560-1
Federal regulations provide, in pertinent part, that:

(b) A state plan must–

(1) Specify a single State agency established or designated to administer or supervise the administration of the plan; and

(2) Include a certification by the State Attorney General, citing the legal authority for the single State agency to–

(i) Administer or supervise the administration of the plan; and

(ii) Make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan.

(c) Determination of eligibility. (1) The plan must specify whether the agency that determines eligibility for families and for individuals under 21 is–

(i) The Medicaid agency; or

(ii) The single State agency for the financial assistance program under Title IV-A (in the 50 States or the District of Columbia)

(2) The plan must specify whether the agency that determines eligibility for the aged, blind, or disabled is–

(i) The Medicaid agency;

(ii) The single State agency for the financial assistance program under Title IV-A (in the 50 States or the District of Columbia); or

(iii) The Federal agency administering the supplemental security income program under Title XVI (SSI). In this case, the plan must also specify whether the Medicaid agency or the Title IV-A agency determines eligibility for any groups whose eligibility is not determined by the Federal agency.

(e) Authority of the single State agency. In order for an agency to qualify as the Medicaid agency–

(1) The agency must not delegate, to other than its own officials, authority to–

(i) Exercise administrative discretion in the administration or supervision of the plan, or

(ii) Issue policies, rules, and regulations on program matters.

(2) The authority of the agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State.

(3) If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency.

(42 Code of Federal Regulations §431.10)

560-2 ADDED 9/07
There are now three programs providing in-home services: the IHSS Plus Waiver, PCSP, and IHSS Residual. (ACWDL 05-21, June 13, 2005)

560-2A ADDED 9/07
To qualify for the IHSS Plus Waiver, Medi-Cal eligibility is required. Individuals not receiving Supplemental Security Income/State Supplementary Payments (SSI/SSP) or other Medi-Cal linked cash-based programs (e.g., CalWORKs) must be determined eligible for federally funded full-scope Medi-Cal by a Medi-Cal eligibility worker (EW). Individuals must also qualify for in-home services through a needs assessment, completed by an IHSS social worker (SW). Individuals receiving at least one of the IHSS Plus Waiver services are considered to be IHSS PLUS WAIVER participants.

Those IHSS PLUS WAIVER services are:
• Personal care; protective supervision; domestic and related services; heavy cleaning; accompaniment to medical appointments and alternative resources; removal of grass, weeds, rubbish, ice and snow; and teaching and demonstration, when they are provided by a spouse or parent of a minor child as allowed under IHSS Regulations Manual of Policies and Procedures (MPP), Section 30.763.41 and 30.763.45;
• Restaurant meal allowance; and/or
• Advance payment for in-home care services
(ACWDL 05-21, June 13, 2005)

560-2B ADDED 9/07
To qualify for PCSP, individuals not receiving SSI/SSP or Medi-Cal-linked to a cash-based program must be determined eligible for federally funded full-scope Medi-Cal by a Medi-Cal EW and be found in need of personal care services through a needs assessment. Effective May 1,

2004, the Medi-Cal State Plan regarding personal care services was expanded to include the following services as federally funded personal care services:
• Ancillary services, including domestic and related services, under W & I Code, Section 14132.95 (d)(2), ***not*** provided by a spouse or parent of a minor child; and
• Protective supervision ***not*** provided by a spouse or parent of a minor child.
(ACWDL 05-21, June 13, 2005)

560-2C ADDED 9/07
IHSS Residual program services will be available to individuals eligible under current IHSS regulations, but who are not eligible for federally funded full-scope Medi-Cal. The services available under the IHSS Residual program have not changed. (ACWDL 05-21, June 13, 2005)

560-3 ADDED
4/11Effective February 1, 2011, counties are required to reduce every IHSS recipient's total authorized hours by 3.6 percent. The 3.6 percent reduction will first be applied to any documented unmet need (excluding protective supervision). Pursuant to the provisions of the statute, the reduction is temporary and each recipient's service hours will be restored, effective July 1, 2012, to the recipient's full authorized level based on the recipient's most recent assessment. Although the 3.6 reduction ended on July 1, 2012, it was reinstated effective August 1, 2012 with a sunset date of June 30, 2013.

All County Letter 10-61, December 17, 2010 and All County Letter 12-33, July 6, 2012 based on the enactment of Section 12301.06 of the California Welfare and Institutions Code.

560-3 ADDED
4/11Effective February 1, 2011, counties are required to reduce every IHSS recipient's total authorized hours by 3.6 percent. The 3.6 percent reduction will first be applied to any documented unmet need (excluding protective supervision). Pursuant to the provisions of the statute, the reduction is temporary and each recipient's service hours will be restored, effective July 1, 2012, to the recipient's full authorized level based on the recipient's most recent assessment. Although the 3.6 reduction ended on July 1, 2012, it was reinstated effective August 1, 2012 with a sunset date of June 30, 2013.

All County Letter 10-61, December 17, 2010 and All County Letter 12-33, July 6, 2012 based on the enactment of Section 12301.06 of the California Welfare and Institutions Code.

560-5 ADDED
1/13Welfare and Institutions Code section 12301.06 has been amended to extend the 3.6 percent reduction effective August 1, 2012 through June 30, 2013. (All County Letter 12-33, July 6, 2012.)

560-6 ADDED

6/13The 3.6% service reduction in IHSS has been increased to 8% for 12 months commencing on July 1, 2013. All-County Letter (ACL) No: 13-47. June 7, 2013

560-7 ADDED
4/14SB 67 added Section 12301.01 to the Welfare and Institutions Code (WIC) and requires the California Department of Social Services (CDSS) to reduce every IHSS recipient's total authorized hours by eight percent, effective July 1, 2013. The eight percent reduction will first be applied to any documented unmet need (excluding protective supervision). (All County Letter 13-47 issued June 30, 2013)

560-8 ADDED
12/11The California Department of Social Services (CDSS) took action to implement a 20-percent reduction in IHSS recipients' total authorized monthly service hours, effective January 1, 2012. W&IC section 12301.07 as specified in Assembly Bill 121 (Chapter 41, Statutes of 2011), All County Letter No. 11-8, November 29, 2011. However, this reduction has been set aside by a Temporary Restraining Order issued on December 1, 2011. See All County Letter 11-8, December 7, 2011.

561-1A REVISED 9/07
Individuals eligible to receive PCSP payments must have a chronic disabling condition expected to last 12 months or end in death. Personal care services may be provided only to a categorically needy beneficiary as defined in W&IC §14050.1. (§51350(b));

561-1B
By September 1, 1993, the California Department of Social Services shall notify Pickle eligible persons, and persons eligible for services under 42 United States Code §1383c(c), they may receive PCSP without an SOC rather than IHSS if they meet other PCSP requirements and agree to accept payment for services in arrears rather than on an advanced basis. (W&IC §14132.95(k))

561-2
Personal care services may be provided only to individuals who would be unable to remain safely at home without the services. (§51350(b))

For purposes of §51350(b), "home" means that place in which the beneficiary chooses to reside.

A person's "home" does not include a board and care facility, a facility licensed by the CDHS, nor a community care facility or a residential care facility licensed by the CDSS. A person receiving an SSI/SSP payment for a nonmedical out-of-home living arrangement is not considered to be living in her or his "home". (§51145.1)

561-2A
The CDHS has defined a "home" as real or personal property, fixed or mobile, located on land or water, in which a person or family lives. (§50044)

561-2B
State law permits PCSP authorization for services "provided in the beneficiary's home and other locations as may be authorized by the director subject to federal approval." (W&IC §14132.95(a)(1))

561-5 ADDED 2/05
All Medi-Cal eligibility determinations are to be completed following Medi-Cal rules. This includes Medi-Cal eligibility determinations for the In-Home Supportive Services (IHSS) and Personal Care Service Program recipients. (All County Welfare Director's Letter 04-27, August 30, 2004)

561-5A ADDED 8/05
Medi-Cal eligibility determinations and redeterminations are to be performed on all applications received by the county requesting in-home services and existing in-home service for persons who are not also eligible for SSI/SSP or other Medi-Cal linked cash-based assistance. These determinations/redeterminations are to be performed by Medi-Cal eligibility workers using Medi-Cal rules, Medi-Cal forms, and notices of action.

Individuals must be determined eligible for whatever Medi-Cal program is appropriate (e.g., Section 1931(b), Aged and Disabled Federal Poverty Level, Pickle, Medically Needy, 250 percent Working Disabled, etc) before a referral is forwarded to the IHSS unit for a needs assessment.

(All County Welfare Director's Letter 05-21. June 13, 2005).

561-6
It is the position of the CDSS that if an "eligible recipient" (i.e., eligible, per CDHS, because the recipient receives a personal care service and the case is not in advance pay, receiving protective supervision, or the recipient has a spouse/parent provider) refuses to cooperate with the county by failing to complete the form SOC 426, or fails to provide information needed to determine his/her eligibility and need for service, the recipient cannot be authorized PCSP "and will not be eligible for the same services under the residual IHSS program", relying on Welfare & Institutions Code (W&IC) §§12300(f) and 14132.95(a) and (p). The CDSS says that, as stated in §30-757.1, a **"PCSP eligible recipient cannot refuse personal care [emphasis added] under PCSP and still receive ancillary services from residual IHSS**." (All-County Welfare Directors Letter No. 99-13, March 29, 1999; All-County Letter (ACL) No. 99-25, April 19, 1999)

561-6A

CDSS has stated that state regulations provide that a PCSP eligible recipient cannot refuse personal care under PCSP and still receive ancillary services from IHSS. The regulation cited by the CDSS provides in pertinent part:

"A person who is eligible for a personal care service provided pursuant to the PCSP shall not be eligible for that personal care service through IHSS." [emphasis added] (§30-757.1, cited in All-County Letter No. 99-25, April 19, 1999)

561-7
IHSS recipients with an SOC who were “potentially eligible for PCSP” were sent form SOC 426, and asked to return these forms to the county social services worker within five days.

It is the position of the CDSS (i.e., there have been no regulations issued) that if a recipient understands his/her responsibility and fails to cooperate, the county should issue a courtesy notice of noncompliance, specifying that the recipient must submit the provider enrollment form to the county within fifteen calendar days or lose eligibility for both IHSS and PCSP. At the end of the fifteen-day period, recipients who have not submitted the form should be sent a notice of action informing them that services will be discontinued in 10 days.

(All-County Letter No. 99-25, April 19, 1999)

561-8 ADDED 9/07
Medi-Cal program rules allow applicants to request Medi-Cal coverage for the three months prior to the month of application, if the applicant incurred a cost for a covered health care service in that retroactive month.

For purposes of PCSP services received by a newly eligible recipient within three months prior to the application date for IHSS, these PCSP services may be reimbursed by Medi-Cal for otherwise eligible Medi-Cal recipients if the recipient incurred out-of-pocket costs. One of the requirements of Medi-Cal’s three-month retroactivity provisions [22 CCR §50197, §50148] is that the recipient actually receives health care services in the retroactive month. This requirement means the services must have been actually received. An unmet need supported by a subsequent assessment would not qualify for Medi-Cal reimbursement. In addition, because the PCSP reimburses recipients directly for services received and paid for, proof of payment must be provided in the form of cancelled checks or such similar proof as DHS may require.
(All County Letter 02-18, February 14, 2002)

561-9 ADDED 4/10
The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law (PL) 104-193, as a general rule, restricts eligibility for non-citizens for all federal public benefits and bars most non-citizens from Supplemental Security Income/State Supplementary Payment (SSI/SSP), but there are a number of exceptions. PL 104-193 (as amended, and reflected in Title 8, U.S. Code (8 USC), Section 1641(b)) also

established the definition for “Qualified Alien” and the New Affidavit of Support for individuals who sponsor immigrants into this country..

Non-citizens who are not Qualified Aliens are not eligible for federally funded public benefits (8 USC, Sec. 1611). Full scope Medi-Cal with federal financial participation (FFP) is one of the federal public benefits barred under these provisions.

Some non-citizens who are Qualified Aliens and entered the United States on or after August 22, 1996, are also barred from federal public benefits for five years (8 USC, Sec. 1613). Exemptions from this ban include refugees and asylees, and those who qualify for the U.S. military veteran or active duty exception.

(ACIN I-18-08, March 12, 2008)

561-9A ADDED 4/10
To be eligible for PCSP or IHSS Plus Waiver, an individual must be eligible for full scope FFP Medi-Cal. The California Department of Health Care Services (DHCS) has sole responsibility for determining who is eligible for full scope FFP Medi-Cal.

Counties must determine IHSS-R eligibility for applicants or recipients who are not eligible for full scope FFP Medi-Cal.

(ACIN I-18-08, March 12, 2008)

562-1 REVISED 8/05
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 the parent of a minor child or a spouse. (§51181; see also Manual of Policies and Procedures (MPP) Handbook §30-767.3)

A child means a person under the age of 21, except for those considered adults per §50014. (§50030(a)) An unborn is considered a child for Medi-Cal purposes (§50030(b))

562-2
All providers of personal care program services must be approved by the Department of Health Services (DHS) and shall sign the "Personal Care Program Provider/Enrollment Agreement" form designated by DHS, agreeing to comply with all applicable laws and regulations governing Medi-Cal and personal care service. (§§51483.1 and 51204)

562-3
PCSP beneficiaries shall be given a choice of service provider who meets personal care provider requirements. (51483.1)

The beneficiary, the beneficiary's personal representative or the legal parent or guardian (if the beneficiary is a minor) shall certify on the provider enrollment document that the provider is

considered to be qualified to provide personal care. (§51204(a); see also Manual of Policies and Procedures Handbook §30-767.4)

562-4
Contract agency personal care providers shall be selected in accord with Welfare and Institutions Code §12302.1. (§51204(b); see also Manual of Policies and Procedures Handbook §30-767.4(b))

562-5
A provider of personal care services who has a grievance or complaint may initiate an appeal within 90 days of the action precipitating the grievance or complaint to the county department. A provider who is dissatisfied with the decision of the county department may seek judicial remedy pursuant to W&IC 14104.5 (§51015.2; see also MPP Handbook §30-767.5)

563-1
The Personal Care Service Program includes personal care and ancillary services.

Personal care services include:

(1) Assisting with ambulation. Ambulation does not include movement solely for the purpose of exercise.

(2) Bathing and grooming.

(3) Dressing.

(4) Bowel and bladder and menstrual care.

(5) Repositioning, transfer skin care (e.g., rubbing skin and repositioning to promote circulation and prevent skin breakdown) and range of motion exercises.

(6) Feeding, hydration assistance, cleaning face and hands following meal.

(7) Assistance with self-administration of medications.

(8) Respiration, nonmedical services, such as assistance with self-administration of oxygen and cleaning oxygen equipment.

(9) Paramedical services, as defined in Welfare and Institutions Code §12300.1. This includes administration of medications, puncturing the skin, or other activities requiring judgment based on training given by a licensed health care professional.

Ancillary services are limited to the following and are subject to time-per-task guidelines established in the Manual of Policies and Procedures (MPP). Ancillary services are:

(1) Domestic services.

(2) Laundry services.

(3) Reasonable food shopping and errands limited to the nearest available stores or facilities consistent with the beneficiary's economy and needs. This includes compiling a list, putting items away, phoning in and picking up prescriptions.

(4) Meal preparation and cleanup including planning menus.

(5) Accompanying the beneficiary to and from appointments with health care practitioners, and to the site where alternative resources provide IHSS, when the beneficiary's presence is required at the destination, and no other Medi-Cal service will provide the transportation.

(6) Heavy cleaning, which is thorough cleaning of the home to remove hazardous debris or dirt.

(7) Yard hazard abatement, which is light work in the yard.

(§51183; see also MPP Handbook §30-780.1)

563-1A ADDED 8/05
Protective supervision, and cases that authorize Domestic and Related –Only services, will receive federal funding under PCSP. If there is a parent (for minor child) or spouse provider, or restaurant meal allowance or advance pay, the case is funded under the IHSS Plus Waiver (All County Letter 05-05, June 2, 2005)

563-2
Personal care services, as set forth in §51183, shall be authorized by the county department based on the Uniform Assessment tool. The needs assessment process shall be governed by the Manual of Policies and Procedures (MPP), §§30-760, 30-761 and 30-763, unless inconsistent with the Medi-Cal Program. (§51350(a); see also MPP Handbook §30-780.2(a))

563-3
Personal care services shall not exceed 283 hours in a calendar month. (§51350(b); see also Manual of Policies and Procedures Handbook §30-780.2(b))

There is no dollar maximum limit. (All-County Letter No. 95-42, August 11, 1995)

563-3B REVISED
1/15

Under PCSP and CFCO, there is no Non-Severely Impaired (NSI)/Severely Impaired (SI) distinction; all cases are eligible for a maximum of 283 hours. If 195 hours are authorized for protective supervision, the remaining service needs may be authorized, up to a maximum of 283 hours, for other PCSP services.
(ACIN I-28-06, April 11, 2006, answer to question 15, All-County Letter No. 14-60, August 29, 2014)

563-4
Grooming excludes cutting with scissors or clipping toenails. (§51350(f); see also Manual of Policies and Procedures (MPP) Handbook §30-780.2(f))

563-5
Menstrual care is limited to external application of sanitary napkin and cleaning. (§51350(g); see also Manual of Policies and Procedures (MPP) Handbook §30-780.2(g))

563-6
Paramedical services include catheter insertion, ostomy irrigation, and bowel program. (§51350(g); see also Manual of Policies and Procedures (MPP) Handbook §30-780.2(g). They also include the need for skin and wound care if decubiti have developed. (§51350(h); see also MPP Handbook §30-780.2(h))

563-7
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 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. (§51350(h)(2); see also Manual of Policies and Procedures (MPP) Handbook §30-780.2(h)(2))

563-8
Following the *Arp* v. *Anderson* court case, counties were instructed that services provided by regional centers can no longer be considered an alternative resource under W&IC §12301(a) and MPP §30-763.61. PCSP and IHSS must be granted as though no services are being provided through a Regional Center. Determination of services to be provided must be based strictly on an assessment of the developmentally disabled applicant. (All-County Letter No. 98-53, July 9, 1998; *Arp* v. *Anderson*, San Diego County Superior Court, No. 711204, Stipulation for Final Judgment, February 18, 1998)

563-9 ADDED 9/07
When the recipient is an institutionally deemed child, a non-parent provider may provide PCSP services even if the parent is present in the home. (All County Letter 00-83, December 7, 2000.)

564-1
The Personal Care Services Program (PCSP) provides personal care services to eligible Medi-Cal beneficiaries pursuant to Welfare and Institutions Code §14132.95 and Title 22, California Code of Regulations and is subject to all other provisions of Medi-Cal statutes and regulations. The program is operated pursuant to Manual of Policies and Procedures (MPP) Division 30. (MPP §30-700.2)

564-3
Under state law, the purpose of the IHSS Program is to provide those supportive services to Aged, Blind and Disabled (ABD) persons who are unable to perform the services themselves and "who cannot safely remain in their homes or abodes of their own choosing unless these services are provided." (W&IC §12300(a))

564-4
The CDHS has defined a "home" as real or personal property, fixed or mobile, located on land or water, in which a person or family lives. (§50044)

564-5A ADDED 5/05
All Medi-Cal eligibility determinations are to be completed following Medi-Cal rules. This includes Medi-Cal eligibility determinations for IHSS and PCSP recipients. (All County Welfare Director's Letter 04-27, August 30, 2004)

566-2
In the PCSP, the following regulations apply to the evaluations of "personal care services":

(a) Personal care services include:

(1) Assisting with ambulation includes 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 includes the cleaning of 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 clothes, fastening and unfastening garments and undergarments and special devices such as back of leg braces, corsets, elastic stockings/garments and artificial limbs or splints.

(4) Bowel, bladder and menstrual care includes 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.

(5) Repositioning, transfer skin care, and range of motion exercises:

(A) This includes moving from one sitting or lying position to another sitting or lying position; e.g., from bed to or from a wheelchair, chair, sofa, etc.; 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 includes reaching for, picking up, grasping utensils and cups, getting food on utensils; bringing food, utensils, cups, to mouth; manipulating food on plate. It also includes cleaning face and hands as necessary following meal.

(7) 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 §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.

"(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."

(§51183(a))

566-3
In the PCSP, the following regulations apply to the evaluation of "ancillary services":

(b) Ancillary services are subject to time per task guidelines when established in MPP §§30-758 and 30-763.235(b) and 30-763.24 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) Storing food and supplies.

(D) Taking out the garbage.

(E) Dusting and picking up.

(F) Cleaning oven and stove.

(G) Cleaning and defrosting refrigerator.

(H) Bringing in fuel for heating or cooking purposes from a fuel bin in the yard.

(I) Changing bed linen.

(J) 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.

(2) Laundry services include washing and drying laundry, and are 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 or 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 a cart or basket; identifying items needed; putting items away; phoning in and picking up prescriptions; and buying clothing.

(4) Meal preparation and cleanup includes 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 county staff have determined that no other Medi-Cal service will provide transportation in the specific case.

(B) Accompaniment to the site where alternative resources provide IHSS 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.

(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

(§51183(b))

567-1 ADDED 5/05
It is the intent of the Legislature that the State Department of Health Services seek approval of a Medicaid waiver under the federal Social Security Act in order that the services available under Article 7 (commencing with Section 12300) of Chapter
3, known as the In-Home Supportive Services program, may be provided as a Medi-Cal benefit under this chapter, to the extent federal financial participation is available. The waiver shall be known as the "IHSS Plus waiver."

(Welfare and Institutions Code (W&IC) 14132.951(a))

The US Department of Health Care Services, Centers for Medicare and Medicaid Services (CMS) approved a Social Security Act § 1915(j) Self-Directed Personal Assistance Services State Plan Option program for California. This program is known as the IHSS Plus Option (IPO)

and became effective October 1, 2009. Individuals eligible for the IHSS Plus Waiver (IPW) program were transitioned into the IPO program.

The IPW was limited to five years with a possibility of renewal; however, during that time, CMS initiated new options to allow recipients in the IPW to be served in a State Plan Option program. The new IPO program continues federal funding for the IPW population. The program criteria will continue to be the same as for the IPW.

(ACIN I-33-10, April 21, 2010)

567-2 ADDED 5/05
To the extent feasible, the IHSS Plus waiver described in subdivision (a) shall incorporate the eligibility requirements, benefits, and operational requirements of the In-Home Supportive Services program as it exists on the effective date of this section. The director shall have discretion to modify eligibility requirements, benefits, and operational requirements as needed to secure approval of the Medicaid waiver.

(Welfare and Institutions Code (W&IC) 14132.951(b))

The US Department of Health Care Services, Centers for Medicare and Medicaid Services (CMS) approved a Social Security Act § 1915(j) Self-Directed Personal Assistance Services State Plan Option program for California. This program is known as the IHSS Plus Option (IPO) and became effective October 1, 2009. Individuals eligible for the IHSS Plus Waiver (IPW) program were transitioned into the IPO program.

The IPW was limited to five years with a possibility of renewal; however, during that time, CMS initiated new options to allow recipients in the IPW to be served in a State Plan Option program. The new IPO program continues federal funding for the IPW population. The program criteria will continue to be the same as for the IPW.

(ACIN I-33-10, April 21, 2010)

567-3 ADDED 5/05
Upon implementation of the IHSS Plus waiver, and to the extent federal financial participation is available, the services available through the In-Home Supportive Services program shall be furnished as benefits of the Medi-Cal program through the IHSS Plus waiver to persons who meet the eligibility requirements of the IHSS Plus waiver. The benefits shall be limited by the terms and conditions of the IHSS Plus waiver and by the availability of federal financial participation.

Upon implementation of the IHSS Plus waiver:(1) A person who is eligible for the IHSS Plus waiver shall no longer be eligible to receive services under the In-Home Supportive Services program to the extent those services are available through the IHSS Plus waiver.

(2) A person shall not be eligible to receive services pursuant to the IHSS Plus waiver to the extent those services are available pursuant to Section 14132.95.
(W&IC §14132.951(c) and (d))

The US Department of Health Care Services, Centers for Medicare and Medicaid Services (CMS) approved a Social Security Act § 1915(j) Self-Directed Personal Assistance Services State Plan Option program for California. This program is known as the IHSS Plus Option (IPO) and became effective October 1, 2009. Individuals eligible for the IHSS Plus Waiver (IPW) program were transitioned into the IPO program.

The IPW was limited to five years with a possibility of renewal; however, during that time, CMS initiated new options to allow recipients in the IPW to be served in a State Plan Option program. The new IPO program continues federal funding for the IPW population. The program criteria will continue to be the same as for the IPW.

(ACIN I-33-10, April 21, 2010)

567-3A ADDED 11/05
Services provided under the IHSS Plus Waiver shall be rendered, under the administrative direction of the State Department of Social Services, in the manner authorized in Article 7 (commencing with Section 12300) of Chapter 3, for the In-Home Supportive Services program.
(W&IC §14132.951(e))

567-3B ADDED 12/06
The IHSS Plus Waiver program provides IHSS Plus Waiver services, to eligible Medi-Cal beneficiaries, subject to Medi-Cal provisions, statutes and regulations, pursuant to Welfare and Institutions Code Section 14132.951 and Title 22, California Code of Regulations, Division 3, and is operated pursuant to Division 30.

These services are available as described in MPP Section 30-757, when services are provided by a parent of a minor child recipient or a spouse; and/or when the recipient receives a Restaurant Meal Allowance; and/or when the recipient receives Advance Payment for in-home care services.

Recipients in any one of the categories described in Section 30-700.31, who have been determined eligible for Medi-Cal, qualify for the IHSS Plus Waiver program.

The IHSS Plus Waiver program is a Section 1115 Demonstration Project. This demonstration project has been approved for 5 years, beginning August 1, 2004. Eligibility and services are limited to the availability of funds and potential extensions to the demonstration.

Individuals who qualify for both IHSS and PCSP funding shall be funded by PCSP.

(§30-700.3 and .4)

The US Department of Health Care Services, Centers for Medicare and Medicaid Services (CMS) approved a Social Security Act § 1915(j) Self-Directed Personal Assistance Services State Plan Option program for California. This program is known as the IHSS Plus Option (IPO) and became effective October 1, 2009. Individuals eligible for the IHSS Plus Waiver (IPW) program were transitioned into the IPO program.

The IPW was limited to five years with a possibility of renewal; however, during that time, CMS initiated new options to allow recipients in the IPW to be served in a State Plan Option program. The new IPO program continues federal funding for the IPW population. The program criteria will continue to be the same as for the IPW.

(ACIN I-33-10, April 21, 2010)

567-3C ADDED 12/06
The IHSS Plus Waiver (replaced by IPO) program will follow the IHSS Program Definitions and Special Definitions, specified in MPP Sections 30-700 and 30-701, unless otherwise specified.

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 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

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

(§30-785(a) and (b))

567-4 ADDED 5/05
Notwithstanding the Administrative Procedure Act, Chapter3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title2 of the Government Code, the department may implement the provisions of this section through all-county welfare director letters or similar publications. Actions taken to implement, interpret, or make specific this section shall not be subject to the Administrative Procedure Act or to the review and approval of the Office of Administrative Law. Upon request of the department, the Office of Administrative Law shall publish the regulations in the California Code of Regulations. All county welfare director letters or similar publications authorized pursuant to this section shall remain in effect for no more than 18 months.

The department may also adopt emergency regulations implementing the provisions of this section. The adoption of regulations implementing this section shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law. Any emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and shall remain in effect for no more than 18 months by which time final regulations shall be adopted. (W&IC §14132.951(h)

567-5 ADDED 5/05
In the event of a conflict between the terms of the IHSS Plus waiver (replaced by IPO) and any provision of this part or any regulation, all-county welfare directors letters or similar publications adopted for the purpose of implementing this part, the terms of the waiver shall control to the extent that the services are covered by the waiver. If the department determines that a conflict exists, the department shall issue updated instructions to counties for the purposes of implementing necessary program changes. The department shall post a copy of, or a link to, the instructions on its Web site.
(W&IC §14132.951(i))

567-6 ADDED 5/05
All Medi-Cal eligibility determinations are to be completed following Medi-Cal rules. This includes Medi-Cal eligibility determinations for IHSS and PCSP recipients. (All County Welfare Director's Letter 04-27, August 30, 2004)

567-6A ADDED 8/05
Medi-Cal eligibility determinations and redeterminations are to be performed on all applications received by the county requesting in-home services and existing in-home service for persons who are not also eligible for SSI/SSP or other Medi-Cal linked cash-based assistance. These determinations/redeterminations are to be performed by Medi-Cal eligibility workers using Medi-Cal rules, Medi-Cal forms, and notices of action.

Individuals must be determined eligible for whatever Medi-Cal program is appropriate (e.g., Section 1931(b), Aged and Disabled Federal Poverty Level, Pickle, Medically Needy, 250 percent Working Disabled, etc) before a referral is forwarded to the IHSS unit for a needs assessment.

(All County Welfare Director's Letter 05-21. June 13, 2005).

567-7 ADDED 8/05
IHSS Plus Waiver (replaced by IPO) eligibility is restricted to individuals who are requesting or receiving in-home care and who have been determined eligible for federally funded full-scope Medi-Cal and who:

- Receive personal care; protective supervision; domestic and related services; heavy cleaning; yard hazard abatement; or teaching and demonstration, when any of the services are provided by a spouse of the recipient or parent of a minor child recipient as allowed under MPP §§30-763.41 and .45;
- Receive Restaurant Meal Allowance; and/or
- Receive Advance Payment for in-home services.

If any of the above components exist in a case, the entire case will be covered under the IHSS Plus Waiver.

(All County Letter 05-05, June 2, 2005; All County Welfare Director's Letter 05-21, June 13, 2005)

567-7A ADDED 12/06
In the IHSS Plus Waiver (replaced by IPO) process, presumptive disability is determined in accordance with Medi-Cal regulations located at Title 22, CCR, Division 3, Section 50167(a)(1)(C).

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.

(§30-785(g)(2) and (3))

567-8B ADDED 12/06
Any aged, blind, or disabled individual who is receiving Medi-Cal personal care services pursuant to subdivision (p) of Section 14132.95, and who would otherwise be deemed a categorically needy recipient pursuant to Section 12305, is eligible to receive a supplementary payment under this article to be used towards the purchase of personal care services. Additionally, any aged, blind, or disabled individual who is receiving services pursuant to Section 14132.951, and who would otherwise be deemed a categorically needy recipient pursuant to Section 12305 is eligible to receive a supplementary payment under this article to be used towards the purchase of services under Section 14132.951.

A supplementary payment pursuant to this section shall be the difference between the following amounts:

(1) A beneficiary's excess income as determined under Section 12304.5.

(2) The beneficiary's nonexempt income as determined pursuant to Section 14005.7, in excess of the income levels for maintenance need pursuant to Section 14005.12.

(Welfare and Institutions Code (W&IC) §12305.1(a) and (b)

567-8C ADDED 4/10

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law (PL) 104-193, as a general rule, restricts eligibility for non-citizens for all federal public benefits and bars most non-citizens from Supplemental Security Income/State Supplementary Payment (SSI/SSP), but there are a number of exceptions. PL 104-193 (as amended, and reflected in Title 8, U.S. Code (8 USC), Section 1641(b)) also established the definition for “Qualified Alien” and the New Affidavit of Support for individuals who sponsor immigrants into this country.

Non-citizens who are not Qualified Aliens are not eligible for federally funded public benefits (8 USC, Sec. 1611). Full scope Medi-Cal with federal financial participation (FFP) is one of the federal public benefits barred under these provisions.

Some non-citizens who are Qualified Aliens and entered the United States on or after August 22, 1996, are also barred from federal public benefits for five years (8 USC, Sec. 1613). Exemptions from this ban include refugees and asylees, and those who qualify for the U.S. military veteran or active duty exception.

(ACIN I-18-08, March 12, 2008)

567-8D ADDED 4/10

To be eligible for PCSP or IHSS Plus Waiver (replaced by IPO), an individual must be eligible for full scope FFP Medi-Cal. The California Department of Health Care Services (DHCS) has sole responsibility for determining who is eligible for full scope FFP Medi-Cal.

Counties must determine IHSS-R eligibility for applicants or recipients who are not eligible for full scope FFP Medi-Cal.

(ACIN I-18-08, March 12, 2008)

567-9 ADDED 11/05

Effective August 1, 2004, under the IHSS Plus Waiver (replaced by IPO) program, caregiver wages paid to a parent for providing in-home services to a minor child are exempt. So are wages paid to a spouse who provides in-home services to his/her spouse. Also exempt under the IHSS Plus Waiver/IPO program are a restaurant meal allowance or advance pay made to a recipient to pay the in-home services caregiver. (ACWDL 05-29, August 29, 2005)

567-9A ADDED 3/07
An in-home caregiver wages paid to a household member shall be exempt as income and property when both of the following conditions are met: 1) The caregiver is being paid for providing the in-home care to his/her spouse or minor child living in the home, and 2) The spouse or minor child is receiving those in-home services through any federal, state or local government program. Payments made by the California Department of Social Services to an in-home care recipient for the purpose of purchasing in-home care services, including restaurant meals, shall be exempt as income and property. For purposes of this income and property exemption, the definition of a minor child is up to age 21.

The effective date of these income and property exemptions is January 1, 2005.

(All County Welfare Directors Letter No.: 07-02, January 18, 2007)

567-10 ADDED 7/06
Parents can work out of the home and still be an IHSS Plus Waiver (now IPO) provider as long as they are not working full-time. MPP 30-763.451(a) requires that to be a paid provider, the parent has left full-time employment or is prevented from obtaining full-time employment because of the need to provide in home supportive services to the child.

Two parents who both work full-time cannot be paid for services in the IPO during the hours they are home in the morning and evening. In order for parents to be paid providers, they must meet the criteria in MPP 30-763.45. MPP 30-763.451(a) requires that the parent has left full-time employment or is prevented from obtaining full-time employment because of the need to provide IHSS to the child.

(ACIN I-28-06, April 11, 2006, answers to questions 6 and 8)

567-11 ADDED 7/06
Institutional Deeming (ID) Waiver recipients are eligible for the IHSS Plus Waiver (IPW) 9 now IPO) as long as the recipient meets all IPW eligibility criteria. ID Waiver cases were previously served in the PCSP, as PCSP is a Medi-Cal benefit. With the implementation of the IPW (also a Medi-Cal benefit) on August 1, 2004, these cases may now be covered under either PCSP or the IPW, depending on the eligibility criteria. If ID Waiver cases meet IPO criteria (i.e. parent or spouse provider, receives advance pay or restaurant meal allowance), then the case would be served under the IPW. Spouses and parents of minor children, therefore, can be paid providers under the IPW, regardless of how the recipient qualified for federally funded full-scope Medi-Cal.

Parents of minor children whose Medi-Cal eligibility is through the ID Waiver are eligible to provide all authorized services, including Protective Supervision under the IPO. Persons whose Medi-Cal eligibility is through the ID Waiver are eligible to receive Protective Supervision under PCSP also, as long as the parent or spouse is not the provider.

(ACIN I-28-06, April 11, 2006, answers to questions 10 and 11)

567-11A ADDED 4/10
Institutionally deemed children who are approved for the Department of Developmental Services (DDS) Waiver are those who are under the age of 18, living at home, not currently elf for $o share of cost Medi-Cal and who meet the target criteria set forth in the DDS Waiver. Through institutional deeming, under the DDS Waiver, children may be determined Medi-Cal eligible regardless of their parent's resources or income. (ACL 00-83)

567-12 ADDED 7/06
Up to eight hours of respite care per week is offered under the IHSS Plus Waiver for periods when the parent(s) must be absent to perform errands related to care of recipient's siblings.

(ACIN I-28-06, April 11, 2006, answer to question 14)

567-13 ADDED 7/06
Under the IHSS Plus Waiver, Non- Severely Impaired recipients may receive up to a total of 195 hours, including any needed protective supervision. (WIC 12303.4(a), MPP 30-765.12). The entire 195 hours can be for protective supervision if no other needed services are paid for by IHSS.

Severely Impaired recipients may receive up to a total of 283 hours, including any needed protective supervision. (WIC 12303.4(b), MPP 30-765.11)

(ACIN I-28-06, April 11, 2006, answer to question 15)

567-14 ADDED 12/06
For purposes of determining overpayments, action on overpayments and demand for repayment for an IHSS Plus Waiver (now IPO) recipient, DHS regulation Sections 50781, 50786 and 50787 (MPP Handbook Sections 30-768.5, .6 and .7) shall apply.

(§30-785(o))

567-15 ADDED 4/10
The US Department of Health Care Services, Centers for Medicare and Medicaid Services (CMS) approved a Social Security Act § 1915(j) Self-Directed Personal Assistance Services State Plan Option program for California. This program is known as the IHSS Plus Option (IPO) and became effective October 1, 2009. Individuals eligible for the IHSS Plus Waiver (IPW) program were transitioned into the IPO program.

The IPW was limited to five years with a possibility of renewal; however, during that time, CMS initiated new options to allow recipients in the IPW to be served in a State Plan Option program. The new IPO program continues federal funding for the IPW population. The program criteria will continue to be the same as for the IPW.

(ACIN I-33-10, April 21, 2010)