

**30-765**                      **COST LIMITATIONS**                      **30-765**

- .1     The following limitations shall apply to all payments made for in-home supportive services:
  - .11    The maximum services authorized per month except as provided in Section 30-765.3, under IHSS to any recipient determined to be severely impaired, as defined in Section 30-753(s)(1) shall be that specified in Welfare and Institutions Code Section 12303.4(b) or as otherwise provided by law.

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- .111    The IHSS service hours for a severely impaired recipient receiving services through the individual provider mode of delivery shall not exceed 283 hours per month effective July 8, 1988. (Welfare and Institutions Code Section 12303.4(b)(1)).
- .112    Repealed by CDSS Manual Letter No. SS-00-02, effective 4/14/00.
- .113    Welfare and Institutions Code Section 12300(g)(2) states:

"Any recipient receiving services under both Section 14132.95 and this article shall receive no more than 283 hours of service per month, combined, and any recipient of services under this article shall receive no more than the applicable maximum specified in Section 12303.4." (See Section 30-765.11.)

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- .12    The maximum services authorized per month except as provided in Section 30-765.3, under non-PCSP to any recipient determined not to be severely impaired shall be that specified in Welfare and Institutions Code Section 12303.4(a) or as otherwise provided by law.

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- .121    The IHSS service hours for a recipient who is not determined to be severely impaired and receives services through the individual provider mode of service delivery shall not exceed 195 hours per month effective July 8, 1988 (Welfare and Institutions Code Section 12303.4(a)(1)).
- .122    Repealed by CDSS Manual Letter No. SS-00-02, effective 4/14/00.

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**30-765 COST LIMITATIONS (Continued)****30-765**

- .13 The statutory maximum service hours per month shall be inclusive of any payment by IHSS for a restaurant meal allowance established in accordance with the Welfare and Institutions Code Section 12303.7.
- .131 The statutory maximum for individuals receiving services through the individual provider mode of service delivery and eligible for the restaurant meal allowance shall be determined by multiplying the statutory maximum hours of service by the county wage rate, subtracting the restaurant meal allowance (see Section 30-757.134(a)(1)(A)) from this product and dividing the remainder by the county hourly wage rate.
- .132 Repealed by CDSS Manual Letter No. SS-00-02, effective 4/14/00.
- .14 The county shall not make monthly payments of IHSS monies to recipients in excess of the computed maximums in Sections 30-765.11, .12 and .13. The sum of the IHSS monthly payment and the recipient's share of cost, if any, shall not exceed the appropriate maximum.
- .2 The statewide wage rate for individual providers shall be determined by the Department. Effective July 8, 1988, the statewide wage rate is \$4.25.

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- .21 DHS regulation Section 51535.2 reads:

Reimbursement Rates for Personal Care Services Program.

- (a) For the individual provider mode for providing personal care services, the reimbursement rate shall be a maximum of \$5.50 per hour of service: provided, however, that the reimbursement rate in each county shall not exceed the rate in each county for the individual provider mode of service in the IHSS program pursuant to Article 7 (commencing with Section 12300) of Part 3 of Division 9 of the Welfare and Institutions Code, as it existed on September 28, 1992.

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- (b) For the contract mode for providing personal care services pursuant to Welfare and Institutions Code Sections 12302 and 12302.1, the reimbursement rates shall be those specified in the contract between the county and the agency contractor not to exceed the following maximum rates for services provided through State fiscal year 1993-1994 as follows:

(1)	Butte	\$ 9.65
(2)	Nevada	\$10.34
(3)	Riverside	\$12.29
(4)	San Diego	\$10.49
(5)	San Francisco	\$12.28
(6)	San Joaquin	\$ 9.50
(7)	San Mateo	\$12.65
(8)	Santa Barbara	\$11.76
(9)	Santa Clara	\$11.11
(10)	Santa Cruz	\$13.61
(11)	Stanislaus	\$10.51
(12)	Tehama	\$11.30
(13)	Ventura	\$11.04

- (c) Nothing in this section is intended to be a limitation on the rights of providers and beneficiaries or on the duties of the Department of Social Services, pursuant to Welfare and Institutions Code Section 12302.2 subdivision (a). Contributions, premiums and taxes paid pursuant to Welfare and Institutions Code Section 12302.2, subdivision (a) shall be in addition to the hourly rates specified in subdivision (a) of this section.

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- .3 IHSS recipients receiving services through the individual provider mode of delivery shall not receive less service hours per month than he/she received during June 1988, without a reassessment of need. The reassessment shall not result in an automatic reduction in authorized hours, unless the recipient no longer needs the hours.
  
- .4 These regulations shall remain in effect until July 1, 1990, unless a later enacted regulation extends or repeals that date.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 12300, 12303.4, and 14132.95, Welfare and Institutions Code.

**30-766 COUNTY PLANS****30-766**

- .1 Each county welfare department shall develop and submit a county plan to CDSS no later than 30 days following receipt of its allocation, which specifies the means by which IHSS will be provided in order to meet the objectives and conditions of the program within its allocation.
  - .11 The plan shall be submitted to CDSS and shall be based upon relevant information, as specified in Welfare and Institutions Code Sections 12301 and 14132.95, including, but not limited to the information specified below:
    - .111 Projected caseload, hours paid, and costs per month/quarter by mode;
    - .112 Modes of IHSS and PCSP service delivery the county intends to use;
    - .113 Estimated program costs for both the IHSS and PCSP programs;
    - .114 Methods the county will utilize to control non-PCSP program costs to comply with required fiscal limitations; and
    - .115 Program design intended to meet PCSP requirements.
  - .12 County plans and amendments shall be effective upon submission.
  - .13 CDSS shall review each county plan for compliance with Welfare and Institutions Code Sections 12300, et seq. and 14132.95, regulations of CDSS and DHS, and when appropriate, issue departmental approval.
    - .131 CDSS, when appropriate, shall adjust funding levels contained in the plan, as a condition of approval.
    - .132 A county plan which includes IHSS administrative costs shall not be issued departmental approval.
    - .133 If, after review, CDSS determines that a county plan is not in compliance, the Department shall require the county to amend its plan.
    - .134 CDSS shall develop a county plan for counties which have not submitted plans within the required time frame, based on CDSS' estimate for those counties. Such plans shall be effective upon written notification to the county.

**30-766 COUNTY PLANS (Continued)****30-766**

- .14 In the event that funds are available for reallocation, special consideration shall be given to those counties which submit their county plans by the due date.
  - .141 CDSS shall be permitted to reallocate funds from counties which are late based on CDSS's estimate for those counties.
- .15 Each county shall monitor its expenditures monthly. Upon discovery by either CDSS or the county that anticipated expenditures will exceed the amount of the county's base allocation, the county shall immediately submit to CDSS for approval an amended plan.
  - .151 Repealed by CDSS Manual Letter No. SS-90-02, effective 10/4/90.
  - .152 Repealed by CDSS Manual Letter No. SS-90-02, effective 10/4/90.
- .16 Counties shall not reduce authorized services or hours of service to recipients in order to remain within their allocation.
- .17 All state-mandated program costs, after the required county contribution, shall be eligible for reimbursement from state social service funds. If appropriated funds are insufficient to reimburse counties for all state-mandated costs, the state shall fully reimburse the counties for all state-mandated program costs, less the required county contribution.
- .18 The portion of county expenditures which, after the county contribution, exceeds the allocation, shall not be eligible for reimbursement from state social service funds if such deficit is caused by:
  - .181 Noncompliance with the requirements of the state-approved county plan or State allocation plan; or
  - .182 Non-state-mandated costs; or
  - .183 IHSS administrative costs.

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- (a) Some examples of situations where reimbursement would not be made are:
- (1) A county chooses to give a wage/benefit increase to IHSS providers which is higher than that provided in the Budget Act; or
  - (2) A county chooses to expand its use of a more expensive service delivery mode beyond the level of caseload and hours growth for each mode that is built into the Budget Act; or
  - (3) A county chooses to enter into a third party contract at an hourly rate higher than the maximum established for that county; or
  - (4) A county chooses to shift to a more expensive mode without providing for noncomitant offsetting savings in other areas, and causing a cost overrun.

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NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; Chapter 939, Statutes of 1992. Reference: Sections 10102, 12301, 12302, 12306, 12308, 13002, and 14132.95, Welfare and Institutions Code; and Chapter 93, Statutes of 1989 (Budget Act of 1989).

<b>30-767</b>	<b>SERVICE DELIVERY METHODS</b>	<b>30-767</b>
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- .1 The county shall arrange for the provision of IHSS through one or more of the methods specified below in accordance with an approved county plan:

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Counties may choose modes of delivery that best meet the needs of their recipient population in their county demographic situation (WIC 12302). However, state reimbursement can be available only within the constraints imposed by the annual budget act (WIC 12300) and state allocation plan (WIC 10102), all of which must be reflected in state-approved individual county plans. Counties which exceed the constraints run the risk of not receiving full reimbursement if the cost overrun was due to non-state mandated costs, i.e., costs within county control, or more expensive modes used beyond amounts approved in an individual county plan.

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**30-767 SERVICE DELIVERY METHODS (Continued)****30-767**

- .11 County Employment.
  - .111 The county shall be permitted to hire service providers in accordance with established county civil service requirements or merit system requirements. The county shall be permitted to consider such providers as temporary employees if approved by the appropriate civil service system.
  - .112 The county shall insure that each service provider is capable of and is providing the services authorized.
- .12 Purchase of Service from an Agency.
  - .121 The county may contract with an agency to provide service in accordance with the requirements of Division 10 and 23. The contract shall include a provision requiring the contractor to maintain a listing of contract recipients, their authorized hours, service hours provided and the amount paid for those services to the contract agency.
  - .122 The county shall insure that the contractor guarantees the continuity and reliability of service to recipients, supervision of service providers, that each service provider is capable of and is providing the service authorized and complies with the requirements of Division 21 (Civil Rights).
  - .123 The county shall insure that preference is given to the selection of providers who are recipients of public assistance or other low-income persons who would qualify for public assistance in the absence of such employment, except in regard to persons recruited by the recipient.
- .13 Purchase of Service From An Individual.
  - .131 The county shall make payment under this delivery method through the payrolling system as described in Section 30-769.
  - .132 The county shall make a reasonable effort to assist the recipient to obtain a service provider when the recipient is unable to obtain one individually.

**30-767 SERVICE DELIVERY METHODS (Continued)****30-767**

- .133 The county shall have the right to change from one to another of the three delivery methods outlined above or from payment in advance to payment in arrears when any of the following apply:
- (a) It has been determined that a recipient is using his/her payment for other than the purchase of authorized services.
  - (b) The recipient has failed to submit time sheets, as specified in Section 30-769.737 within 90 days from the date of payment.
  - (c) The recipient has not provided timely payment to his/her providers.
- .2 Counties may elect to contract with a nonprofit consortium or may create a public authority to provide for the delivery of IHSS.
- .21 The board of supervisors shall establish a public authority by ordinance.
- .211 The public authority shall be separate from the county. Employees of the public authority shall not be considered to be employees of the county for any purpose.
- .212 The ordinance shall designate the governing body of the public authority and specify the qualifications of the individual members, the procedures for nomination, selection, appointment, tenure and removal of members, and such other matters as the board of supervisors deems necessary for the operation of the public authority.
- (a) The board of supervisors may designate itself as the governing body of the public authority.
    - (1) If the board of supervisors is the governing body, the ordinance shall require the appointment of an advisory committee of no more than 11 members.
    - (2) No fewer than 50 percent of the advisory committee shall be consumers as defined in Manual of Policies and Procedures Section 30-753(c)(1).
  - (b) If the board of supervisors does not designate itself the governing body of the public authority, it shall specify by ordinance the membership of the governing body of the public authority.

**30-767 SERVICE DELIVERY METHODS (Continued)****30-767**

- (1) No fewer than 50 percent of the members of the governing body shall be consumers as defined in Manual of Policies and Procedures Section 30-753(c)(1).
- .213 Before appointing members to the governing body or advisory committee, the board of supervisors shall solicit recommendations from the general public and interested persons and organizations through a fair and open process which includes reasonable written notice and a reasonable time to respond.
  - (a) The provisions at Section 30-767.213 shall be met by satisfying the requirements governing legislative bodies outlined in Government Code and other state and federal law, including, but not limited to, the Ralph M. Brown Act (Government Code Section 54950 et seq.) and the Americans with Disabilities Act.
- .214 Prior to initiating delivery of IHSS through a public authority, the county shall enter an agreement with the public authority specifying the purposes, scope or nature of the agreement, the roles and responsibilities of each party including provisions which ensure compliance with all applicable state and federal labor laws, and compliance with all statutory and regulatory provisions applicable to the delivery of IHSS. This agreement shall also specify the fiscal provisions under which the public authority shall be reimbursed for its performance under the agreement. The county, in exercising its option to establish a public authority, shall not be subject to competitive bidding requirements.
- .215 Prior to initiating the delivery of IHSS through a public authority, the county shall submit to the California Department of Social Services a copy of the agreement as specified in Section 30-767.214 along with the following information concerning the public authority:
  - (a) Organization chart of the public authority.
  - (b) Funding provision for public authority costs, including how the proposed rate was developed.
    - (1) The rate development process and the public authority hourly rate must be approved by Department of Health Services prior to initiating the delivery of services.
  - (c) Public authority staffing classifications and duties.
  - (d) A description of how the functional requirements of Welfare and Institutions Code Section 12301.6(e) will be met.

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- (e) The requirements of Welfare and Institutions Code Section 12301.6(e) are listed in Section 30-767.23.

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- .216 If the public authority contracts with another entity to provide the delivery of IHSS, the agreement shall satisfy the requirements of Manual of Policies and Procedures Chapter 23-600 relating to contracting.
- .217 All costs claimed for the delivery of services under an agreement as specified in Section 30-767.214 shall be claimed in compliance with criteria for rate setting found at Section F, attachment 4.19-B of the California Medicaid State Plan.
  - (a) A county shall use county-only funds to fund both the county share and the state share of any increase in the cost of the program, including employment taxes, due to any increase in provider wages or benefits negotiated or agreed to by a public authority or nonprofit consortium unless otherwise provided for in the annual budget act or appropriated by statute. No increase in wages or benefits negotiated or agreed to pursuant to this section shall take effect until the Department has obtained the approval of the State Department of Health Services.
- .22 A county may contract with a consortium for delivery of services.
  - .221 A consortium entering a contract under Section 30-767.22 shall have a governing body composed as described in Section 30-767.212(b)(1), or shall have established an advisory committee composed as described in Sections 30-767.212(a)(1) and (2).
  - .222 Such contracts shall be subject to the provisions of Manual of Policies and Procedures Chapter 23-600.
  - .223 A consortium entering a contract under Section 30-767.22 shall be deemed to be the employer of IHSS personnel referred to recipients as described in Section 30-767.23 for the purposes of collective bargaining over wages, hours and other terms and conditions of employment.
- .23 Any public authority or consortium shall provide the following minimum services:

**30-767 SERVICE DELIVERY METHODS (Continued)****30-767**

- .231 Provide registry services to recipients receiving services pursuant to Section 30-767.23.
- (a) Assistance in finding providers through the establishment of a registry.
  - (b) Investigation of the qualifications and background of potential providers listed on the registry.
  - (c) Establishment of a referral system under which potential providers are made known to recipients.
- .232 Provide access to training for providers and recipients.

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- (a) Access to training for providers and recipients does not mean that the county or the Public Authority is under any obligation:
  - (1) to provide the training directly, to pay for training provided in the community, to pay for the provider's time to attend or to accompany the recipient to training, to pay for transportation to the training, or to pay for any materials required by the training; or
  - (2) to screen or be responsible for the content of any training it tells providers and/or recipients is available in the community; or
  - (3) to ensure that any provider or recipient attended/completed any training.

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- .233 Perform any other function related to the delivery of IHSS.
- .234 Ensure that the requirements of the Personal Care Services Program pursuant to Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are met.
- .24 Any public authority may adopt reasonable rules and regulations for the administration of employer-employee relations.

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- .241 The Employer-Employee Relations Policy for Public Authorities Delivering In-Home Supportive Services is available from the California Department of Social Services as a model for public authorities. Public authorities may adopt, reject, or modify the policy in part or in its entirety.

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- .25 Public authorities and consortia must submit cost reports and such other data as required for the Case Management, Information and Payrolling System (CMIPS).
- .26 Any county that elects to provide for in-home supportive services pursuant to this section shall be responsible for any increased costs to the CMIPS attributable to such election. The Department shall collaborate with any county that elects to provide in-home supportive services pursuant to this section prior to implementing the amount of financial obligation for which the county shall be responsible.
- .3 No recipient of any services specified in Section 30-757.14 or .19 shall be compelled to accept services from any specific individual, except for individuals recruited by the recipient's guardian, conservator, or, in the case of recipients who are minors, by their parents.
- .31 For those recipients who are receiving services through the delivery methods described in .11 and .12 above, hiring preference shall be given to qualified persons recruited by the recipient to deliver services. For the purpose of this section a qualified person is one who meets the minimum requirements established by the contract agency or the County Civil Service or Merit Systems.

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- .4 Personal Care Services Program Providers

DHS regulation Section 51181 reads:

Personal Care Services Provider.

A personal care services provider is that individual, county employee, or county contracted agency authorized by the Department of Health Services to provide personal care services to eligible beneficiaries. An individual provider shall not be a family member, which for purposes of this section means the parent of a minor child or a spouse.

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.5 Personal Care Services Program Provider Enrollment

DHS regulation Section 51204 reads:

Personal Care Services Provider.

All providers of personal care program services must be approved by Department of Health Services and shall sign the "Personal Care Program Provider/Enrollment Agreement" form [SOC 426 1/93]] designated by the Department agreeing to comply with all applicable laws and regulations governing Medi-Cal and the providing of personal care service. Beneficiaries shall be given a choice of service providers.

- (a) Individual providers will be selected by the beneficiary, by the personal representative of the beneficiary, or in the case of a minor, the legal parent or guardian. The beneficiary or the beneficiary's personal representative, or in the case of a minor, the legal parent or guardian shall certify on the provider enrollment document that the provider, in the opinion of the beneficiary, is qualified to provide personal care so long as the person signing is not the provider.
  
- (b) Contract agency personal care providers shall be selected in accordance with Welfare and Institutions Code Section 12302.1. The contract agency shall certify to the designated county department that the workers it employs are qualified to provide the personal care services authorized.

.6 Provider Audit Appeals

DHS regulation Section 51015.2 reads:

Providers of Personal Care Services Grievance and Complaints.

Notwithstanding Section 51015, when a provider of personal care services has a grievance or complaint concerning the processing or payment of money for services rendered, the following procedures must be met:

- (a) The provider shall initiate an appeal, by submitting a grievance or complaint in writing, within 90 days of the action precipitating the grievance or complaint, to the designated county department identifying the claims involved and specifically describing the disputed action or inaction regarding such claims.

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- (b) The designated county department shall acknowledge the written grievance or complaint within 15 days of its receipt.
- (c) The designated county department shall review the merits of the grievance or complaint and send a written decision of its conclusion and reasons to the provider within 30 days of the acknowledgment of the receipt of the grievance or complaint.
- (d) After following this procedure, a provider who is not satisfied with the decision by the designated county department may seek appropriate judicial remedies in compliance with Section 14104.5 of the Welfare and Institutions Code, no later than one year after receiving notice of the decision.

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NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 12301.6, 12302, 12302.1, and 14132.95, Welfare and Institutions Code and Section 54950 et seq., Government Code.

<b>30-768</b>	<b>OVERPAYMENTS/UNDERPAYMENTS</b>	<b>30-768</b>
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- .1 Definition of Overpayment for Non-PCSP Payments
  - .11 Overpayment means that cash payment was made for the purchase of IHSS or services were delivered in an amount to which the recipient was not entitled.
    - .111 Services payments paid pending a state hearing decision as required by MPP 22-022.5 are not overpayments and cannot be recovered.

**30-768 OVERPAYMENTS/UNDERPAYMENTS (Continued)****30-768****.2 Amount of Overpayment for Non-PCSP Payments**

When the county has determined that an overpayment has occurred, the county shall calculate the amount of overpayment as follows:

**.21 Overpayment due to the recipient's failure to use total direct advance payment for the purchase of authorized hours.****.211 Authorization based on an hourly rate**

- a. Determine the number of service hours for which the recipient received a direct advance payment in excess of those service hours actually paid for.
- b. Multiply this amount by the hourly wage rate used in computing the recipient's authorized payment.

**.212 Authorization for a personal attendant**

When services are delivered by a personal attendant, the amount of the overpayment is the difference between the amount that should have been paid and the amount which was actually paid.

**.213 When the recipient receives a direct advance payment to purchase services in a given month, but fails to submit a reconciling time sheet within 45 days from the date of payment, there is a rebuttable presumption that the unreconciled amount is an overpayment.****.22 Overpayment due to excess service authorization****.221 Authorization based on an hourly rate**

- a. Determine the number of service hours for which payment was made in excess of the correct service authorization.
- b. Multiply this amount by the county's lowest individual provider hourly wage rate regardless of the service delivery method used.

**.222 Authorization for a personal attendant**

When services are delivered by a personal attendant, the amount of overpayment is the difference between the amount paid and the amount which would have been paid if the service authorization was correct.

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.23    Overpayment due to incorrect share of cost

Where the correct share of cost was more than the recipient paid, the resulting overpayment is determined by subtracting the amount paid from the correct amount.

.24    Overpayment due to nonpayment of share of cost

Where the service hours were provided to the recipient, but he/she did not pay his/her obligated share of cost, the county should initiate overpayment recovery for the entire amount of the IHSS payment for the month in which the recipient was ineligible.

.25    Overpayment due to nonexpenditure of restaurant meal allowance

Where the recipient received an allowance for the purchase of restaurant meals, and used none of the allowance for that purpose, or if the recipient was ineligible for a restaurant meal allowance he/she received, the entire amount is an overpayment.

.3    Recovery of Overpayments for Non-PCSP Payments

.31    Limitations on amount of Recovery

.311    The repayment liability of the recipient shall be limited to the amount of liquid resources and income excluded or disregarded by the SSI/SSP Program. Liquid resources are cash or financial instruments that can be converted to cash, except funds set aside for burial.

.312    When an overpayment results from the recipient's failure to spend the entire amount of an advance direct payment for the purchase of authorized services, the difference in value between the hours purchased and the hours authorized shall be considered an available resource in determining repayment liability.

.32    Methods of Recovery

.321    The county may recover overpayments using any one or a combination of the methods listed below.

(a)    Balancing

(1)    Balancing means recovery of all or a portion of an overpayment by applying a repayable underpayment against it.

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(2) An underpayment shall not be balanced against an overpayment if the underpayment is discovered and payable prior to the time an overpayment is discovered and adjustable.

(b) Payment Adjustment

(1) Payment adjustment means that the county reduces payment for future authorized services to offset an overpayment.

(2) If the service payment is reduced to adjust for previous overpayments, the recipient shall be responsible for paying the current month's adjustment amount to the service provider in addition to any share of cost.

(c) Voluntary Cash Recovery

(1) Voluntary cash recovery means repayment voluntarily made to the county by a recipient who has incurred an overpayment.

(2) The recipient shall be given the option of voluntary cash repayment of all or a part of the amount to be adjusted in lieu of payment adjustment.

(d) Civil Judgment

The county shall have the authority to demand repayment and file suit for restitution for any unadjusted portion of an overpayment.

.33 Notice of Action

If the county determines that an overpayment has occurred as defined in .11 above and proposes to recover the overpayment, the county shall notify the recipient of the following:

.341 The period of time during which the overpayment occurred.

.342 The reason for the overpayment.

.343 The amount of overpayment and a description of how the amount was calculated.

.344 The method by which the county proposes to recover the overpayment.

.4 Definition of Underpayment for Non-PCSP Payments

.41 Underpayment means the recipient was entitled to more service than was authorized or that the share of cost paid by the recipient was greater than the correct amount.

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.411      An underpayment has occurred when the county has failed to determine the correct share of cost or authorize the correct amount of service when all essential information was available to the county.

.412      An underpayment has not occurred when there is a disagreement in the county's exercise of discretion or opinion, where discretion or opinion is allowed in the determination of the need for service.

.42      Amount of Underpayment

When the county has determined that an underpayment has occurred, the county shall calculate the underpayment as follows:

.421      Incorrect Service Authorization

(a)      Subtract the number of hours actually authorized from the number of hours to which the recipient was entitled.

(b)      Multiply this amount by the county's lowest individual provider hourly wage rate regardless of the service delivery method used.

.422      Share of Cost

When the correct share of cost was less than the recipient paid, the resulting underpayment is determined by subtracting the correct amount from the amount paid.

.423      Restaurant Meals

When the amount paid was less than the amount to which there was entitlement, subtract the amount paid from the correct amount.

.43      Method of Payment

.431      Underpayments shall be adjusted by an increase in the service authorization when the unauthorized service for which there was entitlement was yard hazard abatement or heavy cleaning, and the service was not previously provided through another source at no cost to the recipient.

.432      All other underpayments shall be corrected by a retroactive payment issued to the recipient in an amount equal to that of the calculated underpayment.

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.44 Notice of Action

If the county determines that an underpayment has occurred as defined in .4 above, the county shall notify the recipient of the following:

- .441 The time period during which the underpayment occurred.
- .442 The reason for the underpayment.
- .443 The amount of the underpayment, and a description of how the amount was calculated.
- .444 The method by which the county proposes to adjust the underpayment.

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.5 DHS regulation Section 50781 reads:

Potential Overpayments

- (a) A potential overpayment occurs when any of the following conditions exist, as limited by (c).
  - (1) A beneficiary has property in excess of the property limits for an entire calendar month.
  - (2) A beneficiary or the person acting on the beneficiary's behalf willfully fails to report facts and those facts, when considered in conjunction with the other information available on the beneficiary's circumstances, would result in ineligibility or an increased share of cost.
  - (3) A beneficiary has other health coverage of a type designated by the Department [of Health Services] as not subject to post-service reimbursement, and the beneficiary or the person acting on the beneficiary's behalf willfully fails to report such coverage.

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- (b) A beneficiary of the person acting on the beneficiary's behalf willfully fails to report facts if he/she has completed and signed a Medi-Cal Responsibilities Checklist, form MC 217, and a Statement of Facts and has, within his/her competence, done any of the following:
  - (1) Provided incorrect oral or written information.
  - (2) Failed to provide information which would affect the eligibility or share of cost determination.
  - (3) Failed to report changes in circumstances which would affect eligibility or share of cost within 10 days of the change.
- (c) If a change occurred in a person's circumstances and that change could not have been reflected in the person's eligibility determination for the month in which the change occurred or the month following because of the 10 day notice requirements specified in Section 50179, no potential overpayment exists in that month or in the following month if appropriate.

.6 DHS regulation Section 50786 reads:

Action on Overpayment -- Department of Health Services or County Unit Contracted to Collect Overpayments

- (a) Upon receipt of a potential overpayment referral, the Department's Recovery Section or the county unit contracted to collect overpayments shall:
  - (1) Determine the amount of Medi-Cal benefits received by the beneficiary for the period in which there was a potential overpayment.
  - (2) Compute the actual overpayment in accordance with the following:
    - (A) When the potential overpayment was due to excess property, the actual overpayment shall be the lesser of the:

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**HANDBOOK CONTINUES**

1. Actual cost of services paid by the Department during that period of consecutive months in which there was excess property throughout each month.
  2. Amount of property in excess of the property limit during that period of consecutive months in which there was excess property throughout each month. This excess amount shall be determined as follows:
    - a. Compute the excess property at the lowest point in the month for each month.
    - b. The highest amount determined in a. shall be the amount of the excess property for the entire period of consecutive months.
- (B) When the potential overpayment was due to increased share of cost, the actual overpayment shall be the lesser of the:
1. Actual cost of services received in the share of cost period which were paid by the Department.
  2. Amount of the increased share of cost for the share of cost period(s).
- (C) When the overpayment was due to excess property and increased share of cost, the actual overpayment shall be a combination of (A) and (B).
- (D) When the potential overpayment was due to other factors which result in ineligibility the overpayment shall be the actual cost of services paid by the Department.

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**HANDBOOK CONTINUES**

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**HANDBOOK CONTINUES**

(E) Potential overpayments, due to beneficiary possession of other health coverage that is not subject to post-service reimbursement, shall be processed by the Department to determine and recover actual overpayments in all cases. The actual overpayment in such cases shall be the actual cost of services paid by the Department which would have been covered by a private health insurance or other health coverage, had the coverage been known to the Department. The actual overpayment shall not include any costs which can be recovered directly by the Department from the health insurance carrier or other source.

(3) Refer those cases where there appears there may be fraud to the Investigations Branch of the Department.

(4) Take appropriate action to collect overpayments in accordance with Section 50787.

.7 DHS regulation Section 50787 reads:

Demand for repayment

- (a) The Department or the county unit contracted to collect overpayments shall demand repayment or actual overpayments in accordance with procedures established by the Department.
- (b) The Department or the county unit contracted to collect overpayments may take other collection actions as permitted under state law.

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NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Sections 10554, 12304.5 and 14132.95, Welfare and Institutions Code.



**30-769**      **PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued)**                      **30-769**

.24    General Process

.241    The counties shall:

- (a)    Enter prescribed data on all recipients and providers, as defined in Section 30-767.13, into the payrolling system.
- (b)    Change data as necessary to ensure correct payment to the correct individual.
- (c)    Authorize the disbursement of all funds paid by the payrolling contractor by:
  - (1)    Reviewing all time sheets prior to entry of time sheet data into the system to ensure consistency between hours reported and hours authorized.
  - (2)    Reviewing any significant discrepancies between hours reported and hours authorized to determine the reason and take corrective action as indicated.
  - (3)    Initiating special transactions as described in .25 below.
- (d)    Retain completed time sheets as required by Section 23-353 in such a manner that they are easily accessible for review.
- (e)    Respond to and resolve payment inquiries from recipients and providers. The payrolling contractor will provide all necessary information.

.25    Special Transaction

.251    Special transactions are used to handle situations which fall outside the normal payroll process. Counties shall be held responsible for closely monitoring and controlling the use of the following transactions.

.252    The county shall initiate emergency/supplemental checks for:

- (a)    Payments resulting from retroactive state hearing decisions.
- (b)    Payments resulting from prior underpayments.
- (c)    Payments in excess of the base rate as provided in Section 30-764.

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**30-769**                      **PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued)**                      **30-769**

- (d)      Payments for severely impaired recipients in advance pay status who become eligible for payment between a pay cycle.
  - (e)      Payments where the county finds that an emergency situation exists.
  - (f)      Payments to counties for reimbursements of emergency checks as described in .26 below.
  - (g)      Payments for other unusual situations not provided for by the regular payrolling process and where the county deems appropriate.
  - (h)      Payments for time sheets submitted three or more months beyond the current payroll cycle.
- .253      A request for a replacement check shall be made expeditiously by the county but no sooner than five (5) days from the date the original check should have been received.
- .254      A void transaction shall be used:
- (a)      When a payroll check is returned to the payrolling contractor or county.
  - (b)      When a payroll check is mutilated.
  - (c)      When a payroll check is not in the possession of the county or the payrolling contractor.
- .255      Adjustment transactions shall be used to make adjustments to tax records when any of the following occur:
- (a)      An overpayment.
  - (b)      An underpayment.
  - (c)      An incorrect deduction.
- .26      County issued payments shall only be issued in cases of extreme emergency when the county finds that the emergency check procedure provided in .252 is not adequate.

**30-769                      PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued)                      30-769**

- .261    The county shall issue checks for an amount not to exceed ninety (90%) percent of the amount the recipient/provider should receive.
- .262    The county shall be reimbursed for payments made under .261 above by the payrolling contractor using the emergency/supplemental check transaction.
- .263    The county shall not receive reimbursement until an emergency/ supplemental transaction has been initiated to pay the recipient/ provider the remaining balance.
- .264    The county shall receive a time sheet before the transaction in .261 or .263 above shall occur. Exception: The county may issue a check prior to receipt of a time sheet for a severely impaired recipient who opted for advance pay.
- .27    The counties shall be responsible for verifying eligibility of recipients for IHSS between January 1, 1978 and December 31, 1979 as needed for retroactive tax payments.
- .28    The county shall ensure that all providers are informed of the requirements they must meet in order to be paid.
- .3    The County Has The Sole Responsibility For Determining And Investigating Fraud And Forgery for Non-PCSP
  - .31    The county shall, with no effect on current county procedures:
    - .311    Identify suspected fraud cases;
    - .312    Determine if actual fraud exists;
    - .313    Take appropriate action as necessary.
  - .32    The county will be notified by the payrolling contractor if an original check has already been cashed when a replacement check is requested. The county shall then follow the applicable procedure in the user's manual.
- .4    PCSP Fraud or Forgery

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.41    DHS regulation Section 50782 reads:

Fraud occurs if an overpayment occurs and the beneficiary or the person acting on the beneficiary's behalf willfully failed to report facts as specified in Section 50781(b) with the intention of deceiving the Department, the county department or the Social Security Administration for the purpose of obtaining Medi-Cal benefits to which the beneficiary was not entitled.

.42    If PCSP fraud or forgery occurs, DHS will follow the procedures cited in DHS regulation Section 50793.

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.5     Return Check Procedures

.51    Counties which receive a returned check from a provider or recipient shall follow the applicable procedures in the user's manual.

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**30-769**      **PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued)**                      **30-769**

.6      Refunds/Recoupment

.61      Counties which receive refunds or recoupments shall:

.611      Deposit the money received in a county account; and

.612      Send a monthly check to the payrolling contractor for the amount of refund/recoupment received during the previous month in accordance with applicable procedures in the User's Manual.

.7      Recipient Responsibility

.71      It is the responsibility of the recipient to report to social services staff accurately and completely all information necessary to complete the SOC 311.

.72      The recipient, within his/her physical, emotional, educational or other limitations, shall:

.721      Designate the authorized hours per provider within the total of the recipient's authorized hours.

.722      Designate each provider(s) portion of the share of cost.

.723      Sign and date the prescribed time sheet to:

(a)      Verify payment of the share of cost to the appropriate provider(s).

(b)      Verify that services authorized where rendered by the appropriate provider.

.724      Inform social services staff of any changes affecting the payrolling process.

.73      Payments for authorized services rendered shall be sent to the recipient's appropriate provider. The recipient shall not receive payment for services except as provided in .731 through .734 below.

.731      Severely impaired recipients as defined under Section 30-753, shall have the option of choosing to directly receive their payment at the beginning of each authorized month. Such payment shall be the net amount exclusive of the appropriate withholdings.

**30-769      PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued)      30-769**

- .732 In direct payment cases, where a recipient is incapable of handling his/her financial and legal affairs and has a legal guardian or conservator, direct payment shall be made to the recipient's legal guardian or conservator at such person's request.
- .733 Payment may be made to a recipient's guardian, conservator, substitute payee, or person designated by the recipient.
- .734 When payment is made as a result of a state hearing decision.
- .735 If the recipient is severely impaired he/she shall be notified in writing of the right to hire and pay his/her own provider, and to receive his/her monthly cash payment in advance.
- .736 When direct payment is made to a recipient, guardian, conservator, or substitute payee, the provider shall be hired, supervised, and paid by such payee. In such cases, the recipient or the person authorized to act in the recipient's behalf shall insure that the services provider is capable of and is providing the services authorized.
- .737 It shall be the responsibility of the severely impaired recipient, legal guardian or conservator who receives payment in advance to submit their provider's time sheets at the end of each authorized service month to the appropriate county social services office.

**.8      Provider Benefits**

- .81 The department has elected to provide the worker's compensation coverage required by Welfare and Institutions Code Section 12302.2 through a single statewide insurance policy. Additional insurance coverage will not be reimbursed as an IHSS program cost.
- .82 The department has elected to handle the payment of the unemployment insurance tax, unemployment disability insurance tax, and social security tax required by Welfare and Institutions Code Section 12302.2 through the payroll system.
- .83 The department has elected to require the payroll contractor to deduct the employee's share of the following taxes from the payment to the provider or the recipient:

**30-769 PAYROLLING FOR INDIVIDUAL PROVIDERS (Continued) 30-769**

- .831 Social security.
- .832 State disability insurance.
- .84 The department has elected to deduct and transmit the state and federal income tax withholdings due on the provider's earnings for those providers who voluntarily request this service.
- .9 Excessive Compensation  
  
(See Section 30-769.91 (Handbook) for examples of excessive compensation)

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- .91 Excess compensation to an individual provider but is not necessarily limited to the following circumstances:
  - .911 The provider was paid for more hours than authorized or more hours than worked.
  - .912 The provider was paid at a higher hourly rate than appropriate.
  - .913 The share of cost withheld from provider's payment was less than the recipient affirms was paid to the provider.

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- .92 All excess provider compensation is recoverable. The county shall demand repayment from the provider. The county shall be permitted to seek recovery of excess compensation by civil suit.
- .93 Provider Fraud or Forgery  
  
If the county suspects that excess provider payment occurred because of fraudulent devices of the provider, forgery, or collusion between the provider and the recipient, the county shall investigate the suspected fraud, forgery, or collusion. If the facts warrant prosecution and the county does not have an investigative unit, the county shall refer the matter directly to the county district attorney's office for investigation and possible prosecution.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Section 14132.95, Welfare and Institutions Code.

**30-770 ELIGIBILITY STANDARDS****30-770**

- .1 Persons applying for IHSS under Sections 30-755.112, .113 and .114 shall meet the SSI/SSP eligibility standards except as modified by Section 30-755.1.
- .2 Detailed eligibility standards shall be those located in 20 CFR Part 416, except as modified by IHSS regulations beginning with Section 30-750.
- .3 Definitions.
  - .31 For the purposes of eligibility for IHSS, a child means an individual who is neither married nor the head of a household, and who is under the age of 18, or under the age of 22 and a student regularly attending a school, college, or university, or a course of vocational or technical training designed to prepare him/her for gainful employment.
    - .311 For the purposes of deeming for IHSS, a child means an individual who is neither married nor the head of a household, and who is under the age of 18.
    - .312 Regularly attending school means being enrolled in eight semester or quarterly hours weekly in a college or university, or 12 hours weekly in a secondary school. In a course of vocational or technical training, 15 clock hours weekly are required; without shop practice, at least 12 hours weekly are required.
    - .313 Eligible spouse means an aged, blind, or disabled individual who is the husband or wife of another aged, blind, or disabled individual who has not been living apart from such other aged, blind, or disabled individual for more than six months.
- .4 Residency
  - .41 Residency in State Required

To be eligible for IHSS, an individual shall be a U.S. citizen, or an eligible alien pursuant to Welfare and Institutions Code Section 11104. The individual shall also be a California resident, physically residing in the state except for temporary absence as noted below in Sections 30-770.42 through .45, with the intention to continue residing here.

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Welfare and Institutions Code Section 11104 states:

"Aliens shall be eligible for aid only to the extent permitted by federal law.

"An alien shall only be eligible for aid if the alien has been lawfully admitted for permanent residence, or is otherwise permanently residing in the United States under color of law. No aid shall be paid unless evidence as to eligible alien status is presented."

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.42 Physical Absence from the State

Physical absence from the state indicates a possible change of state residence. The county shall make inquiry of a recipient who has been continuously absent from the state for 30 days or longer in order to ascertain the recipient's intent to maintain California residency. If the inquiry establishes that the recipient is no longer a California resident, authorization for IHSS shall be discontinued.

.421 The county inquiry to the recipient will require the recipient to submit a written statement that:

- (a) Declares his/her anticipated date of return to the state, or his/her intent not to return to the state;
- (b) Declares his/her reason for continued absence from the state; and
- (c) Provides needed information on his/her location and status of household arrangements.

.422 The county will include in the inquiry to the recipient a statement that his/her failure to respond to the inquiry by a specified date will result in his/her ineligibility and the discontinuation of IHSS.

**30-770 ELIGIBILITY STANDARDS (Continued)****30-770****.43 Evidence of Residence Intention**

- .431 The written statement of the recipient is acceptable to establish his/her intention and action on establishing residence unless the statement is inconsistent with the conduct of the person or with other information known to the county.
- .432 If the recipient does not respond by the specified date to the inquiry of residence, it shall be presumed that he/she does not intend to maintain California residency, and authorization for IHSS shall be discontinued when the absence exceeds 60 days in accordance with regulations (Sections 30-759.7 and 10-116).
- .433 If the recipient responds to the inquiry and advises the county that he/she does not intend to return to California, authorization for IHSS shall be discontinued in accordance with regulations.

**.44 Absence from State for More than 60 Days**

- .441 If the recipient responds to the inquiry and advises the county that he/she intends to maintain his/her California residence, but he/she remains or has remained out of state for 60 days or longer, his/her continued absence is prima facie evidence of the recipient's intent to have changed his/her place of residence to a place outside of California, unless he/she is prevented by illness or other good cause from returning to the state at the end of 60 days. Such absence in itself is sufficient evidence to support a determination that the recipient has established residence outside of California. Therefore, his/her intent to return must be supported by one or a combination of the following:
- (a) Family members with whom the recipient lived, currently live in California;
  - (b) The recipient has continued maintenance of his/her California housing arrangements (owned, leased, or rented);
  - (c) The recipient has employment or business interest in California;
  - (d) Any other act or combination of acts by the recipient which establishes his/her intent to reside in California.

**30-770 ELIGIBILITY STANDARDS (Continued)****30-770**

.442 Even if the recipient's intent to reside in California is supported by .441 above, the following evidence shall be utilized to determine the recipient's intent to reside in California:

- (a) The recipient has purchased or leased a place of residence out of state since leaving California;
- (b) The recipient has been employed out-of-state since leaving California;
- (c) The recipient has obtained an out-of-state motor vehicle driver's license after leaving California;
- (d) The recipient has taken any other action which indicates his/her intent to establish residence outside of California.

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.443 Welfare and Institutions Code Section 1110 states that if a recipient is prevented by illness or other good cause from returning to California at the end of 60 days, and has not by act or intent established residence elsewhere, he shall not be deemed to have lost his residence in this state. The following is added by Welfare and Institutions Code Section 11100.1(a):

For purposes of the In-Home Supportive Services Program ..."good cause," as defined in Section 11100, shall include, but is not limited to, the following:

- (1) Outpatient medical treatment necessary to maintain the recipient's health where the medical treatment is not available in California.
- (2) Short-term schooling or training necessary for the recipient to obtain self-sufficiency where training which would achieve that objective is not available or accessible in California.
- (3) Court-issued subpoena or summons.

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**30-770 ELIGIBILITY STANDARDS (Continued)****30-770**

- (a) For outpatient medical treatment out of state, good cause for continuing to receive benefits while absent from the state for more than 60 days shall also include the situation where the medical treatment is not accessible in California.
- (b) Accessible in these regulations means attainable for the recipient in California, given the dysfunctioning and needs of the recipient.
- (c) Other good cause reasons for continuing to receive IHSS benefits while absent from the state for over 60 days shall be consistent with the good cause reasons contained in Welfare and Institutions Code Section 11100.1.
  - (1) The situation shall be of an urgent or emergency nature:
  - (2) The service required shall be necessary to maintain the physical or psychological health of the recipient:
  - (3) The services required or like services shall be either not available or not accessible in California.

.444 A recipient absent from California for more than 60 days and who is not prevented from returning to this state because of illness or other good cause shall have his/her authorization for IHSS discontinued in accordance with regulations.

.45 Absence from the State Exceeding Six Months

.451 Authorization for IHSS shall be suspended for any recipient who leaves the state and who remains absent from the state for a period which exceeds six months, notwithstanding the fact that the recipient has continued to receive IHSS benefits beyond 60 days because he/she was prevented from returning to the state due to illness or other good cause, as specified in Sections 30-770.43 and .44. Suspension of benefits will be in accordance with notice of Action regulations contained in Sections 30-759.7 and 10-116.

**30-770 ELIGIBILITY STANDARDS (Continued)****30-770**

- .452 In-Home Supportive Services shall not be resumed until the recipient, upon returning to the state, requests a reassessment of need from the county, and the reassessment has been completed in accordance with regulations (Section 30-763).
- .46 Outside the United States While Absent from the State
- .461 In-Home Supportive Services shall be discontinued for any recipient who is outside the United States for all of any month, or for 30 days in a row, as such an individual is no longer eligible to receive SSI/SSP. Discontinuation of benefits will be in accordance with notice of action regulations.
- (a) Upon the individual's return to the United States, and upon his/her reestablishment as an SSI/SSP recipient, an SSI/SSP eligible recipient, or an individual who would be eligible for SSI/SSP except for excess income, he/she may again apply for IHSS benefits. The county shall redetermine IHSS eligibility and perform a needs assessment based on current circumstances.
- (b) "United States" includes the 50 states, the District of Columbia, and the Northern Mariana Islands.
- .47 Continuation of IHSS While Absent from the State
- .471 When the county has determined that the recipient is entitled to the continuation of IHSS benefits while absent from the state (the recipient is absent from the state for 60 or more days and is prevented from returning due to illness or other good cause, as determined in Sections 30-770.42, .43, and .44), the following apply:
- (a) The recipient shall continue to receive the same number of hours of IHSS that were authorized prior to his/her temporary absence. This level of authorization will continue until a reassessment is required.
- (b) The recipient's out-of-state individual provider (IP) shall be reimbursed at the county's lowest current IP base rate.
- (c) The recipient must continue to mail time sheets to the county as required by regulations.

**30-770 ELIGIBILITY STANDARDS (Continued)****30-770****.5 State Program Noncitizen Status**

.51 A noncitizen victims of human trafficking, domestic violence, or other serious crimes as defined under the Trafficking and Crime Victims Assistance Program (TCVAP), MPP Chapter 70-100, shall be eligible for IHSS if all other eligibility criteria are met.

.511 A victim of human trafficking must meet the same eligibility criteria as those used for the TCVAP found in MPP Sections 70-102 and 70-103.1. For examples of documentation requirements, please see Sections 70-103.2 through .4.

.512 A victim of domestic violence or other serious crimes must meet the same eligibility criteria as those used for the TCVAP found in MPP Section 70-104.1. For examples of the definition of a noncitizen victim of serious crime, please see Handbook Section 70-104.11. For examples of documentation requirements, please see Section 70-104.12.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Senate Bill 1569 (Chapter 672, Statutes of 2006). Reference: Sections 13283 and 18945, Welfare and Institutions Code.

**30-771 LINKAGE 30-771**

- .1 Aged - An aged individual shall be considered to be one who is 65 years of age or older.
- .2 Blindness - An individual shall be considered to be blind for purposes of IHSS if:
  - .21 He/she has central visual acuity of 20/200 or less in the better eye with use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered as having a central visual acuity of 20/200 or less.
  - .22 He/she is blind as defined under the state plan approved under Title X as in effect for October 1972 and received aid under such plan on the basis of blindness for December 1973, provided that he/she is continuously so defined.
- .3 Disability - An individual shall be considered to be disabled for the purposes of IHSS if one of the following applies:
  - .31 He/she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or can be expected to last for a continuous period of not less than 12 months.
  - .32 In the case of a child under the age of 18, if he/she suffers from any medically determinable physical or mental impairment of comparable severity.
  - .33 He/she is permanently and totally disabled as defined under a state plan approved under Title XIV as in effect for October 1972 and received aid under such plan on the basis of disability for at least one month prior to July 1973 and for December 1973, provided that he/she is continuously disabled as so defined.
- .4 Additional criteria regarding aged, blindness and disabled eligibility shall be applied as outlined in 20 CFR 416, Subpart 1.



**30-773**                      **RESOURCES (Continued)**                      **30-773**

- (c) Automobiles, as defined in 20 CFR 416, Subpart L.
  - (1) One automobile shall be totally excluded regardless of its value if, for the individual or a member of the individual's household, one of the following applies:
    - (A) It is necessary for employment.
    - (B) It is necessary for transportation to a site for medical treatment of a specific ongoing medical problem.
    - (C) It is modified for operation by or transportation of a handicapped person.
  - (2) If no automobile is excluded under (1) above, one automobile shall be excluded from counting as a resource to the extent its current market value does not exceed \$4,500.
    - (A) If the market value exceeds \$4,500, the excess shall be counted against the resources limitation.
  - (3) When the recipient or spouse has more than one automobile, such additional automobile(s) shall be treated as non-liquid resources and shall be counted to the extent of their equity value unless they are the property of a trade or business, or are nonbusiness properties which are essential to the means of self-support, as provided in (d) and (e) below.
- (d) Property of a trade or business which is essential to the means of self-support, as provided in federal guidelines.
- (e) Nonbusiness property which is essential to the means of self-support, as provided in federal guidelines.
- (f) Resources of a blind or disabled individual which are necessary to fulfill a plan for achieving self-support as described in Section 30-775.436.
- (g) Life insurance if the face value does not exceed \$1,500. If the face value exceeds \$1,500, the entire cash surrender value of the insurance shall be counted toward the resources limitation. Term insurance and burial insurance shall be totally excluded.

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- (A) An example of income generated by such exempt property would be rental income generated by an exempt resource.

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- (2) The burden shall be rebuttably presumed to have been met if the applicant/recipient presents a "SERVICE SUMMARY" signed by a representative of the insurance company verifying that the applicant/recipient is a holder of an insurance policy or certificate certified by the State to provide the exemption, and specifying the total amount of qualifying benefits paid out under the policy to date.
- (3) The amount of the qualifying benefits stated to have been paid in the "SERVICE SUMMARY" referred to in Section 30-773.6(m)(2) shall be the amount of the exemption to which the applicant/recipient is entitled.
- (4) If the statement by the insurance company is found to be erroneous, the county shall promptly notify the California Department of Health Services.
- (5) If the statement by the insurance company is such that the county cannot determine whether the applicant/recipient is covered by a qualifying policy or the amount of the benefits paid out on behalf of the beneficiary, the county shall deny the exemption. When an exemption is denied, the county shall refer the recipient to the California Department of Health Services for assistance and shall notify the California Department of Health Services of the reasons for this determination.



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**30-773      RESOURCES (Continued)      30-773**

- .73 During the period that the excess property is held and is under disposition, in accordance with the individual's agreement to dispose of the property, any IHSS payments made shall be considered to be overpayments.
  - .731 The net proceeds from the disposition of the excess property shall be considered to be available for liquidation of overpayments occurring during the disposition period in accordance with Section 30-768.3.
- .74 The disposition of the excess property shall be accomplished within a six-month period in the case of real property and within three months in the case of personal property.
  - .741 The time period shall begin on the date the agreement is signed by the individual.
    - (a) In the case of a disabled individual, the time period shall begin on the date of the disability determination.
  - .742 The time limits may be extended another three months where it is found that the individual had "good cause" for failing to dispose of the property within the original time period.
    - (a) "Good cause" shall exist if, despite reasonable and diligent effort on his/her part, he/she was prevented by circumstances beyond his/her control from disposing of the property.

NOTE: Authority cited: Section 22009(b), Welfare and Institutions Code. Reference: Section 22004, Welfare and Institutions Code.

**30-775      INCOME      30-775**

- .1 Income means the money or other gain periodically received by an individual for labor or service, or from property, investment, operations, etc. Income may be in the form of cash, including checks and money orders; in-kind items; real property; or personal services.
  - .11 When the item of receipt is not in the form of cash, the cash equivalent shall be determined.
  - .12 An individual's or individual and eligible spouse's income shall include all of his/her or their income in cash or in-kind, both earned and unearned.



**30-775**                      **INCOME**                      **30-775**

- .33 Unearned income includes, but is not limited to, the following:
  - .331 Support and maintenance furnished in cash or in-kind.
    - (a) A person who meets the criteria in Section 46-325.51 shall have the household of another SSI/SSP benefit level used to compute share of cost in lieu of counting the support and maintenance as unearned income.
      - (1) A person subject to the above procedure may still be eligible for IHSS if living in his/her own home as defined in Section 30-753.
  - .332 Any payments received as an annuity, pension, retirement, disability, OASDI, unemployment, veteran's or workmen's compensation benefit.
  - .333 Prizes and awards.
  - .334 Gifts, support and alimony payments, and inheritances.
  - .335 Rents, dividends, interests, and royalties.
  - .336 The proceeds of any life insurance policy to the extent that they exceed the amount expended by the beneficiary for purposes of the insured individual's last illness and burial expenses or \$1,500, whichever is less.
  - .337 Those amounts of countable unearned income deemed to be available to the individual from the income of his/her ineligible spouse or parent(s) in the case of a recipient child.
    - (a) When a parent and recipient child live in a household with the parent's spouse, who is not the parent of the child, the income of the parent's spouse shall also be deemed to the child.
    - (b) Deeming procedures shall conform to those specified in 20 CFR 416.1185, as set forth on the form(s) developed and approved by the department.



**30-775      INCOME (Continued)      30-775**

- (d) Home produce.
  - (1) The value of agricultural products which are not raised in connection with a trade or business and are utilized for consumption by the household.
    - (A) If the produce is sold, the net earnings shall be countable as earned income.
- (e) Foster care payments.
  - (1) Payments for the foster care of a child who is not an eligible individual but who resides in the same home as such individual and was placed there by a public or nonprofit agency.
- (f) Support payment from an absent parent.
  - (1) One-third of any payment received from an absent parent for an eligible individual who is a child as defined in Section 30-770.3.
    - (A) The remainder shall be countable as unearned income.
- (g) Readers and educational scholarships for the blind.
  - (1) Funds, not available to meet basic needs, awarded for readers and educational scholarships by a high school, institution of higher learning, or a vocational or technical training institution to a recipient due to his/her blindness while he/she is regularly attending any public school or any institution of higher learning in this state.
- (h) Vendor payments.
  - (1) Payments made from any source to a vendor in order to meet the needs of the recipient for medical or social services, as determined by the county welfare department. When the vendor is the recipient's spouse, the provisions of .213 above shall apply.



**30-775**                      **INCOME (Continued)**                      **30-775**

- (m) Domestic Volunteer payments.
  - (1) Payments made under the Domestic Volunteer Services Act of 1973 to welfare recipients who are VISTA volunteers.
- (n) Supplemental food assistance.
  - (1) The value of supplemental food assistance received under the Child Nutrition Act (WIC) and the National School Lunch Act, as specified in Public Laws 92-433 and 93-150.
- (o) Energy assistance allowances.
  - (1) Payments or allowances made under any federal, state or local laws for the purpose of energy assistance, e.g., Low Income Energy Assistance Program (EAP), Energy Crisis Assistance Program (ECAP), and Crisis Intervention Programs (CIP) payments.
    - (A) Such payments or allowances shall be clearly identified as energy assistance by the legislative body authorizing the program or providing the funds.

.43 The following disregards shall be applied in the order listed below:

- .431 Infrequent or irregular income.
  - (a) Unearned income.
    - (1) Unearned income which does not exceed \$60 per quarter and is received not more than once per quarter or cannot be reasonably anticipated.
  - (b) Earned income.
    - (1) Earned income which does not exceed \$30 per quarter and is received not more than once per quarter or cannot be reasonably anticipated.
- .432 Student exemption.
  - (a) Up to \$1,200 per calendar quarter of the earned income of the recipient who is a child and a student, but in no instance more than \$1,620 per calendar year.



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**30-776      PROVIDER ENROLLMENT (Continued)      30-776**

- (b) Being designated by a recipient (in writing) as the individual from whom the recipient elects to receive his/her authorized services.
  
- .22 Prior to determining an individual who has failed to complete the enrollment requirements within 90 calendar days ineligible to be a provider, the county shall send a notice to the prospective provider informing him/her that he/she will be determined ineligible to be a provider unless he/she completes the remaining provider enrollment requirements.
  - .221 The notice shall include the following:
    - (a) The specific provider enrollment requirements that the individual has failed to complete.
    - (b) The date by which the individual must complete the requirements or be determined ineligible.
  - .222 The notice shall be sent at least 15 calendar days before the 90-day time period for completing the enrollment requirements ends.
  
- .23 The county may extend the period for which an individual may be allowed to complete the enrollment requirements by an additional 45 calendar days for "good cause," which includes, but is not limited to:
  - (a) A delay that is directly attributable to a county error;
  - (b) A delay in the county's receipt of the results of the individual's criminal background check from the Department of Justice;
  - (c) An unforeseen illness, hospitalization, or other medical issue prevents the individual from completing the enrollment requirements.
  
- .3 Provision of services prior to completing enrollment requirements.
  - .31 An individual who provides authorized services to a recipient before he/she has completed all of the enrollment requirements shall be eligible to receive retroactive payment from the IHSS program for authorized services he/she provides prior to being enrolled only when all of the following conditions have been met:
    - .311 The individual completes all of the enrollment requirements within 90 calendar days of the date he/she begins providing authorized services; and
    - .312 Upon completion of the enrollment requirements, the county deems that the individual is eligible to be enrolled as a provider.

**30-776**                      **PROVIDER ENROLLMENT** (Continued)                      **30-776**

- .32 Retroactive payment from the IHSS program for authorized services provided by an individual prior to completion of the enrollment requirements shall be limited to a maximum of 90 calendar days back from the date the individual completes the enrollment requirements and is enrolled as a provider by the county.
- .321 The county shall extend the period for which an individual may be paid retroactively by an additional 45 calendar days for "good cause," as specified in Section 30-776.23.
- .33 When a recipient designates an individual who has not completed the enrollment requirements as the individual from whom he/she elects to receive his/her authorized services, the county shall inform the recipient
- .331 Of the conditions and limitations on retroactive payment for services provided prior to an individual's completion of the enrollment requirements, and
- .332 That the recipient shall accept financial responsibility for paying for the following:
- (a) In the case of an individual who is ultimately deemed ineligible – any and all services provided; or
  - (b) In the case of an individual who is ultimately deemed eligible but who completes the enrollment requirements more than 90 calendar days from the date he/she begins providing services – any and all services provided between the date the individual begins providing services and the date 90 days prior to the date that he/she completes the enrollment requirements.

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.34 Example:

An individual begins providing authorized services for an eligible recipient, on August 12, 2012. The individual successfully completes all of the enrollment requirements and is enrolled as a provider by the county on December 22, 2012.

The individual would be eligible to receive retroactive payment for the authorized services provided to the recipient prior to completion of the enrollment requirements. However, retroactive payment from the IHSS program could only be made for services provided 90 calendar days back from the date that he/she completed the enrollment requirements, which would be September 22, 2012. The individual would not be eligible to receive payment from the IHSS program for those services provided between August 12, 2012 and September 21, 2012. The recipient would be financially responsible for paying the individual for the services he/she provided during this period.

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**30-776      PROVIDER ENROLLMENT (Continued)      30-776**

.4      Provider Enrollment Requirements

.41      The applicant provider shall complete a provider enrollment form.

.411      The provider enrollment form includes the following elements:

- (a)      A statement indicating that an individual who, within the last 10 years, has been convicted of, or incarcerated following a conviction for, a Tier 1 or Tier 2 disqualifying crime(s), as defined in Sections 30-701(t)(1) and 30-701(t)(2), is not eligible to be enrolled as a provider or to receive payment for providing services.
- (b)      A statement informing the applicant provider that as part of the provider enrollment process he/she is required to submit his/her fingerprints and undergo a criminal background check by the California Department of Justice.
- (c)      A statement indicating that if the individual's responses to questions on the provider enrollment form or the results of the criminal background check indicate that the individual has been convicted of, or incarcerated following a conviction for, a disqualifying crime within the last 10 years, he/she will not be eligible to be enrolled as a provider or to receive payment for providing services.
- (d)      A statement indicating that if an individual has been convicted of, or incarcerated following a conviction for, a Tier 2 disqualifying crime(s), he/she may be eligible to be enrolled as a provider in spite of the conviction/incarceration, if he/she meets one of the following conditions:
  - (1)      He/she has obtained a certificate of rehabilitation under Chapter 3.5 (commencing with Section 4852.01) of Title 6 of Part 3 of the Penal Code, or the information or accusation against him/her has been dismissed pursuant to Section 1203.4 of the Penal Code, or
  - (2)      A recipient, who has been informed of the Tier 2 disqualifying crime(s) for which he/she has been convicted/incarcerated, and who wishes to employ the individual in spite of his/her criminal background, submits to the county an individual waiver of the exclusion, or
  - (3)      He/she has applied to the Department and has been granted a general exception of the exclusion.

**30-776**                      **PROVIDER ENROLLMENT (Continued)**                      **30-776**

- (e) A brief explanation of the process that a recipient must follow to request an individual waiver of an individual's exclusion as a provider based on a Tier 2 disqualifying conviction/incarceration and rules and limitations pertaining to the provision of services under an individual waiver.
- (f) A brief explanation of the process for applying for a general exception of an individual's exclusion as a provider based on a Tier 2 disqualifying conviction/incarceration.
- (g) A statement indicating that completion of the provider enrollment form is one of the provider enrollment requirements and that an individual must complete all of the provider enrollment requirements before he/she can be enrolled as a provider and receive payment for providing services.
- (h) Fields for the individual to provide the following information: full name; date of birth; gender; home and mailing addresses; telephone number; email address; Social Security number; driver's license or government-issued identification number, issuing state and expiration date; and primary spoken and written languages.
- (i) Questions asking whether the individual, in the last 10 years, has been convicted of, or incarcerated following a conviction for, a Tier 1 or Tier 2 disqualifying crime(s).
- (j) If the individual has indicated that, within the last 10 years, he/she has been convicted of, or incarcerated following conviction for, a Tier 2 disqualifying crime, a question asking whether he/she has obtained a certificate of rehabilitation or expungement (dismissal pursuant to Penal Code section 1203.4) of the conviction.
- (k) If the individual has obtained a certificate of rehabilitation or an expungement, a statement indicating that he/she must provide the county with a copy of the documentation.
- (l) A declaration indicating that the individual understands and agrees that:
  - (1) He/she cannot receive IHSS program funds as payment for authorized services he/she provides to any eligible recipient of IHSS until he/she has completed the entire provider enrollment process and has been officially enrolled as a provider by the county;

**30-776 PROVIDER ENROLLMENT (Continued)****30-776**

- (2) Completion and submittal of the provider enrollment form is one of the requirements of the provider enrollment process; and
  - (A) He/she must complete all of the provider enrollment requirements within 90 calendar days;
  - (B) The 90 calendar day period begins either when he/she completes the first enrollment requirement or when a recipient designates the individual as his/her provider; and
  - (C) If he/she begins providing authorized services for an eligible recipient before he/she completes the provider enrollment requirements, and he/she is ultimately determined eligible to be enrolled as a provider, he/she will be eligible to be paid retroactively for services he/she provided before completing the requirements no more than 90 calendar days before he/she completed the provider enrollment requirements and was determined eligible to be a provider.
- (3) As part of the provider enrollment process, he/she must provide fingerprints and undergo a criminal background check, and that he/she is responsible for paying the cost of fingerprinting and the background check;
- (4) If it is found, either through the individual's responses on the form, the results of the criminal background check, or some other means, that within the past 10 years, he/she has been convicted of or incarcerated following a conviction for a Tier 1 exclusionary crime, he/she will not be eligible to be an IHSS provider, and the recipient who wished to hire him/her will be informed that he/she is ineligible to be a provider because of a disqualifying criminal conviction which will not be specified;
- (5) If it is found, either through the individual's responses on the form, the results of the criminal background check, or some other means, that within the past 10 years, he/she has been convicted of or incarcerated following a conviction for a Tier 2 exclusionary crime, and he/she has not received a certificate of rehabilitation or had the conviction expunged, then:
  - (A) He/she will not be eligible to be an IHSS provider, unless an IHSS recipient who wishes to hire him/her to provide services, requests an individual waiver, or he/she applies for and is granted a general exception; and

**30-776**                      **PROVIDER ENROLLMENT (Continued)**                      **30-776**

- (B)      The IHSS recipient who wishes to hire him/her as a provider will be informed of his/her conviction and the types of crimes for which he/she was convicted, and the recipient will be directed to keep the information confidential;
  
- (6)      If the individual is ultimately enrolled by the county as an IHSS provider, and the person for whom he/she provides services receives IHSS through the Medi-Cal program, he/she will be considered to be a Medi-Cal provider of personal care services, and therefore, he/she will be required to comply with all Medi-Cal program rules relating to the provision of services;
  
- (7)      Payment for the authorized services he/she provides to an IHSS recipient will be from federal, state and/or county IHSS funds, and any false statement he/she provides, including false entries on a timesheet or withholding of information, may be prosecuted under federal and/or state laws;
  
- (8)      He/she will be required to reimburse the state for any overpayment paid to him/her, and that the amount of any overpayment, individually or in the aggregate, may be deducted from any future warrant to him/her for services provided to any recipient; and
  
- (9)      He/she will be required to provide services without discrimination based on race, religion, color, national or ethnic origin, gender, age, sexual orientation, or physical or mental disability.
  
- (m)      The text of subdivision (a) of Section 273a of the Penal Code, Section 368 of the Penal Code, subdivision (c) of Section 290 of the Penal Code, subdivision (c) of Section 667.5 of the Penal Code, subdivision (c) of Section 1192.7 of the Penal Code, and paragraph (2) of subdivisions (c) and (g) of Section 10980 of the Welfare and Institutions Code.
  
- .412      The provider enrollment form shall be signed by the individual under penalty of perjury.
  
- .413      The completed provider enrollment form shall be returned to the county in person by the individual seeking to become a provider.
  
- .414      When returning the completed provider enrollment form, the applicant provider shall present and allow the county to photocopy the following original documents:
  - (a)      A valid (unexpired) positive photograph identification issued by a U.S. federal or state government agency or by a federally-recognized Native American or Alaskan Native tribal organization.

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- (1) Examples of acceptable identification include: a driver license or identification card issued by a state department of motor vehicles, a U.S. passport, or a U.S. military identification card, or a Native American or Alaskan Native tribal identification card.

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- (b) His/her original Social Security card, or a replacement card issued by the Social Security Administration.
    - (1) Official correspondence from the Social Security Administration showing the individual's Social Security number may be accepted in lieu of the Social Security card.
    - (2) For the purpose of acceptance of the provider enrollment form, a Social Security card imprinted with the notation "Valid for Work Only with DHS Authorization" may be accepted.
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- (A) Refer to Section 30-777 for policies and procedures for verifying an individual's eligibility to work in the United States (U.S.).

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- .415 The county shall retain the signed provider enrollment form and copies of the prospective provider's identification documents in the individual's provider file.
  - (a) If the prospective provider is deemed eligible and is enrolled as a provider, the documents shall be retained for a period of one year beyond the date that the individual stops providing services for any recipient.
  - (b) If the prospective provider is deemed ineligible, the documents shall be retained until the individual has exhausted his/her appeal rights.
- .416 The county shall provide the prospective provider with a copy of the completed provider enrollment form for his/her records.

**30-776**                      **PROVIDER ENROLLMENT (Continued)**                      **30-776**

- .42 The prospective provider shall attend an in-person provider orientation. The prospective provider may only attend the in-person provider orientation after he/she has completed the requirements of Section 30-776.41.
- .421 The orientation shall include the following:
- (a) The requirements to be an eligible IHSS provider.
  - (b) A description of the IHSS program.
  - (c) IHSS program regulations and requirements.
    - (1) Program requirements shall be defined as provider-related processes and procedures which include, but are not limited to, the following:
      - (A) Timesheet requirements, standards and practices; and
      - (B) Any process designed to meet federal provider revalidation requirements; and
      - (C) Cooperation with any process intended to address program integrity and fraud prevention efforts.
  - (d) The consequences of committing fraud in the IHSS program.
  - (e) The Medi-Cal toll-free telephone fraud hotline number and internet web site for reporting suspected fraud or abuse in the provision or receipt of in-home supportive services.
  - (f) The applicable federal and state requirements regarding wages and compensation.
- .422 Any oral and written materials presented at the orientation shall be translated into all languages spoken by a substantial number of the public served by the IHSS Program, in accordance with Section 7295.2 of the Government Code.
- .423 Representatives of the recognized employee organization in the county shall be permitted to make a presentation of up to 30 minutes at the orientation.

**30-776**                      **PROVIDER ENROLLMENT (Continued)**                      **30-776**

- .43 At the conclusion of the provider orientation, the prospective provider shall sign a provider enrollment agreement.
  
- .431 The provider enrollment agreement includes statements indicating that the individual acknowledges and/or understands that he/she:
  - (a) Is required to attend the provider orientation, sign the provider enrollment agreement, and complete all of the other enrollment requirements before he/she can be enrolled as a provider and receive payment for providing services;
    - (1) He/she must complete all of the provider enrollment requirements within 90 calendar days;
    - (2) The 90 calendar day period begins either when he/she completes the first enrollment requirement or when a recipient designates the individual as his/her provider; and
    - (3) If he/she begins providing authorized services for an eligible recipient before he/she completes the provider enrollment requirements, and he/she is ultimately determined eligible to be enrolled as a provider, he/she will be eligible to be paid retroactively for services he/she provided before completing the requirements no more than 90 calendar days before he/she completed the provider enrollment requirements and was determined eligible to be a provider.
  - (b) Was given a description of the IHSS program and information about the requirements for and responsibilities of being provider, the consequences of committing fraud and instructions for reporting suspected fraud or abuse in the program;
  - (c) Received instruction and/or a demonstration of how to complete a timesheet and that he/she understands that only time worked to perform authorized services should be reported on the timesheet, that by signing the timesheet, he/she is certifying that the information reported on it is true and correct, that if he/she is convicted of fraudulently reporting information on the timesheet, in addition to any criminal penalties, he/she may be required to pay civil penalties of at least \$500, and not more than \$1,000, for each instance of fraud;
  - (d) Is required to complete the U.S. Citizenship and Immigration Services' (USCIS) Employment Eligibility Verification (Form I-9) to verify that he/she has a legal right to work in the U.S., and that the recipient(s) for whom he/she provides services will retain a copy of the completed form;

**30-776 PROVIDER ENROLLMENT (Continued)****30-776**

- (e) Has the option to submit Internal Revenue Services' Employee Withholding Allowance Certificate (Form W-4) to request federal income tax withholding and/or California Employment Development Department's Employee Withholding Allowance Certificate (Form DE 4) to request state income tax withholding from my wages, but if he/she does not submit Form W-4 and/or DE 4, there will be no taxes withheld from his/her wages;
  - (f) Cannot be paid for authorized services performed when the recipient is away from his/her home, for example, when the recipient is in the hospital or away on vacation, and that he/she must contact the recipient's social worker for approval of any services that may be performed when the recipient is away from the home;
  - (g) Will receive a notice informing him/her of the services he/she is authorized to perform for each recipient(s);
  - (h) Must cooperate with state or county staff to provide requested information related to the evaluation of a recipient's case; and
  - (i) Accepts the responsibility to follow all program rules and requirements explained at the provider orientation, and that failure to follow the program rules and requirements may result in being terminated as a provider.
- .432 The county shall indefinitely retain the signed provider enrollment agreement in the individual's provider file.
- (a) Pursuant to Government Code section 12168.7, the signed provider enrollment agreement may be retained in electronic format, as long as it is not substantially altered from its original form.
- .433 The county shall provide the prospective provider with a copy of the signed provider enrollment agreement for his/her records.
- .44 The applicant provider shall undergo a criminal background check conducted by the Department of Justice.
- .441 The criminal background check shall establish whether the individual has been convicted of, or incarcerated following a conviction for, any Tier 1 or Tier 2 disqualifying crime(s) within the last 10 years.

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- (a) A list of Tier 2 disqualifying crimes may be accessed on CDSS' website at: [http://www.cdss.ca.gov/agedblinddisabled/res/Tier2\\_Crimes.pdf](http://www.cdss.ca.gov/agedblinddisabled/res/Tier2_Crimes.pdf)

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- (b) An applicant provider who has been convicted of or incarcerated following a conviction for a Tier 2 crime within the last 10 years shall not be deemed ineligible if:
- (1) He/she has obtained a certificate of rehabilitation under Chapter 3.5 (commencing with section 4852.01) of Title 6 of Part 3 of the Penal Code; or
  - (2) The information or accusation against him or her has been dismissed pursuant to section 1203.4 of the Penal Code.
- (c) The last 10 years shall be defined as any point in time during the period 10 years immediately preceding the date the criminal background check results are received by the county.

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- (1) Example: Prospective Provider A has submitted her fingerprints as part of the process to be enrolled as an IHSS provider. The county IHSS office received the CORI results on August 1, 2015, which shows that she was convicted of an exclusionary crime on February 1, 2001, and was incarcerated as a result of the conviction until January 1, 2007. When the social worker examines the CORI to determine the prospective provider's eligibility status, he can only deny her eligibility for exclusionary crimes for which either the date of conviction or the last date of incarceration following the conviction occurred within the 10 years prior to the receipt of the CORI results (from August 1, 2005 to August 1, 2015). Although the social worker sees that the conviction date is out of the range of this time period (February 1, 2001), the prospective provider's last date of incarceration following the conviction is within the time period (January 1, 2007). Therefore, the social worker must deny the prospective provider's enrollment.

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**30-776**                      **PROVIDER ENROLLMENT (Continued)**                      **30-776**

- (d) For the purposes of this section, "incarceration" shall be defined as being held in confinement in a correctional facility, including but not limited to, a jail or prison, or a correctional institution, detention center, colony, farm or camp.
  - (1) Incarceration includes commitment to a state hospital for the care and treatment of the mentally disordered and/or an alternative custody program, including but not limited to, home detention with electronic monitoring, or work, in lieu of confinement, in a work release program.
  - (2) Incarceration does not include parole or probation.
  - (3) If an individual violates the terms of his/her parole or probation and he/she is returned to custody to serve out the remainder of his/her original sentence, the time served counts as incarceration for the original conviction. Therefore, the 10-year period would not begin until after the individual was released from custody for the second time.
- (e) If the criminal background check establishes that the applicant provider has been convicted of, or incarcerated following a conviction for, a disqualifying crime within the last 10 years, the individual shall be deemed ineligible to be a provider.

.442 The criminal background check shall be conducted at the expense of the applicant provider.

.45 Refusal or failure to complete any of the enrollment requirements specified in Sections 30-776.41, 30-776.42, 30-776.43, or 30-776.44, shall result in the applicant provider being deemed ineligible to be a provider in the IHSS program.

.46 An applicant provider shall not be required to complete the enrollment requirements specified in Sections 30-776.41, 30-776.42, 30-776.43, and 30-776.44 more than once, provided that he/she remains active and continuously enrolled as a provider.

.461 Active shall be defined as having submitted at least one (1) timesheet for providing services to any recipient statewide during a period of twelve (12) consecutive months.

.462 A county shall accept a criminal background check clearance for an individual who has been deemed eligible by another county.

- (a) A criminal background check clearance shall be defined as one of the following:
  - (1) A response as described in Section 30-776.582; or

**30-776      PROVIDER ENROLLMENT (Continued)      30-776**

- (2) A Criminal Offender Record Information response which does not include any disqualifying convictions as described in Section 30-776.583(b).
  
- (b) If an individual was determined ineligible to be a provider on the basis of a Tier 2 disqualifying conviction, but his/her exclusion as a provider has been waived by a recipient pursuant to Section 30-776.7, the waiver does not constitute a criminal background clearance.
  
- (c) Existence of a clearance shall be determined by verification through the Case Management, Information, and Payrolling System (CMIPS).
  
- .463 When an individual is providing services to a recipient(s) in a county other than the one in which he/she underwent the criminal background check, or when an individual is providing services for recipients in more than one county, the county which originally secured the criminal background check information from the Department of Justice shall be referred to as the originating county.
  - (a) The originating county shall be responsible for:
    - (1) Providing all other counties in which the individual is providing services to a recipient with copies of the provider enrollment form submitted to the originating county pursuant to Section 30-776.41 and the provider enrollment agreement completed by the prospective provider in the originating county pursuant to Section 30-776.43 to be placed in the provider files in the county IHSS office or IHSS public authority office.
    - (2) Following the procedures outlined in Section 30-776.8 for Notifications of Subsequent Arrest and/or Disposition information.
    - (3) Following the procedures outlined in Section 30-776.6 for providing notice of an individual's ineligibility to be enrolled as a provider to:
      - (A) The provider; and
      - (B) Any and all recipient(s) for whom the individual provides services in the originating county.
    - (4) Within three (3) calendar days, informing any other county(ies) in which the individual provides services for recipients subsequent to the county of origin, that the individual is ineligible to continue to provide services due to a subsequent conviction for a disqualifying crime.

**30-776**                      **PROVIDER ENROLLMENT** (Continued)                      **30-776**

- (A) The county(ies) in which the individual provides services subsequent to the originating county shall be responsible for following the procedures outlined in Section 30-776.6 for providing notice of an individual's ineligibility to be enrolled as a provider to any and all recipient(s) for whom the individual provides services in that county.
  - 1. The originating county shall not provide the subsequent arrest notice provided by the Department of Justice to another county(ies) as this information must be kept confidential; however, if public documents, including but not limited to court records, are used to establish that an arrest resulted in a conviction for a disqualifying crime, such documentation may be shared with the other county(ies) so that the other county(ies) have information necessary to fulfill the requirement to provide notice to recipients receiving services from the disqualified individual in that county(ies).
- .5 Procedures for the criminal background check.
  - .51 The county shall establish and maintain authorization from the Department of Justice to receive criminal background check information on individuals seeking to become IHSS providers.
    - .511 As part of the Department of Justice authorization process, the county shall request to receive notifications of subsequent arrest and/or disposition information.
  - .52 The county shall comply with all Department of Justice requirements and directives on the receipt, handling, storage, dissemination and destruction of criminal background check information.
    - .521 If an applicant provider is deemed ineligible to be enrolled as a provider based on information contained in the criminal background check information received from the Department of Justice, the county shall retain the criminal background check information until such time that the individual has exhausted all of his/her rights to appeal the ineligibility decision.
  - .53 The county shall provide the applicant provider with the necessary form(s) and instructions for having his/her fingerprints scanned and transmitted to the Department of Justice as required for the criminal background check.

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- .531 In addition to the Department of Justice's designated form for requesting Live Scan fingerprint imaging service, on which the county shall have provided all county-specific information, the county may provide the following information:
- (a) Notification that valid photo identification shall be presented to the Live Scan Operator along with the Live Scan request form;
  - (b) Information about the location of nearby Live Scan sites.
  - (c) Notification that the fingerprinting and criminal background check shall be conducted at the provider's expense.
  - (d) Contact information for the Department of Justice's automated telephone service to check on the status of a fingerprint submission.
  - (e) Notification that if the individual seeking to become a provider is a minor the Live Scan agency may require the individual to provide parental consent for fingerprinting.
- .54 After the applicant provider has submitted his/her fingerprints, and the Department of Justice has completed processing them, the Department of Justice will transmit the result to the county.
- .55 Pursuant to Welfare and Institutions Code Section 15660(a), the Department of Justice shall secure the criminal record of a person to determine whether the person has:
- .551 Ever been convicted of a violation or attempted violation of Section 243.4 of the Penal Code, a sex offense against a minor; or any felony that requires registration pursuant to Section 290 of the Penal Code; or
  - .552 Within the past 10 years has been convicted of or incarcerated as a result of committing a violation or attempted violation of Sections 273a and 273d, or subdivision (a) or (b) of Section 368 of the Penal Code, or as the result of committing theft, robbery, burglary, or any felony.
- .56 Pursuant to Penal Code Section 11105(n)(2)(A), the Department of Justice shall disseminate the following information:
- .561 Every conviction for a violation or attempted violation of any offense specified in Welfare and Institutions Code Section 15660(a); and

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- .562 Every arrest for a violation or attempted violation of an offense specified in Welfare and Institutions Code Section 15660(a) for which the individual is presently awaiting trial, whether he/she is incarcerated or has been released on bail or on his/her own recognizance pending trial.
  
- .57 Unless a conviction is for an offense for which registration is required pursuant to Penal Code Section 290, the Department of Justice shall only disseminate information if the conviction occurred within 10 years of the date of the request for information or if the conviction occurred over 10 years ago but the subject of the request was incarcerated within 10 years of the request for information. Conviction information for offenses requiring registration as a sexual offender shall be disseminated without regard to when the conviction or incarceration occurred.

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- .58 Dependent on the type of response received from the Department of Justice, the county shall take the following action:
  - .581 If the county receives a notification that the Department of Justice has received the fingerprint transaction but that there will be a delay in processing/ responding, it shall await the final response and, when it is received, proceed as specified below.
  
  - .582 If the county receives a response stating that there is no criminal information on the individual meeting the dissemination criteria pursuant to Welfare and Institutions Code Section 15660, it shall:
    - (a) Consider the prospective provider to have met the criminal background check enrollment requirement, and
  
    - (b) Provided that the other enrollment requirements specified in 30-776.41, 30-776.42, and 30-776.43, have been met, deem the individual eligible to be enrolled as a provider.
  
  - .583 If the county receives Criminal Offender Record Information, which is a response containing all criminal offender record information meeting the dissemination criteria pursuant to Welfare and Institutions Code Section 15660, it shall:

**30-776**                      **PROVIDER ENROLLMENT (Continued)**                      **30-776**

- (a) Review the information to determine whether:
  - (1) The applicant provider has been convicted of, or incarcerated following a conviction for, a Tier 1 or Tier 2 disqualifying crime(s), and
    - (A) Crimes involving fraud against a government health care or supportive services program may be prosecuted under various sections of the Penal Code and/or Welfare and Institutions Code.
    - (B) When a county learns that an individual has been convicted of a crime involving fraud against a public social services program, the county is responsible for obtaining additional information, including but not limited to, court documents, necessary for determining whether the program against which the fraud was committed was a government health care or supportive services program.
  - (2) The conviction, or incarceration following the conviction, occurred within the last 10 years.
- (b) If both of the conditions specified in (a)(1) and (2) above are met, deem the individual ineligible to be enrolled as a provider.
- (c) If only one of the above conditions are met, or if neither are met:
  - (1) Deem the prospective provider to have met the criminal background check enrollment requirement, and
  - (2) Provided that the other enrollment requirements specified in sections 30-776.41, 30-776.42, and 30-776.43, have been met, deem the individual eligible to be enrolled as a provider.

.59 If the county receives verifiable documentation, including but not limited to, Federal Bureau of Investigation background check, or court documents from another state, indicating that, within the last 10 years, the applicant provider has been convicted of, or incarcerated following a conviction for, a Tier 1 disqualifying crime, in another jurisdiction, the county shall deem the individual ineligible to be enrolled as a provider.

**30-776**                      **PROVIDER ENROLLMENT (Continued)**                      **30-776**

- .6 Providing notice of an individual's eligibility or ineligibility to be enrolled as a provider.
  - .61 Within 20 calendar days of the county's determination of a prospective provider's eligibility or ineligibility to be enrolled as a provider, the county shall provide notice of the individual's eligibility or ineligibility to:
    - .611 The prospective provider; and
    - .612 Any and all recipients for whom the prospective provider is providing or is seeking to provide services.
  - .62 CDSS has developed various notices designated as "Required – No Substitutions Allowed" which shall be used to inform both prospective providers and recipients of an individual's eligibility or ineligibility to be enrolled as a provider.

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- .621 These notices may be accessed on CDSS' Forms/Brochures web page at: <http://www.cdss.ca.gov/cdssweb/PG183.htm>.

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- .63 When a prospective provider or provider is deemed to be ineligible to be a provider for any reason:
  - .631 The notice to the individual shall include:
    - (a) The specific reason he/she was deemed ineligible;
    - (b) In the case of a provider who is found ineligible based on a conviction for a disqualifying crime subsequent to being enrolled, the date on which he/she will no longer be eligible to receive payment for services provided;
      - (1) In order to allow for mailing and receipt of the notice, and time for the recipient(s) to find and hire a new provider(s), the county shall allow the individual to remain eligible to provide services and receive payment for services provided for current recipients only for a period of 20 calendar days from the date the county deems the individual ineligible.
    - (c) Any actions the individual may take to be deemed eligible, if appropriate;

**30-776      PROVIDER ENROLLMENT (Continued)**

**30-776**

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- (1) For example, if the individual has been deemed ineligible because of his/her failure to complete one or more of the provider enrollment requirements, the notice should indicate that if the individual successfully completes these requirements he/she would then be eligible to be enrolled as a provider.

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- (d) If the individual has been deemed to be ineligible based on a disqualifying criminal conviction, information about his/her right to appeal the county's decision and the process for requesting an appeal.
- .632 The notice to any and all recipients shall include:
- (a) The name of the individual deemed ineligible to provide services;
- (b) In the case of a provider who is found ineligible based on a conviction for a disqualifying crime subsequent to being enrolled, the date on which the individual will no longer be eligible to receive payment for services provided;
- (c) A statement informing the recipient that he/she must choose another individual to provide his/her services, and that if he/she chooses to continue receiving services from the individual deemed ineligible, he/she will be responsible for reimbursing the individual for any services he/she provides; and
- (d) The telephone number the recipient can call for assistance in finding a new provider.
- .633 When an individual is found to be ineligible due to a conviction, or incarceration following a conviction, for a disqualifying crime within the last 10 years, along with the appropriate notice of ineligibility, the county shall provide the individual who has been found ineligible to be a provider with the following:
- (a) An unaltered copy of his/her criminal offender record information as provided to the county by the Department of Justice; and
- (b) Information on how the individual may contest the accuracy and completeness of, and refute any erroneous or inaccurate information in his/her criminal offender record information.

**30-776 PROVIDER ENROLLMENT (Continued)****30-776**

- .7 Policies and Procedures for Individual Waiver of Disqualifying Convictions.
- .71 A recipient shall be permitted to choose as his/her provider an individual who has been found to be ineligible based on a conviction(s), or incarceration following a conviction(s), for a disqualifying Tier 2 crime(s) within the last 10 years, but who otherwise meets all provider enrollment requirements, by requesting an individual waiver of the exclusion.
- .72 A recipient shall not be permitted to request an individual waiver of an exclusion based on an ineligible individual's conviction(s), or incarceration following a conviction, within the last 10 years, for a disqualifying Tier 1 crime(s).
- .73 When an individual is found to be ineligible to be a provider based on a conviction(s), or incarceration following a conviction(s), for a disqualifying Tier 2 crime(s) within the last 10 years, the county shall provide to the recipient:
- .731 Information explaining the process for requesting an individual waiver of an ineligible individual's exclusion based on a disqualifying Tier 2 conviction(s); and
- .732 An individual waiver request form which includes:
- (a) The specific Penal Code sections, names and descriptions that describe in plain language the ineligible individual's disqualifying conviction(s); and
- (b) A statement that the recipient, or his/her authorized representative, if applicable, is aware of the individual's conviction(s) and that he/she agrees to waive the individual's exclusion and employ the individual as his/her provider.
- .74 The individual waiver form shall be signed by the recipient, or by the recipient's authorized representative, if applicable, and returned to the county by mail or in person.
- .741 Except for a parent, guardian, or person having legal custody of a minor recipient, a conservator of an adult recipient, or a spouse or registered domestic partner of a recipient, an individual shall not sign his/her own individual waiver form as the recipient's authorized representative.
- (a) Upon receipt of the completed waiver request, the county shall determine whether the waiver request was signed by the recipient or another individual who has authority to sign a waiver on his/her behalf.
- (1) If the waiver request was signed by the recipient or an individual who has authority to sign on his/her behalf, the county shall:

**30-776**      **PROVIDER ENROLLMENT (Continued)**      **30-776**

- (A) Provide notice to the recipient acknowledging receipt of the waiver request and indicating that the individual is eligible to begin providing and receive payment for providing his/her authorized services; and
  - (B) Provide notice to the individual indicating that he/she is eligible to begin providing and receive payment for providing authorized services for the recipient who signed the waiver.
    - 1. If an individual began providing authorized services for the recipient before a valid waiver request was received by the county, the individual cannot be paid retroactively for services he/she provided more than 90 days back from the date that the county acknowledged receipt of the valid waiver request.
  - (2) If the waiver request was signed by an individual who does not have authority to sign on his/her behalf, the county shall provide notice to the recipient indicating that the waiver was invalid because it was signed by an individual who does not have authority to sign the waiver on behalf of the recipient.
- .742 The county shall retain the waiver form and a copy of the individual's criminal offense record information until the date that the convictions that are the subject of the waiver request are no longer within the 10-year exclusionary period.
- .75 A provider hired pursuant to an individual waiver may be employed only by the recipient who requested that waiver, and the waiver shall only be valid with respect to convictions that are specified in that waiver.
- .751 A new waiver shall be required if the individual is subsequently convicted of another disqualifying Tier 2 crime(s).
- (a) When the county receives information indicating that an individual who has been providing services under a waiver has been convicted of another disqualifying Tier 2 crime, the county shall provide notice of the provider's ineligibility to continue to provide services to both the recipient and the provider as specified in Sections 30-776.632 and 30-776.73.
- .76 An individual who is eligible to receive payment for services provided to a recipient under an individual waiver shall be permitted to provide services to an additional recipient(s) in the originating county, as defined in Section 30-776.463, if the additional recipient(s) request an individual waiver of the individual's exclusion.

**30-776 PROVIDER ENROLLMENT (Continued)****30-776**

.77 An individual who is eligible to receive payment for services provided to a recipient under an individual waiver shall not be permitted to provide services to the same recipient or any additional recipient(s) in a county other than the originating county, as defined in Section 30-776.463, unless and until he/she undergoes another criminal background check in the county(ies) in which he/she wishes to provide services under a waiver.

.8 An enrolled provider who has been working under an individual waiver, as provided for under Section 30-776.7, may become eligible to work as a provider without an individual waiver or general exception due to lapsing of the ten-year time period referenced in Section 30-776.583(a)(2).

.81 The following conditions must be met for the enrolled provider to be eligible to work as a provider without an individual waiver or general exception:

(a) The county has not notified the Department of Justice to terminate sending subsequent arrest notifications as provided under Section 30-776.93 at any time subsequent to the provider's enrollment; and

(b) The enrolled provider's criminal offender record information and subsequent arrest and disposition notifications, as required under Sections 30-776.583 and 30-776.91, indicate that the enrolled provider has not had a conviction(s) for a disqualifying crime(s) during the previous ten years.

.82 When a provider who has been working under an individual waiver requests to work for a recipient without an individual waiver due to his/her becoming eligible as specified in Section 30-776.8, the county shall:

(a) Review the provider's case file to determine if the provider has become eligible to work as a provider without an individual waiver as specified in Section 30-776.8.

(1) If the county determines that the provider is eligible to work without an individual waiver or general exception as specified in Section 30-776.8, the county shall:

(A) Provide documentation within the provider's case notes indicating the provider's ineligibility for Tier 2 criminal conviction under Section 30-776.583(b) has expired due to the lapse of the ten-year time period referenced in Section 30-776.583(a)(2) and that the provider is now eligible to serve recipients without the need for an individual waiver or general exception; and

(B) Provide notice to the provider that his/her status has changed to eligible to work as a provider without a waiver or general exception as of the date that the ten-year time period referenced in Section 30-776.583(a)(2) lapsed.

**30-776      PROVIDER ENROLLMENT (Continued)      30-776**

- (2) If the county determines that the provider remains ineligible to work as a provider without a waiver, the county shall notify the provider accordingly.

.9 Procedures for Notifications of Subsequent Arrest and/or Disposition Information.

.91 Counties will receive notifications of subsequent arrest and disposition information from Department of Justice for those individuals for whom criminal background checks were requested. The notification may include information about a subsequent arrest, including but not limited to, date of the arrest, code violation, and/or information about the disposition of the subsequent arrest.

.92 When a notification of subsequent arrest and disposition information is received from the Department of Justice, the county shall:

.921 Review the notification to determine whether it includes information only about a subsequent arrest or disposition of a subsequent arrest.

- (a) If the notification includes information only about a subsequent arrest, and not disposition of a subsequent arrest, whether or not the arrest is for a disqualifying crime, the county shall not take any action to deem individual ineligible.

- (b) If the notification includes information about the disposition of a subsequent arrest, the county shall determine whether there has been a conviction for a Tier 1 or Tier 2 disqualifying crime within the last 10 years.

- (1) If the conviction is not for a disqualifying crime, the county shall not take any further action.

- (2) If the conviction is a for Tier 1 or Tier 2 disqualifying crime, the county shall deem the individual ineligible to continue to be enrolled as a provider.

- (A) The county shall provide the individual and all recipients for whom the individual provides services with notice of the individual's ineligibility as outlined in Section 30-776.6.

- (i) The notices shall indicate that the individual may continue to provide services and receive payment for providing services for 20 calendar days in order to allow the recipient(s) adequate time to find and hire a new provider(s).

**30-776**            **PROVIDER ENROLLMENT** (Continued)                      **30-776**

- .922    The county shall retain the following information:
  - (a)    The notification of subsequent arrest and/or disposition information that the county received from the Department of Justice; and
  - (b)    A copy of the notice informing the individual of his/her ineligibility;
  
- .93    The county shall follow Department of Justice procedures to notify the Department of Justice to terminate sending subsequent arrest notifications under the following conditions:
  - .931    When a county deems an individual ineligible to be enrolled as a provider, and the individual has exhausted all of his/her rights to appeal the ineligibility determination; or
  - .932    An individual who has been enrolled as a provider has stopped providing services for any recipient for a period longer than one year.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code. Reference: Sections 12300, 12301.22, 12301.24, 12301.25, 12305.81, 12305.86, and 12305.87, Welfare and Institutions Code; Section 12168.7, Government Code; Sections 13040 and 13041, Unemployment Insurance Code; Immigration Reform and Control Act of 1986, Public Law 99-603 (8 United States Code Section 1324a); 26 United States Code Section 3402; 26 Code of Federal Regulation Section 31.3402(f)(2)-1(a).

**30-777**                      **PROVIDER EMPLOYMENT ELIGIBILITY VERIFICATION**                      **30-777**

- .1     The recipient, prior to hiring an individual to be his/her provider, shall verify that the individual is legally authorized to work in the U.S.
  
- .11    Verification of the individual's authorization to work in the U.S. shall be accomplished by obtaining, completing, signing, retaining, and otherwise complying with all of the requirements contained in the most current version of U.S. Citizenship and Immigration Services' (USCIS) Employment Eligibility Verification (Form I-9).

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- .111    The completed Form I-9 shall be retained by the recipient in such a manner as to protect the provider's confidential information, including but not limited to his/her social security number, address and telephone number.
  
- .112    A copy of the completed Form I-9 shall also be retained by the county on behalf of the recipient. This copy shall also be retained in such a manner as to protect the provider's confidential information, including, but not limited to, his/her social security number, address, and telephone number.
  
- .12    Information about Form I-9 requirements may be accessed on USCIS' web site at: <http://www.uscis.gov/I-9>.

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NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code. Reference: Immigration Reform and Control Act of 1986, Public Law 99-603 (8 United States Code 1324a).

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.1      Scope of Services

DHS regulation Section 51183 reads:

Personal Care Services.

Personal care services include (a) personal care services and (b) ancillary services prescribed in accordance with a plan of treatment.

(a)      Personal care services include:

- (1)      Assisting with ambulation, including walking or moving around (i.e. wheelchair) inside the home, changing locations in a room, moving from room to room to gain access for the purpose of engaging in other activities. Ambulation does not include movement solely for the purpose of exercise.
- (2)      Bathing and grooming including cleaning the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub, or shower, reaching head and body parts for soaping, rinsing, and drying. Grooming includes hair combing and brushing, shampooing, oral hygiene, shaving and fingernail and toenail care.
- (3)      Dressing includes putting on and taking off, fastening and unfastening garments and undergarments, and special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.
- (4)      Bowel, bladder and menstrual care including assisting the person on and off toilet or commode and emptying commode, managing clothing and wiping and cleaning body after toileting, assistance with using and emptying bedpans, ostomy and/or catheter receptacles and urinals, application of diapers and disposable barrier pads.

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**HANDBOOK CONTINUES**

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**30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY**  
(Continued)**30-780**

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- (5) Repositioning, transfer, skin care, and range of motion exercises.
- (A) Includes moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, chair, or sofa, and the like, coming to a standing position and/or rubbing skin and repositioning to promote circulation and prevent skin breakdown. However, if decubiti have developed, the need for skin and wound care is a paramedical service.
- (B) Such exercises shall include the carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function, improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities; and assistive walking.
- (6) Feeding, hydration assistance including reaching for, picking up, grasping utensil and cup; getting food on utensil, bringing food, utensil, cup to mouth, manipulating food on plate. Cleaning face and hands as necessary following meal.
- (7) Assistance with self-administration of medications. Assistance with self-administration of medications consists of reminding the beneficiary to take prescribed and/or over-the-counter medications when they are to be taken and setting up Medi-sets.
- (8) Respiration limited to nonmedical services such as assistance with self-administration of oxygen, assistance in the use of a nebulizer, and cleaning oxygen equipment.
- (9) Paramedical services are defined in Welfare and Institutions Code Section 12300.1 as follows:
- (A) Paramedical services include the administration of medications, puncturing the skin or inserting a medical device into a body orifice, activities requiring sterile procedures, or other activities requiring judgment based on training given by a licensed health care professional.

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**HANDBOOK CONTINUES**

<b>30-780</b>	<b>PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY</b>	<b>30-780</b>
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- (B) Paramedical services are activities which persons could perform for themselves but for their functional limitations.
  - (C) Paramedical services are activities which, due to the beneficiary's physical or mental condition, are necessary to maintain the beneficiary's health.
- (b) Ancillary services are subject to time per task guidelines when established in Sections 30-757 of the Department of Social Services' Manual of Policies and Procedures and are limited to the following:
- (1) Domestic services are limited to the following:
    - (A) Sweeping, vacuuming, washing and waxing of floor surfaces.
    - (B) Washing kitchen counters and sinks.
    - (C) Cleaning the bathroom
    - (D) Storing food and supplies.
    - (E) Taking out the garbage.
    - (F) Dusting and picking up.
    - (G) Cleaning oven and stove.
    - (H) Cleaning and defrosting refrigerator.
    - (I) Bringing in fuel for heating or cooking purposes from a fuel bin in the yard.
    - (J) Changing bed linen.
    - (K) Miscellaneous domestic services (e.g., changing light bulbs and wheelchair cleaning, and changing and recharging wheelchair batteries) when the service is identified and documented by the case worker as necessary for the beneficiary to remain safely in his/her home.

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**HANDBOOK CONTINUES**

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- (2) Laundry services include washing and drying laundry, and is limited to sorting, manipulating soap containers, reaching into machines, handling wet laundry, operating machine controls, hanging laundry to dry if dryer is not routinely used, mending, or ironing, folding, and storing clothing on shelves, in closets or in drawers.
- (3) Reasonable food shopping and errands limited to the nearest available stores or other facilities consistent with the beneficiary's economy and needs; compiling a list, bending, reaching, and lifting, managing cart or basket, identifying items needed, putting items away, phoning in and picking up prescriptions, and buying clothing.
- (4) Meal preparation and cleanup including planning menus; e.g., washing, peeling and slicing vegetables; opening packages, cans and bags, mixing ingredients; lifting pots and pans; reheating food, cooking and safely operating stove, setting the table and serving the meals; cutting the food into bite-size pieces; washing and drying dishes, and putting them away.
- (5) Assistance by the provider is available for accompaniment when the beneficiary's presence is required at the destination and such assistance is necessary to accomplish the travel limited to:
  - (A) Accompaniment to and from appointments with physicians, dentists and other health practitioners. This accompaniment shall be authorized only after staff of the designated county department has determined that no other Medi-Cal service will provide transportation in the specific case.
  - (B) Accompaniment to the site where alternative resources provide in-home supportive services to the beneficiary in lieu of IHSS. This accompaniment shall be authorized only after staff of the designated county department have determined that neither accompaniment nor transportation is available by the program.

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**HANDBOOK CONTINUES**

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<b>30-780</b>	<b>PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY</b>	<b>30-780</b>
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- (6) Heavy Cleaning which involves thorough cleaning of the home to remove hazardous debris or dirt.
  - (7) Yard hazard abatement which is light work in the yard which may be authorized for:
    - (A) removal of high grass or weeds and rubbish when this constitutes a fire hazard.
    - (B) removal of ice, snow or other hazardous substances from entrances and essential walkways when access to the home is hazardous.
  - (c) Ancillary services may not be provided separately from personal care services listed in subsection (a) above.
- .2 Personal Care Services Program Tasks

DHS regulation Section 51350 reads:

Personal Care Services.

- (a) Personal care services as specified in Section 51183 are provided when authorized by the staff of a designated county department based on the state approved Uniformity Assessment tool. To the extent not inconsistent with statutes and regulations governing the Medi-Cal program, the needs assessment process shall be governed by the Department of Social Services' Manual of Policies and Procedures Sections 30-760, 30-761, and 30-763.
- (b) Personal care services may be provided only to a categorically needy beneficiary as defined in Welfare and Institutions Code, Section 14050.1, who has a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or that is expected to result in death within 12 months and who is unable to remain safely at home without the services. The services shall be provided in the beneficiary's home or other locations as may be authorized by the Director subject to federal approval. Personal care services authorized shall not exceed 283 hours in a calendar month.

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**HANDBOOK CONTINUES**

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**30-780 PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY**  
(Continued)**30-780**

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- (c) Personal care services will be prescribed by a physician. The beneficiary's medical necessity for personal care shall be certified by a licensed physician. Physician certification shall be done annually.
- (d) Registered nurse supervision consists of review of the service plan and provision of supportive intervention. The nurse shall review each case record at least every twelve months. The nurse shall make home visits to evaluate the beneficiary's condition and the effectiveness of personal care services based on review of the case record or whenever determined as necessary by staff of a designated county department. If appropriate, the nurse shall arrange for medical follow-up. All nurse supervision activities shall be documented and signed in the case record of the beneficiary.
- (e) Paramedical services when included in the personal care plan of treatment must be ordered by a licensed health professional lawfully authorized by the State. The order shall include a statement of informed consent saying that the beneficiary has been informed of the potential risks arising from receipt of such services. The statement of informed consent shall be signed and dated by the beneficiary, the personal representative of the beneficiary, or in the case of a minor, the legal parent or guardian.
- (f) Grooming shall exclude cutting with scissors or clipping toenails.
- (g) Menstrual care is limited to external application of sanitary napkin and cleaning. Catheter insertion, ostomy irrigation and bowel program are not bowel or bladder care but paramedical.
- (h) Repositioning, transfer skin care, and range of motion exercises have the following limitations:
  - (1) Includes moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, or sofa, coming to a standing position and/or rubbing skin and repositioning to promote circulation and prevent skin breakdown. However, if decubiti have developed, the need for skin and wound care is a paramedical service.

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- (2) Range of motion exercises shall be limited to the general supervision of exercises which have been taught to the beneficiary by a licensed therapist or other health care professional to restore mobility restricted because of the injury, disuse or disease. Range of motion exercises shall be limited to maintenance therapy when the specialized knowledge or judgment of a qualified therapist is not required and the exercises are consistent with the beneficiary's capacity and tolerance. Such exercises shall include the carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function, improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities; and assistive walking.

.3 Personal Care Services Program Required Documentation

DHS regulation Section 51476.2 reads:

Personal Care Services Records.

Each county shall keep, maintain, and have readily retrievable, such records as are necessary to fully disclose the type and extent of personal care services provided to a Medi-Cal beneficiary. Records shall be made at or near the time the service is rendered or the assessment or other activity is performed. Such records shall include, but not be limited to the following:

- (a) Time sheets
- (b) Assessment forms and notes
- (c) All service records, care plans, and orders/prescriptions ordering personal care.

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<b>30-780</b>	<b>PERSONAL CARE SERVICES PROGRAM (PCSP) ELIGIBILITY</b> (Continued)	<b>30-780</b>
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- .4 Eligibility for PCSP shall be limited to those IHSS recipients who do not receive IHSS advance payment as specified in Section 30-769.731.

NOTE: Authority cited: Sections 10553 and 10554, Welfare and Institutions Code; and Chapter 939, Statutes of 1992. Reference: Section 14132.95, Welfare and Institutions Code; and the State Plan amendment, Approved pursuant to Sections 12301.2 and 14132.95(b), Welfare and Institutions Code.

<b>30-785</b>	<b>IN-HOME SUPPORTIVE SERVICES (IHSS) PLUS WAIVER PROGRAM</b>	<b>30-785</b>
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- (a) Program and Special Definitions
  - (1) The IHSS Plus Waiver program will follow the IHSS, Program Definitions and Special Definitions, specified in MPP Section 30-700 and 30-701, unless otherwise specified.
- (b) Eligibility
  - (1) A person is eligible for the IHSS Plus Waiver who is a California resident, living in his/her own home and is aged, blind or disabled according to Medi-Cal based definitions, and;
  - (2) Has been found eligible for full-scope federally funded Medi-Cal based upon either:
    - (A) receipt of cash assistance through SSI/SSP, CalWORKs cash aid or Foster Care, or
    - (B) an eligibility determination completed by a Medi-Cal Eligibility Worker for full-scope federally funded Medi-Cal, in accordance with Medi-Cal regulations located at Title 22, California Code of Regulations (CCR), Division 3, Subdivision 1, Chapters 1 and 2, and;
  - (3) Has an assessed need, based upon a needs assessment as described in MPP Section 30-761, and;
  - (4) Receives at least one of the following:
    - (A) Restaurant Meal Allowance as specified in MPP Section 30-757.134;
    - (B) Advance Pay as specified in MPP Section 30-769.73;
    - (C) Service(s) provided by his/her spouse as allowed in MPP Section 30-763.41; or
    - (D) Service(s) as a minor child provided by his/her parent as allowed in MPP Section 30-763.45, and;

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(Continued)

(5) Any applicable share of cost has been met.

(A) In determining the applicable share of cost the following shall apply;

1. Medi-Cal rules regarding share of cost will be followed for purposes of determining Medi-Cal eligibility in accordance with Title 22, CCR, Division 3, Chapter 2, Articles 10, 11 and 12.
2. To the extent a recipient comes within the terms of the supplemental payment program described in Welfare and Institutions Code Section 12305.1, a share-of-cost compensation as described in that section shall be performed. The applicable share of cost for such recipients shall include the supplementary payment authorized in that section.

(c) Process for Determination of Eligibility for IHSS Plus Waiver Services

- (1) The process for determining eligibility for the IHSS Plus Waiver program shall be in accordance with MPP Section 30-755.2.

(d) Need

- (1) Designated county staff shall determine the recipient's level of ability, dependence, physical assistance and need in accordance with MPP Section 30-756.

(e) Program Content

- (1) IHSS Plus Waiver program content shall be the same as the program content expressed in MPP Section 30-757.
  - (A) A person who is eligible for a service provided pursuant to the IHSS Plus Waiver shall not be eligible for any service through the IHSS program.
  - (B) A person who is eligible for all of their services pursuant to the PCSP shall not be eligible for any service through the IHSS Plus Waiver or IHSS programs.

(f) Time Per Task and Frequency Guidelines

- (1) When assessing the need for services the assessed time shall be in accordance with MPP Section 30-758.

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(Continued)

## (g) Application Process

- (1) The IHSS Plus Waiver application process shall follow the MPP Section 30-759, except for 30-759.3.
- (2) Presumptive disability is determined in accordance with Medi-Cal regulations located at Title 22, CCR, Division 3, Section 50167(a)(1)(C).
- (3) Additionally, for those not already determined eligible for full-scope federally funded Medi-Cal, a determination for Medi-Cal eligibility must be completed before final eligibility for the IHSS Plus Waiver can be established.
- (4) Intercounty transfers of the IHSS Plus Waiver service case must be coordinated with the intercounty transfer of the Medi-Cal eligibility case.

## (h) Responsibilities

- (1) IHSS Plus Waiver applicant/recipient and county responsibilities shall be the same as the responsibilities specified in MPP Section 30-760(b).

## (i) Needs Assessment Standards

- (1) Services shall be authorized only in cases which meet the conditions established in MPP Section 30-761.1 and eligibility as specified in MPP Section 30-785(b).
- (2) Needs Assessments are performed in accordance with MPP Section 30-761.2, except;
  - (A) A reassessment must be completed prior to the end of the twelfth calendar month from the last assessment.
- (3) IHSS staff shall be staff of a designated county department as specified in MPP Section 30-761.3.

## (j) Service Authorization

- (1) Authorization for services shall be determined in accordance with MPP Section 30-763.

## (k) Individual Provider's Compensation

- (1) The computation of payment, rate of compensation and employer responsibilities for the IHSS Plus Waiver program shall follow the guidelines specified in MPP Section 30-764.

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(Continued)

- (l) Cost Limitations
  - (1) The cost limitations that apply to all payments made for IHSS Plus Waiver Services shall follow the guidelines specified in MPP Section 30-765.
- (m) County Plans
  - (1) Each county welfare department shall develop and submit a county plan to CDSS no later than 30 days following receipt of its allocation, which specifies the means by which the IHSS Plus Waiver program will be provided in order to meet the objectives and conditions within its allocation as specified in MPP Section 30-766.
- (n) Service Delivery Methods
  - (1) The county shall arrange for the provision of IHSS Plus Waiver through one or more of the Service Delivery Methods as specified in MPP Sections 30-767.11, .12 and .13.
- (o) Overpayment/Underpayments
  - (1) For purposes of determining overpayments, action on overpayments and demand for repayment for an IHSS Plus Waiver recipient. DHS regulation Sections 50781, 50786 and 50787 (MPP Handbook Sections 30-768.5, .6 and .7) shall apply.
- (p) Payrolling for Individual Providers
  - (1) Counties shall follow the payrolling-for-individual-providers procedures, specified in MPP Section 30-769, for individual providers who provide services to IHSS Plus Waiver recipients.
- (q) Provider Identification
  - (1) Proof of provider identification shall follow the guidelines specified in IHSS, Provider Identification, MPP Section 30-776.

NOTE: Authority cited: Sections 10553, 10554, 12300, 14132.95, and 14132.951, Welfare and Institutions Code; and 42 USC, Section 1315(a) of the Social Security Act. Reference: Sections 12300, 12305.1, 14132.95, and 14132.951, Welfare and Institutions Code, and Special Terms and Conditions (STC) for the California IHSS Plus Waiver, granted under Section 1115 Demonstration Project.

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