65 or older, blind or so disabled that you cannot be expected to be able to work at any job for the next 12 months. MPP 30-771

442 You have not provided sufficient information to establish eligibility or need for service. MPP 30-760.1

443 You have no assessed need for services and you can remain safely in your own home without services and, if applicable, retain your employment. MPP 30-761

444 To the estate of ########################## *(B1):* We have been notified of the death of ################################ (B2) # (B3) ########################## (B1). MPP 30-763.1
NOTE TO WORKER: This code will suppress all other messages.

445 The In-Home Supportive Services Program has been notified that you are not eligible for federally-funded Medi-Cal.

State Hearings

461 To comply with a recent State Hearing order. *(No new application date is required.)* MPP 22-027

462 You have been authorized additional In-Home Services and you have conditionally withdrawn a request for State Hearing. MPP 22-054

463 You have requested a State Hearing prior to the date a decrease of services was to be effective. MPP 22 022.5

464 You have requested a State Hearing prior to the date a change in your share of cost was to be effective. MPP 22-022.5

465 You have requested a State Hearing prior to the date a discontinuance of services was to be effective. *(No new application date is required.)* MPP 22-022.5

Leave Codes

470 You are temporarily ineligible for In-Home Services because you are hospitalized. MPP 30-701

471 You are temporarily ineligible for In-Home Services because you are staying in a skilled nursing facility. MPP 30-701

472 You are temporarily ineligible for In-Home Services because you are staying in an intermediate care facility. MPP 30-701

473 You are temporarily ineligible for In-Home Services because you are staying in a community care facility. MPP 30-701

474 You are temporarily suspended from receiving California paid In-Home Services because you have been absent from the State for a period exceeding six months. In-Home Services shall not be resumed until you have returned to California and a reassessment of need has been completed. MPP 30-770.45

477 You are temporarily ineligible for IHSS – Residual because your SOC exceeds assessed needs for IHSS. W&IC 12304.5

Able and Available Spouse

490 Your spouse is able and available to provide domestic, related, heavy cleaning, yard hazard abatement and teaching and demonstration services at no cost to you. MPP 30-763.41

491 Your spouse is able and available to provide domestic services at no cost. MPP 30-763.41

492 Your spouse is able and available to provide related services at no cost. MPP 30-763.41

493 Your spouse is able and available to provide yard hazard abatement services at no cost. MPP 30-763.41

494 Your spouse is able and available to provide teaching and demonstration services at no cost. MPP 30-763.41

495 Your spouse is able and available to provide heavy cleaning services at no cost. MPP 30-763.41

496 Your spouse is able and available to provide partial meal preparation services at no cost. MPP 30-763.41

497 Your spouse is able and available to provide partial transportation services at no cost. MPP 30-763.41

498 Your spouse is able and available to provide partial protective supervision services at no cost. MPP 30-763.41

499 Your spouse is able and available to provide transportation services at no cost. W&IC 12301

500 Your spouse is able and available to provide protective supervision services at no cost. W&IC 12301

Change from Advance to Arrears Payment

510 You are changed from advance to arrears payment because you failed to meet your obligation to submit your providers' timesheets within 90 days of payment. MPP 30-767.133

511 You are changed from advance to arrears payment because you failed to meet your obligation to provide timely payment to your providers. MPP 30-767.133

512 You are changed from advance to arrears payment because you failed to meet your obligation by using your payment for other than purchase of authorized IHSS. MPP 30-767.133

Restaurant Meal Allowance

520 You are no longer eligible for a restaurant meal allowance because you have no need for meal preparation services. MPP 30-757.134

521 You are no longer eligible for an In-Home Service restaurant meal allowance because you are eligible to receive that allowance from the Social Security Administration. MPP 30-757.134

522 You have requested discontinuance of the restaurant meal allowance. MPP 30-757.134

523 You are not eligible for a restaurant meal allowance in place of meal preparation services because you are not aged or disabled. MPP 30-757.134

Share of Cost

526 Your request for reimbursement of overpaid share of cost for the period MM/YYYY because you were not included in the State's payment of medically recognized expenses for that period is denied. Contact your IHSS Social Worker for additional details.

527 You are being reimbursed $XXXXX.XX of overpaid share of cost for the period of MM/CCYY because you were not included in the State's payment of medically recognized expenses for that period.

528 The change in your IHSS Share-of-Cost shown above is due to the April1, 2005 Cost of Living Adjustments to your SSI/SSP benefit level. If your provider(s) timesheets for services rendered after April1, 2005 were processed or payment was received before ##/##/##, the previous share-of-cost was used and you may be reimbursed for each month affected. If your provider(s) timesheets or payments for services rendered after April1, 2005 are processed after ##/##/##, the updated share-of-cost will be used. If you paid a higher share-of-cost to your provider, for these services, you must arrange to be reimbursed from your provider(s). MPP 30-755.233.

532 Pay your share of cost for IHSS – Residual to your individual provider. MPP 30-755.233

533 Pay your share of cost for IHSS – Residual to the County Welfare Department. MPP 30-755.233

534 Pay your share of cost for IHSS – Residual to the agency who provides your services. MPP 30-755.233

535 You are not eligible to receive IHSS – Residual because you have not paid your obligated share of cost for In-Home Services. MPP Section 30-755.233(a)

536 Pay $_____share of cost to your Individual Provider and pay $_____share of cost to the county social services department. MPP Section 30-755.233(b)(2)

537 Pay $_____share of cost to your contract provider and pay $_____share of cost to your county social services department. MPP Section 30-755.233(b)(2)

538 Pay $_____share of cost to your Individual Provider and pay $_____share of cost to your contract provider. MPP Section 30-755.233(b)(2)

539 You are not eligible to receive IHSS – Residual because you stated you will not pay your share of cost for In-Home Services. MPP Section 30-755.233(d)

Time for Task

540 As a result of reassessment of your need for In-Home Services of laundry, food shopping, and other shopping/errands, the changes shown above have been made in your authorization for In-Home Services in accordance with statewide standards. MPP 30-758

Mode of Service Delivery

550 You will be contacted by our contract service agency to schedule the days that services will be provided. MPP 30-767.1

554 Please contact your County Social Worker when you select an individual provider. MPP 30-767.1

555 You will be contacted by a county welfare employee to schedule the days that service will be provided. MPP 30-767.1

Income Eligible to PCSP

561 The recipient, spouse, or recipient's parents may be able to request reimbursement for Medi-Cal services, including PCSP services that were provided and paid for within three months before application for PCSP on _____. This reimbursement is a Medi-Cal decision

Teaching and Demonstration

580 MPP 30-757.18 You will receive the following teaching and demonstration services. These services are limited to no more than three months: _____, _____, _____, _____.

Recipient Request

581 MPP 30-761 You can remain safely in your own home without additional services although you have requested additional service hours for: _____, _____, _____, _____

582 MPP 22-028 To comply with a recent State Hearing order you will be in receipt of a one time payment for the period of _____ to _____ for underassessed hours of the following services: