DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, California 95814

January 3, 2001

REASON FOR THIS TRANSMITTAL

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

ALL-COUNTY INFORMATION NOTICE NO. I-01-01

TO: ALL COUNTY WELFARE OFFICES
ALL COUNTY REGIONAL CENTER'S AND FIELD OFFICES
INDEPENDENT LIVING CENTERS
ALL AREA BOARDS
LEGAL AID PROGRAMS
REGIONAL CENTERS
LABOR UNIONS
PUBLIC AUTHORITIES
CONTRACT PROVIDERS

SUBJECT: TYLER V. ANDERSON POSTER, NOTICE AND CLAIM FORMS

The purpose of this All County Information Notice (ACIN) is to inform counties about their responsibilities in the implementation of the judgment in the Tyler v. Anderson class action lawsuit, and to request that other organizations assist us with implementing the judgment. This lawsuit is a result of the California Department of Social Services (CDSS) denying range of motion (ROM) exercises as a paramedical service to In-Home Supportive Services (IHSS) recipients. The members of the class include recipients, applicants, and providers of IHSS who were denied payment for ROM exercises from June 17, 1990 through March 31, 1994 (except in Amador, Calaveras, Fresno, Los Angeles, San Bernardino and Tehama counties because they continued to provide ROM services). Under the terms of the judgment, class members must be notified and given a six-month time frame to file a claim. The time period to file a claim is February 1, 2001 through July 31, 2001.

In order to comply with the judgment, all county welfare offices are required to do the following:

1. Display the poster in a prominent location in every office having contact with the public for the six-month period beginning February 1, 2001 through July 31, 2001.

2. Give a Tyler notice and Tyler claim form to anyone asking about the case.

All other organizations listed above are requested to display the posters in prominent locations for the six-month period beginning February 1, 2001 through July 31, 2001 and hand out claim forms when requested. We have attached a copy of the Tyler v. Anderson judgment for your information.

Also attached are copies of the Poster(s), Notice(s) and Claim Forms to be posted and distributed for the Tyler v. Anderson lawsuit. If additional copies are needed, camera ready copies of the Notice and Claim Forms in both English and Spanish are being sent with this letter. Another source for accessing these forms is through the CDSS website: www.dss.cahwnet.gov/getinfo/default.htm.

If prospective claimants need more information or need claim forms in Cambodian, Chinese, Russian or Vietnamese, please direct them to the Tyler information toll free number 1-877-508-1327.

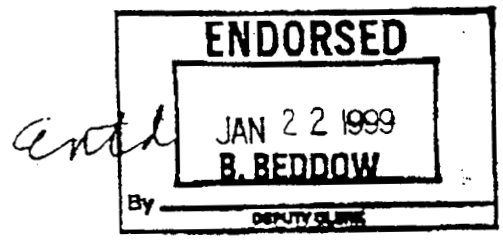
If you need further clarification on the judgment or more information regarding the contents of this notice, please contact Patricia Johnston, Chief of Adult Programs Management Bureau at (916) 229-4000 or Dreama Larish, Analyst at (916) 229-0336.

Sincerely,

Original Signed By
Donna L. Mandelstam on 1/3/01

DONNA L. MANDELSTAM
Deputy Director
Disability and Adult Programs Division

Attachments



SUPERIOR COURT OF CALIFORNIA

SACRAMENTO COUNTY

KATHRYN E. TYLER, GARY TYLER, JACK D. TYLER, a minor, and MATHEW L. TYLER, a minor, both minors by their parents and guardians ad litem, KATHRYN E. TYLER and JACK TYLER, individually and on behalf of other similarly situated, Plaintiffs-Petitioners, v. ELOISE ANDERSON, Director, State Department of Social Services, and STATE DEPARTMENT OF SOCIAL SERVICES, Defendants-Respondents.	CASE NO. 376230 JUDGMENT

The parties' Joint Motion To Approve Class Action Settlement And Entry Of Judgment was heard on January 22, 1999 at 1:30 p.m. in Department 33, Judge Lloyd G. Connelly, Judge presiding. Charles Wolfinger appeared for plaintiffs, and Mateo Munoz, Deputy Attorney General, appeared for defendants.

This court, having considered the pleadings and papers on file herein and the argument of counsel,

HEREBY ORDERS, ADJUDGES AND DECREES:

I. DECLARATORY JUDGMENT

This court makes the following declaration of the parties' rights and duties under Code of Civil Procedure section 1060:

A. Defendants' Violations Of State Laws

Defendants violated the rights of plaintiffs and the certified class defined as ". . .all applicants for or recipients of In-Home Supportive Services and their providers, who since June 17, 1990, have been denied range of motion exercises under the IHSS program solely because of defendants' policy prohibiting them as a paramedical service under Welfare and Institutions Code section 12300.1, before it was amended by Assembly Bill 1773, Stats.1992, c.939" (Order. . . Granting Plaintiffs' Motion For Class Certification, filed May 23, 1994) (collectively "certified class") as follows. Defendants' enforcement of their official policy prohibiting range of motion exercises as a paramedical service under the In-Home Supportive Services Program (IHSS) from about 1990 to 1993 (ROM prohibition policy) violated Welfare and Institutions Code section 12300.1 (before it was amended by Assembly Bill 1773, Stats.1992, c.939), because that section gave defendants no discretion to prohibit range of motion exercises when ordered by a licensed health care professional.

B. Defendants' Duty To Pay Retroactive Benefits

1. As a result of the violations of state laws, defendants have a duty to pay plaintiffs and the class retroactive benefits as follows:

a. all IHSS compensation for range of motion exercises provided that was denied pursuant to their ROM prohibition policy from June 17, 1990 through March 31, 1994;

b. prejudgment interest at the legal rate of 7% on the amount of benefits from the date of the first payment was originally owed but for defendants' ROM prohibition policy to the date of this judgment; and

c. postjudgment interest at the legal rate of 7% on the amount of benefits from the date of this judgment until paid.

2. Eligibility conditions for retroactive benefits:

A class member is eligible for retroactive benefits based on the ROM prohibition policy based on all the following:

a. At any time from June 17, 1990 through March 31, 1994, a doctor prescribed range of motion exercises for an IHSS recipient or applicant, and

b. At any time from June 17, 1990 through March 31, 1994, a provider performed range of motion exercises prescribed for an IHSS recipient or applicant and was not paid therefor.

II. WRIT OF MANDATE TO PAY RETROACTIVE BENEFITS

Let a writ of mandate issue pursuant to Code of Civil Procedure section 1085 on behalf of plaintiffs and the certified class, commanding defendant Anderson, her successors in office, defendant State Department of Social Services (DSS), its officers, employees, agents, representatives, and all other persons acting in their behalf or subject to their control or supervision (collectively "defendants") , including their

statutory agents, the board of supervisions of each county of California and the directors of each county welfare department to (collectively "county") to comply with their mandatory duties as follows:

A. Develop An Explanatory Notice And A Claim Form

1. Develop an explanatory notice about the right to claim retroactive benefits (notice) and a provider/recipient claim form (claim form), which are written in plain language in English and Spanish.

2. Develop a poster size notice not less than 17" x 22" in size (public notice), with the contents of the notice and in a format that attracts attention when posted in a public space.

B. Identify Class Members

1. Identify IHSS recipient class members and their providers and their last known addresses:

a. Identify all IHSS recipients and providers from June 17, 1990 through March 31, 1994 in all counties except in Los Angeles, Fresno, San Bernardino, Amador, Tehama and Calavares Counties.

b. Determine the current mailing address from the IHSS payrolling system for all members currently receiving IHSS.

c. Determine any updated mailing address for those recipients and providers not in the current IHSS payrolling system, by using Medi-Cal records or if unavailable, by using the address matching services of the Franchise Tax Board.

d. Obtain a list of all persons and their updated addresses whose notices are returned in order to allow review by defendants and class counsel.

2. Identify IHSS applicant class members and their providers:

a. Develop a list of all county welfare offices and organizations and agencies designated by plaintiffs including regional centers, independent living centers, areas boards, and legal aid programs for mailing poster notices and regular notices and claim forms.

C. Notify Class Members About Retroactive Benefits

1. Mail notices and claim forms and the public notices to all persons and others identified in paragraph II.B above.

2. Mail sufficient numbers of public notices, plus a copy of the notice and claim form to:

a. Each county welfare department with instructions to display the posters in prominent locations in every office having contact with the public for six (6) month period beginning with the effective date of the claim period as contained in the regulations.

b. All organizations and groups on a list supplied by plaintiffs' counsel with a letter request to display the posters in a prominent location for six (6) month period beginning with the effective date of the claim period as contained in the regulations, and with camera ready copies of the notice of rights and claim form.

3. Mail all notices in the week before the start of the claiming period.

4. Returned notices will be retained for review by defendants and class counsel for 60 days after the close of the claim period.

D. Determine Eligibility For Retroactive Benefits

1. Defendants have the discretion and reserve the right to process claims centrally or in affected individual counties using county staff.

2. The claim period shall be six calendar months beginning in the month after the effective date of the regulations implementing this judgment under paragraph III.A.

3. Proof of eligibility conditions:

a. A doctor's statement that an IHSS recipient or applicant was prescribed range of motion exercises and the hours of such exercises prescribed monthly during the relevant time period. The doctor signing the statement need not be the doctor prescribing the range of motion exercises, but must base the statement on the medical records of the recipient or applicant.

b. A recipient, applicant or provider's statement, signed under penalty of perjury, that range of motion exercises were provided during the relevant time period and the hours provided monthly.

c. An IHSS applicant must also submit proof of meeting all other categorical and financial eligibility conditions for the receipt of IHSS during the relevant period and

a statement indicating filing an application for IHSS benefits during the relevant period.

4. Computation of amount of retroactive benefits

a. The amount of hours authorized for ROM each month multiplied by the county's applicable individual provider hourly wage during each month for which benefits are claimed.

b. The amount of hours for range of motion retroactive benefits may not exceed the applicable statutory grant maximum. The applicable statutory grant maximum shall be based on the additional monthly hours of range of motion exercises allowed during each month of the retroactive period.

c. A share of cost will be calculated for applicants utilizing the current SSI/SSP payment standards in computing the amount of retroactive benefits due.

5. As appropriate, issue regulations and other implementation plans (e.g., CMIPS instructions, automated notice of action messages) concerning claim processing, which must include:

a. Limit eligibility information for retroactive benefits from class members to the claim form.

b. Use existing case files to establish all IHSS status and income eligibility conditions.

c. Provide adverse information in notice of action with an opportunity to submit additional information.

E. <u>Issue Notice Of Action</u>

Issue and mail a Notice of Action on each claim as follows:

1. Within sixty (60) days after receiving the claim form.

2. For every month retroactive benefits are claimed:

a. the computation of the amount due and prejudgment and postjudgment interest; or

b. reasons and facts why no amount is due or less due than claimed, including a statement of what additional information is needed or adverse information, and that the claimant must provide it within forty-five (45) days from the date of the Notice of Action.

3. The total retroactive benefits and prejudgment and postjudgment interest.

4. A statement about the taxability of wages, withholding taxes, and deeming for SSI recipients whose providers are currently spouses or parents of minor children recipients.

5. A statement about the right to a state hearing and the procedures for obtaining one.

F. Issue Payment

1. Mail payment on or before the 10th of the month or hold them for mailing on or before the 10th of the following month.

2. Except as extended by subparagraph II.F.1, mail payment within 30 days after the date of a notice of action for payment is mailed to the claimant.

III. WRIT OF MANDATE ON COMPLIANCE AND OTHER ISSUES

Let a writ of mandate issue pursuant to Code of Civil Procedure section 1085 on behalf of plaintiffs and the certified class and commanding defendants to take the following actions:

A. Issue Regulations

1. Develop regulations, notices, claim forms and other implementation procedures in consultation with class counsel.

2. Provide plaintiffs' counsel with the defendants' final text of proposed regulations, notice, claim forms and public notice no later than 45 days before filing the regulations with the Office of Administrative Law.

3. DSS shall use its best efforts to issue emergency regulations to implement this judgment.

B. Issue Reports

Send class counsel the following:

1. Bimonthly status report on all actions taken on the judgment and include basic implementation records, including contracts with all agencies. The first status report is due monthly.

2. Identification: number of recipient and provider class members identified from IHSS payrolling system; number with current addresses; number updated through Medi-Cal; number updated through Franchise Tax Board. The report is due one month after the date of mailing the notices.

3. Monthly claim reports by county with the number of claims received, approved, denied, pending, and amount of wages and interest paid, and number of claims sent to individual class

members and date(s) of mailing; number returned undelivered for those with mailing addresses from IHSS payrolling system, Medi-Cal, and Franchise Tax Board. The first report is due by the 10th of the second month of the claiming period.

4. Returned notices: The parties will explore the feasibility of remailing returned notices.

5. Defendants' obligation to issue reports shall terminate at the point there are no pending claims, including fair hearings.

C. Produce Implementation Records

1. On request and within a reasonable period of time, allow plaintiffs and their counsel or agents to inspect any and all records used by defendants in implementing this judgment.

2. Without request and monthly, send plaintiffs' counsel all fair hearing decisions and related agency position statements.

D. Extend Time For Claiming Attorney Fees And Costs

Plaintiff may file any motion for attorney fees and costs for work up to and including the date of the judgment within ninety days of the date of this judgment, and this judgment modifies and extends any and all statutory time limits for filing cost memoranda and fee motions, including under Code Civil Procedure section 1033 and California Rules of Court 870(b)(3) and 870.1(b).

E. Retain Jurisdiction

As provided for by current California law, the court retains jurisdiction over this case to insure compliance with the judgment and to make such further orders thereon.

Dated: JAN 22 1999

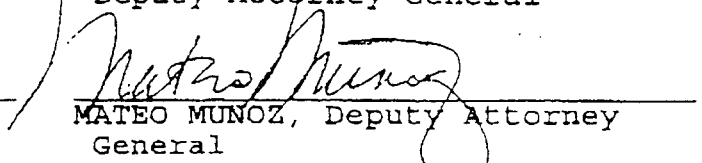
LLOYD G. CONNELLY
JUDGE OF THE SUPERIOR COURT

Approved as to form
and content

CHARLES WOLFINGER
Attorney for Plaintiffs

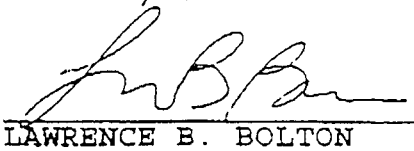
Dated: 1/7/99

BILL LOCKYER, Attorney General, State of California
FRANK S. FURTEK, Supervising Deputy Attorney General



MATEO MUNOZ, Deputy Attorney General
Attorneys for Defendants

Dated: 1/8/99



LAWRENCE B. BOLTON
Deputy Director, Legal Division
California Statre Department of Social Services

Dated: 1/8/99

tyljud3

TYLER NOTICE

THE IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM MAY OWE YOU MONEY

The State of California did not pay for “Range of Motion” services for the aged, blind or disabled people in the IHSS Program from June 17, 1990 through March 31, 1994. A Court ordered us to pay certain persons in a lawsuit called Tyler v. Anderson.

ARE YOU ELIGIBLE TO GET PAID?

At any time between June 17, 1990 and March 31, 1994:

(1) A doctor or chiropractor prescribed range of motion exercises for an IHSS recipient or an IHSS applicant.
(2) Someone gave range of motion exercises to the IHSS recipient or IHSS applicant at home.
(3) IHSS did not pay anyone for the range of motion exercises.
(4) You are the provider/worker/homemaker who did not get paid.

OR

You are the IHSS recipient/client who paid your provider but did not get paid by IHSS or any other program.

OR

You are the IHSS applicant who paid your provider but did not get paid by IHSS or any other program.

HOW CAN YOU GET PAID?

You must fill out the Tyler Claim Form that comes with this notice.

You must mail the Tyler Claim Form on or before July 31, 2001 to:

California Department of Social Services
Tyler Claim
744 P Street, M.S. 19-04
Sacramento, California 95814

Your claim must be postmarked no later than July 31, 2001 or it will be denied as late.

At no cost to you, you can get help, a Tyler Claim Form or more information by calling our toll-free number at 1-877-508-1327. You can also get help or a Tyler Claim Form by calling your county IHSS office.

DEADLINE FOR MAILING WITH POSTMARK: JULY 31, 2001

បើសិនជាលោកអ្នកមិនអាចអានសំណៅនេះបានទេ សូមទូរស័ព្ទទៅលេខឥតបង់ប្រាក់សំរាប់សេចក្តីបកប្រែ ។
Cambodian

如果您不能夠閱讀這份表格，請打免費電話索取翻譯本。
Chinese

Если вы не можете прочесть/понять эту форму, пожалуйста, позвоните по бесплатному номеру телефона, указанному выше.
Russian

Nếu quý vị không đọc hiểu nội dung thông báo này, xin gọi số điện thoại miễn phí bên trên để xin một bản dịch.
Vietnamese

TYLER CLAIM FORM

The claimant must file this form. The claimant is the provider not paid for range of motion exercises, or the In-Home Supportive Services (IHSS) recipient or applicant who paid the provider for the range of motion but was not paid by In Home Supportive Services or any other program.

A CLAIMANT can be any one of the following:

RECIPIENT/CLIENT: An aged, blind or disabled person who received IHSS at any time between June 17, 1990 and March 31, 1994.

PROVIDER/WORKER/HOMEMAKER: A person who provided services to an IHSS Recipient or Applicant at any time between June 17, 1990 and March 31, 1994.

APPLICANT: An aged, blind or disabled person who applied for IHSS and was denied receipt of IHSS at any time between June 17, 1990 and March 31, 1994.

INSTRUCTIONS TO THE CLAIMANT FOR COMPLETING THIS FORM:

1) Parts A – F: Fill out completely. Please Print. Sign your name in Part F.
2) Part G: Get person who received range of motion (In-Home Supportive Services (IHSS) recipient or applicant) to sign the release of medical information to the doctor or chiropractor filling out Part H.
3) Part H: Get the doctor or chiropractor, who prescribed range of motion or has person's medical records, to fill out and sign Part H.
4) Completed Parts A – H: Mail this entire form no later than July 31, 2001 to the address below.
   Please do not separate.

CDSS – Tyler Claim
744 P Street, Mail Station 19-04
Sacramento, California 95814-5512

You can get help or more information from us by calling our toll free number at 1-877-508-1327. You can also get help by calling your county IHSS office.

Your claim must be postmarked no later than July 31, 2001 or it will be denied as late.

DEADLINE FOR MAILING WITH POSTMARK JULY 31, 2001

បើសិនជាលោកអ្នកមិនអាចអានសំណៅនេះបានទេ សូមទូរស័ព្ទទៅលេខឥតបង់ប្រាក់សំរាប់សេចក្តីបកប្រែ ។
Cambodian

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Если вы не можете прочесть/понять эту форму, пожалуйста, позвоните по бесплатному номеру телефона, указанному выше.
Russian

Nếu quý vị không đọc hiểu nội dung thông báo này, xin gọi số điện thoại miễn phí bên trên để xin một bản dịch.
Vietnamese

PART A: CLAIMANT SEEKING PAYMENT

NAME (LAST, FIRST MI)	SOCIAL SECURITY NUMBER	BIRTHDATE (XX/XX/XXXX)

1. Are you the Recipient, Applicant or Provider Claimant? (Please check the one that applies to you, see the definition of each on the first page)

   ☐ RECIPIENT ☐ APPLICANT ☐ PROVIDER

PART B: IHSS RECIPIENT OR APPLICANT WHO RECEIVED RANGE OF MOTION EXERCISES

THIS PERSON RECEIVED RANGE OF MOTION EXERCISES:

NAME (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER	BIRTHDATE (XX/XX/XXXX)

CURRENT ADDRESS (N UMBER, STREET, APARTMENT/SPACE NUMBER)	TELEPHONE NUMBER
	( )

CITY	COUNTY	STATE	ZIP CODE

COMPLETE QUESTIONS 1-3 BELOW ONLY IF THIS PERSON WAS THE IHSS APPLICANT WHO WAS DENIED IHSS SERVICES:

1. When was the applicant denied IHSS? (month/year) _____/_____

2. What county denied the application? _____

3. Did you receive Supplemental Security Income/State Supplementary Payment income at any time during June 1990 – March 1994?

   ☐ YES ☐ NO

   If yes, check each year that the applicant got Supplemental Security Income/State Supplementary Payment income

   ☐ 1990 ☐ 1991 ☐ 1992 ☐ 1993 ☐ 1994

PART C: IHSS PROVIDER OF RANGE OF MOTION EXERCISES

THIS PERSON PROVIDED THE RANGE OF MOTION EXERCISES TO THE IHSS RECIPIENT OR APPLICANT NAMED IN PART B .

NAME (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER	BIRTHDATE (XX/XX/XXXX)

CURRENT ADDRESS (N UMBER, STREET, APARTMENT/SPACE NUMBER)	TELEPHONE NUMBER
	( )

CITY	COUNTY	STATE	ZIP CODE

PART D: HOURS OF RANGE OF MOTION EXERCISES PROVIDED

List the number of hours that range of motion exercises were provided to the IHSS recipient or applicant for each month between June 17, 1990 and March 31, 1994, for which you want to be paid:

1990	
MONTH	HOURS
JUNE 17TH - 30TH	
JULY	
AUGUST	
SEPTEMBER	
OCTOBER	
NOVEMBER	
DECEMBER	

1991	
MONTH	HOURS
JANUARY	
FEBRUARY	
MARCH	
APRIL	
MAY	
JUNE	
JULY	
AUGUST	
SEPTEMBER	
OCTOBER	
NOVEMBER	
DECEMBER	

1992	
MONTH	HOURS
JANUARY	
FEBRUARY	
MARCH	
APRIL	
MAY	
JUNE	
JULY	
AUGUST	
SEPTEMBER	
OCTOBER	
NOVEMBER	
DECEMBER	

1993	
MONTH	HOURS
JANUARY	
FEBRUARY	
MARCH	
APRIL	
MAY	
JUNE	
JULY	

1993	
MONTH	HOURS
AUGUST	
SEPTEMBER	
OCTOBER	
NOVEMBER	
DECEMBER	

1994	
MONTH	HOURS
JANUARY	
FEBRUARY	
MARCH	

In what county(s) did you receive or provide the range of motion exercises? _____

PART E: PAYMENT CLAIMED

Answer only one of these questions:

1. ***If you are the Provider - Claimant:*** Were you paid for providing the hours of range of motion exercises listed above? ☐ YES ☐ NO

2. ***If you are the Recipient or Applicant - Claimant:*** Did you pay your provider for providing range of motion exercises and have not been paid by IHSS or any other program? ☐ YES ☐ NO

PART F: CLAIMANT'S DECLARATION UNDER PENALTY OF PERJURY

As the Claimant for Tyler v. Anderson I understand that the information provided on this Claim Form is subject to verification and that my signature on this form is an authorization for such investigation.

I, the undersigned, declare under penalty of perjury that the above statements are true and correct.

SIGNATURE OF PERSON FILING CLAIM OR PARENT OR GUARDIAN OF CLAIMANT	DATE

PART G: AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION BY THE IHSS RECIPIENT OR APPLICANT

_____ received the range of motion exercises listed in Part D.
(Name of person in Part B)

I or my authorized agent allow the doctor or chiropractor filling out Part H to release any medical information in my file relating to my need for range of motion exercises to the California Department of Social Services.

PATIENT SIGNATURE OR AUTHORIZED REPRESENTATIVE	DATE

PRINT RELATIONSHIP IF NOT IHSS RECIPIENT OR PROVIDER

PART H: DOCTOR OR CHIROPRACTOR CERTIFICATION

Dear Doctor or Chiropractor:

This claim is for payment for providing range of motion exercises to the IHSS recipient or applicant (patient listed above) at any time between June 17, 1990 and March 31, 1994 (claim period). A court has ordered us to make the payments to eligible claimants.

One condition for payment is that a doctor or chiropractor must have prescribed the range of motion exercises or must state, based on a review of the patient's medical records that the patient was prescribed range of motion exercises.

Please review your records. If your records show that the patient was prescribed range of motion exercises at any time during the claim period, please fill out part H and sign at the end. The claimant may not be paid without this information. Thank you for your help.

DOCTOR IDENTIFICATION

NAME (LAST, FIRST, MI)	LICENSE NUMBER	SPECIALITY

BUSINESS ADDRESS	TELEPHONE NUMBER
	( )

CITY	STATE	ZIP CODE

PRESCRIPTION FOR RANGE OF MOTION EXERCISES

1. At any time during the claim period did you prescribe range of motion exercises for the patient?
   ☐ YES ☐ NO

2. Based on your review of the patient's medical file, was the patient prescribed range of motion exercises during the claim period?
   ☐ YES ☐ NO

AMOUNT OF HOURS PRESCRIBED

How much range of motion exercise was prescribed during any of the following months?

		1990
Month	Minutes	Time per Week
JUNE 17TH 30TH		
JULY		
AUGUST		
SEPTEMBER		
OCTOBER		
NOVEMBER		
DECEMBER		

		1991
Month	Minutes	Time per Week
JANUARY		
FEBRUARY		
MARCH		
APRIL		
MAY		
JUNE		
JULY		
AUGUST		
SEPTEMBER		
OCTOBER		
NOVEMBER		
DECEMBER		

		1992
Month	Minutes	Time per Week
JANUARY		
FEBRUARY		
MARCH		
APRIL		

		1992
Month	Minutes	Time per Week
MAY		
JUNE		
JULY		
AUGUST		
SEPTEMBER		
OCTOBER		
NOVEMBER		
DECEMBER		

		1993
Month	Minutes	Time per Week
JANUARY		
FEBRUARY		
MARCH		
APRIL		
MAY		
JUNE		
JULY		
AUGUST		
SEPTEMBER		
OCTOBER		
NOVEMBER		
DECEMBER		

		1994
Month	Minutes	Time per Week
JANUARY		
FEBRUARY		
MARCH		

Additional Comments/Considerations: _____

_____

_____

CERTIFICATION

I certify that I am licensed to practice in the State of California and that prescribing range of motion exercises falls within the scope of my practice and license. In my judgment range of motion exercises was necessary to maintain the patient's health and could be performed by the patient for himself or herself but for his or her functional impairment.

I, the undersigned, declare under penalty of perjury that the above statements are true and correct.

DOCTOR SIGNATURE	DATE

NOTIFICACION TYLER

ES POSIBLE QUE EL PROGRAMA DE SERVICIOS DE CASA Y CUIDADO PERSONAL (IHSS) LE DEBA DINERO

El Estado de California no pagó por servicios relacionados al "arco de movimiento" para las personas ancianas, ciegas, o discapacitadas en el programa de IHSS entre el 17 de junio de 1990 y el 31 de marzo de 1994. La corte nos ordenó que pagáramos a ciertas personas en una demanda llamada Tyler v. Anderson.

¿REUNE USTED LOS REQUISITOS PARA RECIBIR UN PAGO?

En cualquier momento entre el 17 de junio de 1990 y el 31 de marzo de 1994:

(1) Un doctor o quiropráctico recetó ejercicios para el arco de movimiento a un beneficiario de IHSS o un solicitante de IHSS.
(2) Alguien proporcionó ejercicios para el arco de movimiento al beneficiario de IHSS o al solicitante de IHSS en su hogar.
(3) El programa de IHSS no le pagó a nadie por los ejercicios para el arco de movimiento.
(4) Usted es el proveedor que no fue pagado;

o,

Usted es el beneficiario/cliente que le pagó a su proveedor pero no fue reembolsado ni por IHSS ni por ningún otro programa;

o,

Usted es el solicitante que le pagó a su proveedor pero no fue reembolsado ni por IHSS ni por ningún otro programa.

¿COMO PUEDE RECIBIR SU PAGO?

Tiene que llenar el formulario de reclamación Tyler que viene con esta notificación.

Tiene que enviar el formulario de reclamación Tyler a más tardar para el 31 de julio de 2001 al:

California Department of Social Services
Tyler Claim
744 P Street, M.S. 19-04
Sacramento, California 95814

Su reclamo se tiene que marcar con matasellos a más tardar para el 31 de julio de 2001, o se lo negará por tardanza.

Sin costo a usted, puede obtener ayuda, un formulario de reclamación Tyler o mayor información llamando nuestro número gratuito al 1-877-508-1327. Tambien puede obtener ayuda o un formulario de reclamación Tyler al llamar a su oficina IHSS del condado.

FECHA LIMITE PARA EL MATASELLOS ES EL 31 DE JULIO DE 2001

FORMULARIO DE RECLAMACION TYLER

El reclamante tiene que presentar este formulario. El reclamante puede ser el proveedor que no fue pagado por ejercicios para el arco de movimiento, o puede ser el beneficiario o solicitante de Servicios de Casa y Cuidado Personal (IHSS) que le pagó al proveedor por los ejercicios, pero no fue reembolsado ni por IHSS ni por ningún otro programa.

Un RECLAMANTE puede ser cualquiera de las siguientes personas:

BENEFICIARIO/CLIENTE: Una persona de edad avanzada, ciega o discapacitada que recibió IHSS en cualquier momento entre el 17 de junio de 1990 y el 31 de marzo de 1994.

PROVEEDOR: Una persona que proporcionó servicios a un beneficiario o solicitante en cualquier momento entre el 17 de junio de 1990 y el 31 de marzo de 1994 .

SOLICITANTE: Una persona de edad avanzada, ciega o discapacitada que solicitó IHSS y fue negada en cualquier momento entre el 17 de junio de 1990 y el 31 de marzo de 1994.

INSTRUCCIONES AL RECLAMANTE PARA LLENAR ESTE FORMULARIO:

1) Partes A – F: Llene completamente el formulario. Favor de usar letra de molde. Firme su nombre en la parte F.
2) Parte G: Haga que la persona que recibió los ejercicios para el arco de movimiento (el beneficiario o solicitante de IHSS) firme la autorización para que el doctor o quiropráctico que llene la parte H comparta su información médica con el Estado.
3) Parte H: Haga que el doctor o quiropráctico que recetó los ejercicios para el arco de movimiento, o que tiene los archivos médicos de la persona, llene y firme la parte H.
4) Partes completadas A – H: Mande este formulario entero a más tardar para el 31 de julio de 2001 a la siguiente dirección.
Favor de no separar las hojas.

CDSS – Tyler Claim
744 P Street, Mail Station 19-04
Sacramento, California 95814-5512

Puede obtener ayuda o más información llamando a nuestro número gratuito al 1-877-508-1327. También puede obtener ayuda llamando a su oficina local de IHSS.

Su reclamo se tiene que marcar con matasellos a más tardar el 31 de julio de 2001, o se lo negará por tardanza.

FECHA LIMITE PARA LA FECHA POSTAL ES EL 31 DE JULIO DE 2001

PARTE A: RECLAMANTE QUE SOLICITA EL PAGO

NOMBRE (APELLIDO, NOMBRE, INICIAL DEL NOMBRE QUE USA EN MEDIO)	NUMERO DE SEGURO SOCIAL	FECHA DE NACIMIENTO (MM/DD/AAAA)

1. ¿Qué clase de reclamante es usted: Beneficiario, Solicitante o Proveedor? (Favor de marcar el que pertenece a usted; vea la definición de cada uno en la primera página)

☐ BENEFICIARIO ☐ SOLICITANTE ☐ PROVEEDOR

PARTE B: BENEFICIARIO O SOLICITANTE DE IHSS QUE RECIBIO EJERCICIOS PARA EL ARCO DE MOVIMIENTO

ESTA PERSONA RECIBIO LOS EJERCICIOS PARA EL ARCO DE MOVIMIENTO:

NOMBRE (APELLIDO, NOMBRE, INICIAL DEL NOMBRE QUE USA EN MEDIO)	NUMERO DE SEGURO SOCIAL	FECHA DE NACIMIENTO (MM/DD/AAAA)

DIRECCION ACTUAL (NUMERO, CALLE, NUMERO DE APARTAMENTO O ESPACIO)	NUMERO DE TELEFONO
	( )

CIUDAD	CONDADO	ESTADO	CODIGO POSTAL

COMPLETE LAS PREGUNTAS 1-3 A CONTINUACION SOLAMENTE SI ESTA PERSONA FUE EL SOLICITANTE AL QUE SE LE NEGARON LOS SERVICIOS DE IHSS:

1. ¿Cuándo se le negaron al solicitante los servicios de IHSS? (mes/año) _____/_____

2. ¿Cuál condado negó la solicitud? _____

3. ¿Recibió beneficios de Ingresos Suplementales de Seguridad/Pagos Suplementarios del Estado durante cualquier momento durante junio de 1990 - marzo de 1994?

   ☐ SI ☐ NO

   Si contestó “SI”, marque cada año en que el solicitante recibió beneficios de Ingresos Suplementales de Seguridad/Pagos Suplementarios del Estado

   ☐ 1990 ☐ 1991 ☐ 1992 ☐ 1993 ☐ 1994

PARTE C: PROVEEDOR DE IHSS QUE PROPORCIONO LOS EJERCICIOS PARA EL ARCO DE MOVIMIENTO

ESTA PERSONA PROPORCIONO LOS EJERCICIOS PARA EL ARCO DE MOVIMIENTO AL BENEFICIARIO O SOLICITANTE DE IHSS NOMBRADO EN LA PARTE B.

NOMBRE (APELLIDO, NOMBRE, INICIAL DEL NOMBRE QUE USA EN MEDIO)	NUMERO DE SEGURO SOCIAL	FECHA DE NACIMIENTO (MM/DD/AAAA)

DIRECCION ACTUAL (NUMERO, CALLE, NUMERO DE DEPARTAMENTO O ESPACIO)	NUMERO DE TELEFONO
	( )

CIUDAD	CONDADO	ESTADO	CODIGO POSTAL

PARTE D: HORAS EN QUE SE PROPORCIONARON LOS EJERCICIOS PARA EL ARCO DE MOVIMIENTO

Anote el número de horas en que se proporcionaron los ejercicios para el arco de movimiento al beneficiario o solicitante de IHSS, en cada mes entre el 17 de junio de 1990 y el 31 de marzo de 1994, por las que quiere ser pagado:

1990	
MES	HORAS
JUNIO 17 - 30	
JULIO	
AGOSTO	
SEPTIEMBRE	
OCTUBRE	
NOVIEMBRE	
DICIEMBRE	

1991	
MES	HORAS
ENERO	
FEBRERO	
MARZO	
ABRIL	
MAYO	
JUNIO	
JULIO	
AGOSTO	
SEPTIEMBRE	
OCTUBRE	
NOVIEMBRE	
DICIEMBRE	

1992	
MES	HORAS
ENERO	
FEBRERO	
MARZO	
ABRIL	
MAYO	
JUNIO	
JULIO	
AGOSTO	
SEPTIEMBRE	
OCTUBRE	
NOVIEMBRE	
DICIEMBRE	

1993	
MES	HORAS
ENERO	
FEBRERO	
MARZO	
ABRIL	
MAYO	
JUNIO	
JULIO	

1993	
MES	HORAS
AGOSTO	
SEPTIEMBRE	
OCTUBRE	
NOVIEMBRE	
DICIEMBRE	

1994	
MES	HORAS
ENERO	
FEBRERO	
MARZO	

¿En cuál(es) condado(s) recibió o proporcionó usted los ejercicios para el arco de movimiento?_____

PARTE E: PAGO RECLAMADO

Conteste solamente una de las siguientes preguntas:

1. ***Si usted es el Reclamante - Proveedor:*** ¿Se le pagó a usted para proporcionar las horas de ejercicios para el arco de movimiento indicadas arriba? ☐ SI ☐ NO

2. ***Si usted es el Reclamante - Beneficiario o Solicitante:*** ¿Usted le pagó al proveedor para proporcionar los ejercicios para el arco de movimiento, y no ha sido reembolsado ni por IHSS ni por ningún otro programa? ☐ SI ☐ NO

PARTE F: DECLARACION DEL RECLAMANTE BAJO PENA DE PERJURIO

Como reclamante para Tyler v. Anderson, yo entiendo que la información proporcionada en este formulario de reclamación está sujeta a la verificación y que mi firma en este formulario autoriza tal investigación.

Yo, la persona que firma a continuación, declaro bajo pena de perjurio que las declaraciones anteriores son verdaderas y correctas.

FIRMA DE LA PERSONA QUE PRESENTA EL RECLAMO, O PADRE O TUTOR LEGAL DEL RECLAMANTE	FECHA

PARTE G: AUTORIZACION DEL BENEFICIARIO O SOLICITANTE DE IHSS PARA COMPARTIR INFORMACION MEDICA

_____recibió las horas de ejercicios para el arco de movimiento anotadas en la parte D.
(Nombre de la persona en la parte B)

Yo o mi agente autorizado le permite al doctor que llene la parte H que comparta con el Departamento de Servicios Sociales de California (California Department of Social Services) *cualquier información médica en mi expediente que esté relacionada con mi necesidad de los ejercicios para el arco de movimiento.*

FIRMA DEL PACIENTE O REPRESENTANTE AUTORIZADO	FECHA

ESCRIBA SU RELACION SI NO ES BENEFICIARIO NI PROVEEDOR DE IHSS

PARTE H: CERTIFICACION DEL DOCTOR O QUIROPRACTICO

Estimado Doctor o Quiropráctico:

Este reclamo es para el pago al beneficiario o solicitante de IHSS (el paciente nombrado arriba) para la proporción de ejercicios para el arco de movimiento en cualquier momento entre el 17 de junio de 1990 y el 31 de marzo de 1994 (el período de reclamación). La corte nos ha ordenado que hagamos los pagos a los reclamantes elegibles.

Una condición para que se reciba el pago es que un doctor o quiropráctico tiene que haber recetado los ejercicios para el arco de movimiento, o tiene que declarar, según una revisión del expediente médico del paciente, que al paciente se le recetaron los ejercicios para el arco de movimiento.

Favor de revisar sus expedientes. Si sus expedientes muestran que al paciente se le recetaron los ejercicios para el arco de movimiento en cualquier momento durante el período de reclamación, favor de llenar la parte H y firmar al final. Al reclamante no se le puede pagar sin esta información. Gracias por su ayuda.

IDENTIFICACION DEL DOCTOR/QUIROPRACTICO

NOMBRE (NOMBRE, APELLIDO, INICIAL DEL NOMBRE QUE USA EN MEDIO)	NUMERO DE LICENCIA	ESPECIALIDAD

DIRECCION DE NEGOCIOS	NUMERO DE TELEFONO
	( )

CIUDAD	ESTADO	CODIGO POSTAL

RECETA PARA LOS EJERCICIOS PARA EL ARCO DE MOVIMIENTO

1. En cualquier momento durante el período de reclamación, ¿le recetó usted los ejercicios para el arco de movimiento al paciente?
   ☐ SI ☐ NO

2. Según su revisión del expediente médico del paciente, ¿se le recetaron al paciente los ejercicios para el arco de movimiento durante el período de reclamación?
   ☐ SI ☐ NO

CANTIDAD DE HORAS RECETADAS

¿Cuánto ejercicio para el arco de movimiento fue recetado durante los meses siguientes?

		1990
Mes	Minutos	Total por Semana
JUNIO 17 - 30		
JULIO		
AGOSTO		
SEPTIEMBRE		
OCTUBRE		
NOVIEMBRE		
DICIEMBRE		

		1991
Mes	Minutos	Total por Semana
ENERO		
FEBRERO		
MARZO		
ABRIL		
MAYO		
JUNIO		
JULIO		
AGOSTO		
SEPTIEMBRE		
OCTUBRE		
NOVIEMBRE		
DICIEMBRE		

		1992
Mes	Minutos	Total por Semana
ENERO		
FEBRERO		
MARZO		
ABRIL		

		1992
Mes	Minutos	Total por Semana
MAYO		
JUNIO		
JULIO		
AGOSTO		
SEPTIEMBRE		
OCTUBRE		
NOVIEMBRE		
DICEMBRE		

		1993
Mes	Minutos	Total por Semana
ENERO		
FEBRERO		
MARZO		
ABRIL		
MAYO		
JUNIO		
JULIO		
AGOSTO		
SEPTIEMBRE		
OCTUBRE		
NOVIEMBRE		
DICIEMBRE		

		1994
Mes	Minutos	Total por Semana
ENERO		
FEBRERO		
MARZO		

Comentarios/consideraciones adicionales_____

_____

_____

CERTIFICACION

Yo certifico que tengo licencia para practicar en el Estado de California y que el recetar los ejercicios para el arco de movimiento está dentro de la esfera de mi profesión y licencia. A mi juicio, los ejercicios para el arco de movimiento fueron necesarios para mantener la salud del paciente, y los pudiera hacer el paciente mismo(a) si no fuera por su impedimento funcional.

Yo, la persona que firma a continuación, declaro bajo pena de perjurio que las declaraciones anteriores son correctas y verdaderas.

FIRMA DEL DOCTOR/QUIROPRACTICO	FECHA