STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

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

February 26, 1986

ALL-COUNTY INFORMATION NOTICE NO. I-18-86

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: IN-HOME SUPPORTIVE SERVICES (IHSS) STATEWIDE CASE REVIEW

In July 1985, the Adult and Family Services Operations Bureau (AFSOB) conducted a statewide case review of the In-Home Supportive Services Program. The purpose of this review was to determine the level of statewide compliance with IHSS regulations. Counties are urged to assess their error cases and the statewide review findings to identify problem areas in their own systems and develop corrective actions as appropriate.

With the forthcoming statewide implementation of the IHSS Case Management Information and Payroll System (CMIPS), it is particularly critical that counties review these findings to take this opportunity to eliminate as many potential problem areas as possible to facilitate a smoother conversion to CMIPS.

Methodology

Data for this review were collected from a statewide random sample of IHSS recipients that received services in the month of May 1985. The sample consisted of 313 cases drawn from 38 counties. Each case was reviewed in the county by AFSOB staff with no recipient contact. Upon completion of review of the sample cases in each county, the reviewer discussed the preliminary findings with county program management. Counties' comments were taken into consideration in developing the final findings.

The sample, although valid statewide, is not large enough to permit analysis of individual county data or to make county comparisons.

The review document consisted of a four-page worksheet (see attached). Questions covered the following areas: application, eligibility determination, income eligibility, needs assessment, program content, notices of action, and protective supervision.

Major Findings

Of the approximately 40 items reviewed for the study, the results indicate a high rate of compliance, 90 percent or greater, with state regulations for nearly all items (see tables). These favorable statewide findings indicate that counties have been generally successful in administering the IHSS Program within the parameters of the regulations. Four items are considered to be of concern based on a compliance rate of less than 90 percent. There are an additional six items in the tables which show a rate of compliance of less than 90 percent. However, these items have not been highlighted in this report because of the small number of cases falling into these review categories.

The four items of concern are as follows:

1. Timely Application Processing

   An eligibility determination must occur within 30 days of the application. Determinations occurring after 30 days are allowed on an exception basis if a prerequisite disability or blindness determination has not been received in the 30-day period and program linkage cannot be presumed. Such an exception must be properly documented in the case record (Review question II.C. and II.C.(a.); Manual of Policies and Procedures (MPP) Section 30-759.2).

   -- Statewide, approximately 21 percent of the cases took longer than the 30-day limit to complete the eligibility determination. None of these cases included documentation of a valid reason for exceeding the 30-day limit. (See Table 4)

2. Timely Needs Assessment

   An initial needs assessment must be completed within 30 days following the date of application (Review question IV.A.; MPP Section 30-759.2)

   -- Approximately 17 percent of the cases did not meet this requirement. (See Table 7)

3. Timely Eligibility Redetermination

   A redetermination of eligibility must occur within 12 months of the previous determination unless a change in the recipient's situation necessitates a redetermination sooner (Review question II.D.; MPP Section 30-755.21).

   -- In approximately 12 percent of the cases, a redetermination of eligibility was not completed within the required 12 months. (See Table 4)

4. Notices of Action

Notices of Action to applicants generally must be sent within 30 days of the application (new application). Notices must also be sent to recipients for every reassessment.

-- For cases involving new applications, approximately 35 percent did not comply with notice of action requirements. Notices were not timely (i.e., not sent within 30 days) for approximately 33 percent of such cases, and no notices were sent in approximately 2 percent of such cases (Review question VI.B.1.; MPP Section 30-759.2).

-- For cases involving a reassessment where there was no change, approximately 27 percent did not comply with the requirement that a notice be sent (Review question VI.B.2.; Welfare and Institutions Code (WIC) Section 12300.2, and All-County Letter 84-10).

-- For cases in which a reassessment resulted in a decrease in hours or a discontinuance, approximately 16 percent of the cases did not comply with notice of action requirements. This included approximately 5 percent in which a notice was not sent timely and approximately 11 percent in which a notice was not sent at all. A notice must be sent at least 10 days prior to the effective date of the action, exclusive of the day of mailing and the effective day of the action, to be timely. (Review question VI.B.4.; MPP Section 10-116.32). (See Table 11)

In addition to the above, the case review identified the following two concerns:

1. In certain cases a factor other than 4.33 was used to convert "Total weekly hours to be purchased by IHSS" to the "Monthly hours authorized sub-total" on the SOC 293, needs assessment form. The use of a factor other than 4.33 will not correctly convert weekly hours to monthly hours and creates the potential for authorization of the incorrect number of hours; and

2. In certain cases the SOC 293 needs assessment form did not reflect all modifications provided at the 1982 statewide implementation training on SB 633 (1981) and AB 223 (1981). Modifications include: (a) deleting the service "Changing bed linen and making bed," as a Related Service and including it within Domestic Services, and (b) calculating domestic hours as a separate monthly factor (not weekly) to be added to the monthly hours authorized sub-total. Again, the potential for authorization of the incorrect number of hours is created by not implementing these modifications.

We thank the counties for their cooperation in completing this review. Any questions regarding the review should be directed to your Adult and Family Services Operations Consultant at (916) 445-0623 or ATSS 485-0623.

LOREN D. SUTER
Deputy Director
Adult and Family Services

cc: CWDA

IHSS REVIEW WORKSHEET

COUNTY:	REVIEWER:
DISTRICT OFFICE:	REVIEW DATE: / /

CASE NAME:	CASE NUMBER:	SOCIAL WORKER:

I. APPLICATION (SOC 295)

REVIEW THE APPLICATION ON FILE.

	YES	NO
A. Is there an application on file? (30-009.223)	☐	☐
B. Indicate date of application ____/____/____ (MONTH/DATE/YEAR)		
C. Was the application signed? (30-009.223)	☐	☐
D. Was the application dated? (30-009.223)	☐	☐

II. ELIGIBILITY DETERMINATION (CASE RECORD)

A. Indicate type of eligibility (30-755.1) ☐ STATUS ELIGIBLE ☐ INCOME ELIGIBLE

	YES	NO
B. Is there verification in the case record to substantiate eligibility? (30-755.2)	☐	☐

Indicate Type: ☐ VIEWED M/C CARD ☐ VIEWED SDX FILE ☐ VIEWED SSI/SSP AWARD LETTER

☐ OTHER ______________________________

	YES	NO
C. Was the initial determination of eligibility completed within 30 days from the date of application?	☐	☐

____/____/____ DATE OF APPLICATION ____/____/____ DATE ELIGIBILITY DETERMINATION ________ NO. OF MONTHS

	YES	NO
(a.) If "NO", was there a valid reason for an exception? (30-7592)	☐	☐
D. If the case has been open more than 12 months was the latest redetermination of eligibility completed within 12 months from the previous recertification of eligibility? (30-755.21)	☐	☐

________ PREVIOUS ELIG. DETERMINATION ________ CURRENT ELIG. DETERMINATION ________ NO. OF MONTHS ☐ N/A

III. INCOME ELIGIBLES (SOC 310, MC 210, SOC 294)

DO NOT COMPLETE SECTION III. FOR CASES THAT ELIGIBILITY WAS DETERMINED AS STATUS ELIGIBLE.

	YES	NO
A. Is there a statement of facts in the case record for the latest eligibility determination? (30-755.262)	☐	☐
(a.) Was it signed and dated by the applicant or person acting for the applicant?	☐	☐
B. Does the case record contain verification of income reported on the statement of facts? (30-755.262)	☐	☐
C. Does the case record contain an IHSS Income Eligibility Share of Cost form for the eligibility determination under review? (30-755.264)	☐	☐
(1) Was a Share of Cost computed?	☐	☐
(2) Was it signed and dated by the Social Service Worker?	☐	☐

IV. NEEDS ASSESSMENT (SOC 293)

	YES	NO
A. Was the initial needs assessment completed within 30 days following the date of application? (30-759.2)	☐	☐

____/____/____ DATE OF APPLICATION ____/____/____ SOCIAL SERVICE STAFF COMPLETION DATE ________ NO. OF DAYS

	YES	NO
(1) Was a face-to-face contact made with the recipient within 30 days following the date of application? (30-759.2)	☐	☐
B. If the case under review has been open more than 12 months was the reassessment made within 12 months from the prior beginning authorization period? (30-761.212)	☐	☐

____/____/____ PRIOR BEGINNING AUTHORIZATION DATE ____/____/____ CURRENT AUTHORIZATION DATE ________ NO. OF MONTHS ☐ N/A

	YES	NO
(1) Was a face-to-face contact made with the recipient within 12 months from the previous face-to-face contact?	☐	☐

☐ N/A

(CONTINUED ON REVERSE)

C. The current Needs Assessment under review must contain the following: (30-761.27) — YES / NO

Item	YES	NO
(1) Recipient Information: Name, Address, City, State, Age, Sex	☐	☐
(2) Indication of Physical Functioning	☐	☐
(3) Indication of Mental/Emotional Functioning	☐	☐
(4) Recipient Living Arrangement	☐	☐
(5) Total Weekly Hours	☐	☐
(6) Level of Services	☐	☐
☐ SEVERLY IMPAIRED ☐ NON-SEVERELY IMPAIRED		
(7) Service Delivery Method(s)	☐	☐
☐ COUNTY ☐ INDIVIDUAL ☐ CONTRACT		
(8) Authorization Period Indicated	☐	☐
(9) Social Service Staff Signature and Date	☐	☐
D. Are weekly hours computed correctly? (30-761.272)	☐	☐

- Verify CWDs figures by adding the figures in Column <u>To Be Purchased By IHSS</u>

F2 Related Services ________ Subtotal

F4 Non-Med. Personal Services + ________ Subtotal

F5a Med. Appt. + ________

F5b Alternate Resources + ________

F7 Protective Supervision + ________

F8 Teaching and Dem. + ________

F9 Paramed. Services + ________

Total Weekly Hours ________

Item	YES	NO
E. Did the recipient opt for restaurant allowance? (30-757.134.) If "NO" skip to "F"	☐	☐
(1) Were service hours from Column To Be Purchased by IHSS Line F2a, b, d, entered on Line 11?	☐	☐
(2) Was Line 11 subtracted from Line 10 correctly computing total weekly hours, Line 12?	☐	☐
F. Is the case under review classified as Severely Impaired? (30-753y) If "NO", skip to "G"	☐	☐
(1) Do Total Need For IHSS hours add up to 20 or more?	☐	☐

- F4 a—k (Non-Med. Pers. Serv.) = ________
- F9 Paramedical Services (If hours are indicated in F4c also add hours) = ________
- F2a Preparation Meals = ________
- F2b Meal Clean Up = ________

Must be 20 hours or more = ________ TOTAL

Item	YES	NO
G. Are monthly hours computed correctly?	☐	☐

________ × 4.33 = ________ + ________ + ________ = ________

TOTAL WEEKLY HOURS (LINE 12) × 4.33 = TOTAL + DOMESTIC SERVICE HOURS + HEAVY CLEAN YARD HAZARD = TOTAL MONTHLY HOURS

V. PROGRAM CONTENT (NEEDS ASSESSMENT AND CASE RECORD)

Item	YES	NO
A. If the recipient is in a shared living arrangement, were the service hours prorated? (30-763.23) If "NOT" shared living arrangement skip to "B"	☐	☐
(1) Does the recipient have a spouse in the home not a recipient of IHSS? If "NO", skip to "(2)"	☐	☐
(a.) Is the spouse able to perform certain specified tasks?	☐	☐
1. If "NO", is there verification in the case record describing his/her inability to perform tasks?	☐	☐
(2) Is the recipient under 18 years of age and living with his/her parent(s)? If "NO", skip to "B"	☐	☐
(a.) If services purchased from parent were each of the conditions met? (30-763.244)	☐	☐
(b.) If services purchased from provider were each of the conditions met? (30-763.245)	☐	☐

(CONTINUED)

	YES	NO
B. Were Paramedical Services Allowed? (30-757.19) If "NO", skip to "VI"	☐	☐
(1) Were services allowed in accordance to 30-757.19?	☐	☐
(2) Is there a SOC 321 containing documentation and verification for the need of paramedical services by a licensed health care professional?	☐	☐

VI. NOTICE OF ACTION (NA 690)

	YES	NO
A. Is the CWD using the form NA 690 series?	☐	☐
If "NO", indicate form used ______________		
B. Was the NOA sent timely for the assessment under review?	☐	
1. ☐ NEW APPLICATIONS — NA must be mailed within 30 days following the date of application (30-759.2).	☐ NOT TIMELY	☐ NO NOA SENT
2. ☐ REASSESSMENT-NO CHANGE — NA must be mailed before ending date of previous assessment period.		
3. ☐ INCREASE IN HOURS — the recipient must receive the NA by the effective date of change.		
4. ☐ ADVERSE ACTION (Decrease in hours or discontinuance) — NA must be mailed 12 calendar days prior to the effective date of the adverse action.		
C. Was the NOA sent to inform the recipient of a decrease in hours? If "NO", skip to "VII"	☐	☐
(1) Does it contain a reason for the change in hours?	☐	☐
(2) Does it contain a regulation citation for the change?	☐	☐

(CONTINUED ON REVERSE)

PROTECTIVE SUPERVISION
IHSS REVIEW WORKSHEET (CONTINUED)

VIII. PROTECTIVE SUPERVISION

	YES	NO
A. For all cases		
(1) For the latest assessment under review, is a need for protective supervision indicated in the Total Need column? If "NO", stop here. .... If "YES", continue.	☐	☐
(2) Indicate the number of hours entered in the Total Need column for protective supervision. ____________		
(3) Has protective supervision been authorized? (Hours entered in the column) (To Be Purchased By In-Home Supportive Services (IHSS))	☐	☐
(a.) Indicate hours authorized. ____________		
(4) Does the recipient have a housemate who provides IHSS? (Not a spouse)	☐	☐
(5) Does the recipient have an able and available spouse who provides IHSS?	☐	☐
(6) Is the recipient receiving the statutory maximum benefit? If "NO", briefly explain the reason(s) (e.g., alternative resources, etc.) .... ____________ ____________	☐	☐
B. For cases opened prior to May 1, 1984:		
(1) Was there an increase in protective supervision hours authorized since the last assessment done prior to May 1, 1984?	☐	☐
(2) If "YES", indicate amount of hours increased. ____________ (NOTE: This includes recipients who are now receiving protective supervision, but were not receiving it prior to May 1, 1984.)		
(3) If the recipient: • has received protective supervision since before May 1, 1984 and • has a housemate, but • did not receive an increase in authorized protective supervision hours after May 1, 1984.		
Is the reason for "NO" increase documented in the case record? .... If "YES", briefly indicate the reason. ____________ ____________	☐	☐
(4) NOTE: If the recipient has a housemate who provides IHSS and there has been an increase in protective supervision hours authorized since the last assessment done prior to May 1, 1984:		
(a.) Does the Notice of Action (NOA) granting the increase in hours state that "Hours for protective supervision are authorized based on the Miller v. Woods and Community Services for the Disabled v. Woods court action?	☐	☐
(b.) Was the authorized increase in hours effective May 1, 1984?	☐	☐
If "NO", indicate the effective date. ____ / ____ / ____ (MONTH, DAY, YEAR)		

TABLE 1

CHARACTERISTICS OF CASES REVIEWED

Characteristic	CASES Number	CASES Percent
Total - Type of Eligibility	313	100.0
1. Status eligible	281	89.8
2. Income eligible	32	10.2
Total - Level of Services	313	100.00
1. Severely impaired	40	12.8
2. Non-severely impaired	272	86.9
3. Unknown	1	0.3
Total - Service Delivery Method	313	100.00
1. County	4	1.3
2. Individual provider	263	84.0
3. Contract	46	14.7

TABLE 2

CHARACTERISTICS OF CASES REVIEWED

Characteristic	CASES Number	CASES Percent
Services Received - All Cases		
1. Related services	290	92.7
2. Non-medical personal services	222	70.9
3. Medical appointment	137	43.8
4. Alternate resources	4	1.3
5. Protective supervision	12	3.8
6. Teaching and demonstration	4	1.3
7. Paramedical services	11	3.5
8. Restaurant allowance	3	1.0
Services Received - Severely Impaired		
1. Non-medical personal services	39	97.5
2. Paramedical services	4	10.0
3. Meal preparation	36	90.0
4. Meal clean-up	32	80.0

TABLE 3

APPLICATION

Review Item	CASES: Yes Number	Yes Percent	No Number	No Percent
1. Application on file	312	99.7	1	0.3
2. Application signed	308	98.4	5	1.6
3. Application dated	304	97.1	9	2.9

TABLE 4

ELIGIBILITY DETERMINATION

Review Item	CASES			
	Yes		No	
	Number	Percent	Number	Percent
1. Verification in case record to substantiate eligibility	306	97.8	7	2.2
2. Initial determination of eligibility completed within 30 days	247	78.9	66	21.1
3. If no, valid reason for exception	0	0.0	66	100.0
4. For cases open more than 12, months, latest redetermination of eligibility completed within 12 months...	214	88.1	29	11.9

TABLE 5

ELIGIBILITY DETERMINATION

Type of Verification	CASES	
	Number	Percent
Total	306	100.0
1. Medi-Cal card	205	67.0
2. SDX file	57	18.6
3. SSI/SSP award letter	16	5.2
4. Other	28	9.2

TABLE 6

INCOME ELIGIBLES

Review Item	CASES			
	Yes		No	
	Number	Percent	Number	Percent
1. Statement of facts in case record for latest eligibility determination	31	96.9	1	3.1
2. Statement of facts signed and dated by applicant or person acting for applicant	31	96.9	1	3.1
3. Case record contains verification of income...	31	96.9	1	3.1
4. Case record contains an IHSS Income Eligibility Share of Cost form	31	96.9	1	3.1
5. Share of cost computed	31	96.9	1	3.1
6. Share of cost form signed and dated by social service worker	31	96.9	1	3.1

TABLE 7

NEEDS ASSESSMENT

Review Item	CASES			
	Yes		No	
	Number	Percent	Number	Percent
1. Initial needs assessment completed within 30 days...	260	83.1	53	16.9
2. Face-to-face contact made within 30 days...	295	94.3	18	5.7
3. Weekly hours computed correctly	265	84.7	48	15.3
4. Monthly hours computed correctly	294	93.9	19	6.1
5. For cases open more than 12 months, reassessment made within 12 months from prior authorization period	218	90.8	22	9.2
6. Face-to-face contact made within 12 months from previous face-to-face contact	223	92.9	17	7.1
7. For severely impaired cases, total IHSS hours equal 20 or more	39	97.5	1	2.5

TABLE 8

NEEDS ASSESSMENT

Review Item	CASES			
	Yes		No	
	Number	Percent	Number	Percent
Needs assessment contains:				
1. Name, address, age, sex	307	98.1	6	1.9
2. Indication of physical functioning	308	98.4	5	1.6
3. Indication of mental/emotional functioning	304	97.1	9	2.9
4. Recipient living arrangement	295	94.3	18	5.7
5. Total weekly hours	296	94.6	17	5.4
6. Authorization period	299	95.5	14	0.5
7. Social service staff signature and date	306	97.8	7	2.2

TABLE 9

PROGRAM CONTENT

Review Item	CASES			
	Yes		No	
	Number	Percent	Number	Percent
1. For shared living arrangements, service hours prorated	125	98.4	2	1.6
2. Recipient has spouse in home that is not an IHSS recipient	12	9.6	113	90.4
3. Spouse able to perform certain specified tasks	7	58.3	5	41.7
4. If no, verification in case record describing his/her inability to perform tasks	4	80.0	1	20.0
5. Recipient under 18 years of age and living with parents	5	4.0	120	96.0
6. Services purchased from parent and each condition met	2	66.7	1	33.3
7. Services purchased from provider and each condition met	1	100.0	0	0.0
8. Paramedical services allowed	12	3.8	301	96.2
9. Services allowed in accordance with 30-757.19	11	91.7	1	8.3
10. SOC 321 contains documentation and verification...	10	83.3	2	16.7

TABLE 10

NOTICE OF ACTION

Review Item	CASES			
	Yes		No	
	Number	Percent	Number	Percent
1. CWD using Form NA 690 series [1]	200	63.9	96	30.7
2. Hours decreased or case discontinued and Notice of Action (NOA) sent	17	5.4	296	94.6
3. NOA contains reason for change in hours	17	100.0	0	0.0
4. NOA contains regulation citation for change in hours	16	94.1	1	5.9

1) 17 unknowns (5.4%)

TABLE 11

NOTICE OF ACTION

Review Item	CASES					
	Timely		Not Timely		No NOA Sent	
	Number	Percent	Number	Percent	Number	Percent
NOA sent timely for assessment under review:						
1. New applications	45	65.2	23	33.3	1	1.5
2. Reassessment-No change	112	65.5	13	7.6	46	26.9
3. Increase in hours	32	59.3	20	37.0	2	3.7
4. Adverse action	16	84.2	1	5.3	2	10.5

TABLE 12

PROTECTIVE SUPERVISION (ALL CASES)

Review Item	CASES			
	Yes		No	
	Number	Percent	Number	Percent
1. Need for protective supervision indicated...	12	3.8	301	96.2
2. Protective supervision authorized	12	100.0	0	0.0
3. Recipient has housemate who provides IHSS (not a spouse)	7	58.3	5	41.7
4. Recipient has able and available spouse who provides IHSS	0	0.0	12	100.0
5. Recipient receives statutory maximum benefit	2	16.7	10	83.3

TABLE 13

PROTECTIVE SUPERVISION
(Cases Opened Prior to May 1, 1984)

	CASES			
	Yes		No	
	Number	Percent	Number	Percent
1. Increase in protective supervision hours authorized since last reassessment done prior to May 1, 1984	4	40.0	6	60.0
2. Recipient received protective supervision before May 1, 1984, had housemate, but did not receive increase in hours after May 1, 1984, and reason for no increase documented in case record	1	20.0	4	80.0
3. For recipients with housemates who provided IHSS and received increases in protective supervision hours since last assessment done prior to May 1, 1984:				
a. NOA sent in accordance with 30-763.632	0	0.0	1	100.0
b. Authorized increase in hours effective May 1, 1984	0	0.0	1	100.0