

**State of California  
Office of Administrative Law**

**In re:**  
**Department of Social Services**

**Regulatory Action:**

**Title MPP, California Code of Regulations**

**Adopt sections:**

**Amend section: 30-754.2**

**Repeal sections:**

**NOTICE OF APPROVAL OF CHANGES  
WITHOUT REGULATORY EFFECT**

**California Code of Regulations, Title 1,  
Section 100**

**OAL Matter Number: 2016-0624-01N**

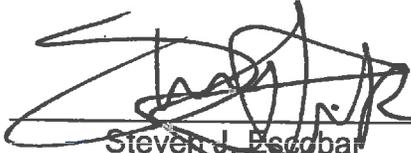
**OAL Matter Type: Nonsubstantive (N)**

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As a change without regulatory effect, the Department of Social Services is correcting a grammatical error in form SOC 873 (10/16), which is incorporated by reference in section 30-754.2 of the Manual of Policies and Procedures, so that a provision in the form aligns with the same language in Welfare and Institutions Code section 14132.95, subdivision (a)(4).

OAL approves this change without regulatory effect as meeting the requirements of California Code of Regulations, title 1, section 100.

Date: July 19, 2016

  
Steven J. Escobar  
Attorney

For: Debra M. Cornez  
Director

Original: Will Lightbourne  
Copy: Kenneth Jennings

## NOTICE PUBLICATION/REGULATIONS SUBMISSION

(See Instructions on reverse)

For use by Secretary of State only

STD. 400 (REV. 01-2013)

OAL FILE NUMBERS	NOTICE FILE NUMBER	REGULATORY ACTION NUMBER	EMERGENCY NUMBER
Z-		2016-0624-01N	
For use by Office of Administrative Law (OAL) only			
NOTICE		REGULATIONS	

AGENCY WITH RULEMAKING AUTHORITY  
California Department of Social ServicesAGENCY FILE NUMBER (if any)  
ORD #0615-08

## A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

1. SUBJECT OF NOTICE		TITLE(S)	FIRST SECTION AFFECTED	2. REQUESTED PUBLICATION DATE
3. NOTICE TYPE <input type="checkbox"/> Notice re Proposed Regulatory Action <input type="checkbox"/> Other		4. AGENCY CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)
OAL USE ONLY	ACTION ON PROPOSED NOTICE <input type="checkbox"/> Approved as Submitted <input type="checkbox"/> Approved as Modified <input type="checkbox"/> Disapproved/Withdrawn		NOTICE REGISTER NUMBER	PUBLICATION DATE

## B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S) IHSS Health Care Certification	1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S)
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2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) (Including title 26, if toxics related)

SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)	ADOPT
	AMEND 30-754.2 incorporated form SOC 873 (10/16)
	REPEAL
TITLE(S) MPP	

3. TYPE OF FILING

<input type="checkbox"/> Regular Rulemaking (Gov. Code §11346)	<input type="checkbox"/> Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §§11346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.	<input type="checkbox"/> Emergency Readopt (Gov. Code, §11346.1(h))	<input checked="" type="checkbox"/> Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
<input type="checkbox"/> Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4)	<input type="checkbox"/> Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)	<input type="checkbox"/> File & Print	<input type="checkbox"/> Print Only
<input type="checkbox"/> Emergency (Gov. Code, §11346.1(b))		<input type="checkbox"/> Other (Specify) _____	

4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)

5. EFFECTIVE DATE OF CHANGES (Gov. Code, §§ 11343.4, 11346.1(d); Cal. Code Regs., title 1, §100)

<input type="checkbox"/> Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))	<input type="checkbox"/> Effective on filing with Secretary of State	<input checked="" type="checkbox"/> \$100 Changes Without Regulatory Effect	<input type="checkbox"/> Effective other (Specify)
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6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY

<input type="checkbox"/> Department of Finance (Form STD. 399) (SAM §6660)	<input type="checkbox"/> Fair Political Practices Commission	<input type="checkbox"/> State Fire Marshal
<input type="checkbox"/> Other (Specify) _____		

7. CONTACT PERSON

Kenneth Jennings	TELEPHONE NUMBER (916) 651-8862	FAX NUMBER (Optional) (916) 654-3286	E-MAIL ADDRESS (Optional) kenneth.jennings@dss.ca.gov
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8. I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.

SIGNATURE OF AGENCY HEAD OR DESIGNEE

DATE

TYPED NAME AND TITLE OF SIGNATORY

BRIAN DOUGHERTY, Deputy Director, Administration Division

For use by Office of Administrative Law (OAL) only

Amend Section 30-754 to read:

**30-754 HEALTH CARE CERTIFICATION**

**30-754**

.1 As a condition of receiving services, each applicant shall provide a health care certification.

.11 - .13 (Continued)

.2 The health care certification shall be provided on a department-approved form, incorporated in its entirety herein by reference, the California Department of Social Services In-Home Supportive Services Program Health Care Certification (SOC 873 (10/16)).

.21 - .653 (Continued)

Authority Cited: Sections 10553 and 10554, Welfare and Institutions Code.

Reference: Section 12309.1, Welfare and Institutions Code.

**IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM  
HEALTH CARE CERTIFICATION FORM**

**A. APPLICANT/RECIPIENT INFORMATION (To be completed by the county)**

Applicant/Recipient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

County of Residence: \_\_\_\_\_ IHSS Case #: \_\_\_\_\_

IHSS Worker Name: \_\_\_\_\_

IHSS Worker Phone #: \_\_\_\_\_ IHSS Worker Fax #: \_\_\_\_\_

**B. AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION  
(To be completed by the applicant/recipient)**

I, \_\_\_\_\_, (PRINT NAME) authorize the release of health care information related to my physical and/or mental condition to the In-Home Supportive Services program as it pertains to my need for domestic/related and personal care services.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(APPLICANT/RECIPIENT OR LEGAL GUARDIAN/CONSERVATOR)

Witness (if the individual signs with an "X"): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**TO: LICENSED HEALTH CARE PROFESSIONAL\* --**

The above-named individual has applied for or is currently receiving services from the In-Home Supportive Services (IHSS) program. State law requires that in order for IHSS services to be authorized or continued a licensed health care professional must provide a health care certification declaring the individual above is unable to perform some activity of daily living independently and without IHSS the individual would be at risk of placement in out-of-home care. This health care certification form must be completed and returned to the IHSS worker listed above. The IHSS worker will use the information provided to evaluate the individual's present condition and his/her need for out-of-home care if IHSS services were not provided. The IHSS worker has the responsibility for authorizing services and service hours. The information provided in this form will be considered as one factor of the need for services, and all relevant documentation will be considered in making the IHSS determination.

IHSS is a program intended to enable aged, blind, and disabled individuals who are most at risk of being placed in out-of-home care to remain safely in their own home by providing domestic/related and personal care services. IHSS services include: housekeeping, meal preparation, meal clean-up, routine laundry, shopping for food or other necessities, assistance with respiration, bowel and bladder care, feeding, bed baths, dressing, menstrual care, assistance with ambulation, transfers, bathing and grooming, rubbing skin and repositioning, care/assistance with prosthesis, accompaniment to medical appointments/alternative resources, yard hazard abatement, heavy cleaning, protective supervision (observing the behavior of a non-self-directing, confused, mentally impaired or mentally ill individual and intervening as appropriate to safeguard recipient against injury, hazard or accident), and paramedical services (activities requiring a judgment based on training given by a licensed health care professional, such as administering medication, puncturing the skin, etc., which an individual would normally perform for him/herself if he/she did not have functional limitations, and which, due to his/her physical or mental condition, are necessary to maintain his/her health). The IHSS program provides hands-on and/or verbal assistance (reminding or prompting) for the services listed above.

*\*Licensed Health Care Professional means an individual licensed in California by the appropriate California regulatory agency, acting within the scope of his or her license or certificate as defined in the Business and Professions Code. These include, but are not limited to: physicians, physician assistants, regional center clinicians or clinician supervisors, occupational therapists, physical therapists, psychiatrists, psychologists, optometrists, ophthalmologists and public health nurses.*

# IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM HEALTH CARE CERTIFICATION FORM

Applicant/Recipient Name: \_\_\_\_\_ IHSS Case #: \_\_\_\_\_

## C. HEALTH CARE INFORMATION (To be completed by a Licensed Health Care Professional Only)

**NOTE: ITEMS #1 & 2 (AND 3 & 4, IF APPLICABLE) MUST BE COMPLETED AS A CONDITION OF IHSS ELIGIBILITY.**

1. Is this individual <u>unable</u> to independently perform one or more activities of daily living (e.g., eating, bathing, dressing, using the toilet, walking, etc.) or instrumental activities of daily living (e.g., housekeeping, preparing meals, shopping for food, etc.)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. In your opinion, is one or more IHSS service recommended in order to prevent the need for out-of-home care (See description of IHSS services on Page 1)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If you answered "NO" to either Question #1 OR #2, skip Questions #3 and #4 below, and complete the rest of the form including the certification in PART D at the bottom of the form. If you answered "YES" to both Question #1 AND #2, respond to Questions #3 and #4 below, and complete the certification in PART D at the bottom of the form.	
3. Provide a description of any physical and/or mental condition or functional limitation that has resulted in or contributed to this individual's need for assistance from the IHSS program:	
4. Is the individual's condition(s) or functional limitation(s) expected to last at least 12 consecutive months OR expected to result in death within 12 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO

*Please complete Items # 5 - 8, to the extent you are able, to further assist the IHSS worker in determining this individual's eligibility.*

5. Describe the nature of the services you provide to this individual (e.g., medical treatment, nursing care, discharge planning, etc.):  
 \_\_\_\_\_
6. How long have you provided service(s) to this individual?  
 \_\_\_\_\_
7. Describe the frequency of contact with this individual (e.g., monthly, yearly, etc.):  
 \_\_\_\_\_
8. Indicate the date you last provided services to this individual: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**NOTE: THE IHSS WORKER MAY CONTACT YOU FOR ADDITIONAL INFORMATION OR TO CLARIFY THE RESPONSES YOU PROVIDED ABOVE.**

## D. LICENSED HEALTH CARE PROFESSIONAL CERTIFICATION

By signing this form, I certify that I am licensed in the State of California and all information provided above is correct.

Name:	Title:
Address:	
Phone #:	Fax #:
Signature:	Date:
Professional License Number:	Licensing Authority:

PLEASE RETURN THIS FORM TO THE IHSS WORKER LISTED ON PAGE 1.