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April 12, 2019

ALL COUNTY LETTER (ACL) NO. 19-36

TO: ALL COUNTY WELFARE DIRECTORS
ALL IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
MANAGERS

SUBJECT: **RELEASE OF ADDITIONAL REASONABLE ACCOMMODATION
INFORMATION AND RESOURCES FOR BLIND AND VISUALLY
IMPAIRED (BVI) APPLICANTS AND RECIPIENTS**

REFERENCE: Title II of the Americans with Disability Act of 1990 (ADA), 42
United States Code (U.S.C.) sections 12131-65
ADA Title II regulations, 28 Code of Federal Regulations, Part 35
Sections 504 and 508 of the Rehabilitation Act of 1973, 29 U.S.C.
sections 701 and 794
California Government Code section 11135
California Civil Code section 54 et seq.
[ACIN NO. I-25-15](#), DATED APRIL 9, 2015
[ACL NO. 15-60](#), DATED JULY 22, 2015
[ACL NO. 17-76](#), DATED JULY 14, 2017

The purpose of this All County Letter (ACL) is to provide counties with additional information regarding reasonable accommodations for Blind and Visually Impaired (BVI) applicants and recipients of In-Home Supportive Services (IHSS). In addition to the forms and notices previously updated in ACL 15-60 (dated July 22, 2015), additional alternative forms and Notices of Action (NAs), as well as alternative timesheet systems, have been updated as part of the California Department of Social Services' (CDSS) continuing effort to assist County Welfare Departments (CWDs) with their obligations to comply with Title II of the Americans with Disabilities Act of 1990 (ADA) and implementing regulations, Sections 504 and 508 of the Rehabilitation Act of 1973, California Government Code section 11135, and California Civil Code section 54 et seq., ensuring access to IHSS resources and program services. CDSS will continue to make additional forms and NAs available in 18-point font, Braille, audio compact disc (CD), and data (text) CD formats.

CDSS reminds counties that they are responsible for offering reasonable accommodations in the form of alternative formats and auxiliary aids to each applicant and recipient who identifies as blind or visually impaired. County representatives should also proactively offer reasonable accommodations to each applicant and recipient who exhibits or mentions having functional difficulties with reading or seeing. Counties must record these preferences in the Case Management, Information and Payrolling System (CMIPS).

BACKGROUND

As stated in ACL 15-60, CDSS worked collaboratively with advocates and the Department of Health Care Services (DHCS) to develop and implement alternative formats for specific IHSS program documents including Braille, 18-point font, audio CD (i.e., audio files containing audible recordings of document text and information), and data CD (i.e., text files that can be read by adaptive software). The alternative formats allow BVI applicants and recipients to independently access and complete these IHSS documents. The initial forms and NAs that were updated or released in 18-point font and/or audio CD and data CD formats included numerous NAs, the SOC 293 (Needs Assessment), the SOC 295L (Application for Social Services), and the SOC 2261L (IHSS Individual Provider Timesheet).

Telephone Timesheet System

Since August 1, 2015, CDSS has provided blind recipients in all California counties with the option to use the Telephone Timesheet System (TTS), enabling recipients to review and approve their providers' timesheets electronically over the telephone. CDSS provided counties with direction and instruction on the implementation of the TTS. (See ACL 15-60.) CDSS now also provides visually impaired recipients with the option to use the TTS.

BVI Training and Resources

Initial training on BVI information for county IHSS workers to address the new formats and updates made to CMIPS occurred during July and August 2015. This training included the items needed to capture BVI information in CMIPS.

Informational Notifications sent on July 30 and July 31, 2015, included implementation instructions for counties and described the training and outreach materials. Counties received instructions on how to place their initial order of TTS CDs and Braille labels, and how to request future orders. The labels are printed with "IHSS Info" in Braille and placed on the county envelopes used to mail TTS CDs to recipients who opt for the TTS. CDSS modified CMIPS to implement these TTS accommodations.

CDSS conducted a webinar on August 19, 2015, to inform counties of additional resources to assure communication with BVI applicants and recipients, supporting

meaningful access to the IHSS program. This webinar included information on the alternative formats (e.g., TTS, 18-point font timesheets, and NA options) available for BVI applicants and recipients. It also informed counties regarding the CMIPS tracking changes that took place to implement the new BVI accommodations.

Additionally, each county received:

- A list of BVI recipients residing within their county.
- A list of new BVI services.
- Materials for county staff training including sample TTS CDs, a copy of the TTS CD script, and an audio CD.

In April 2016, CDSS distributed an IHSS BVI poster to all county IHSS offices and Public Authorities, informing applicants and recipients that communication accommodations are available. The poster encouraged BVI applicants and recipients to ask their county IHSS representative or social worker how to obtain needed accommodations to best access the IHSS program.

Counties are required to display these posters in their office lobbies.

BVI Fact Sheets

Also in April 2016, CDSS developed three IHSS educational fact sheets for county social workers to inform their applicants and recipients about BVI accommodations:

- **Blind and Visually Impaired Accommodations:** This fact sheet informs BVI applicants and recipients of available alternative formats of necessary IHSS program documents to enable participation in the program.
- **Alternative Formats:** This fact sheet informs BVI applicants and recipients of their options to receive alternative formats of IHSS notices by mail, as well as options to approve provider timesheets. It also describes how to request these alternative formats, in addition to information on filing a complaint.
- **Telephone Timesheet System:** This fact sheet describes the TTS, explaining how the TTS allows authorized IHSS recipients to review and electronically sign timesheets or to reject a timesheet through an interactive telephone system.

The BVI poster and three fact sheets can be found at the following link under the *Blind and Visually Impaired Resources* section: [IHSS Fact Sheets](http://www.cdss.ca.gov/inforesources/IHSS/Fact-Sheets)
(<http://www.cdss.ca.gov/inforesources/IHSS/Fact-Sheets>)

Electronic Timesheet System

As shared in ACL 17-76 on July 14, 2017, CDSS successfully piloted and implemented

the Electronic Timesheet System (ETS) which allows BVI recipients to approve or reject electronically submitted provider timesheets via smartphone, tablet, or personal computer. The ETS reduces the time for an IHSS or Waiver Personal Care Services (WPCS) timesheet to be received at the centralized Timesheet Processing Facility (TPF). The ETS is optional for IHSS and WPCS recipients and providers, and it fully replaces paper timesheets for recipients who opt to use the system.

CDSS created an ETS webpage, which includes information on and instructions to register for the system. CDSS also published ten learning modules. The ETS webpage is located at the following link, with the learning modules accessible under the *Electronic Timesheet Website Learning Options* section: [ETS Webpage](http://www.cdss.ca.gov/inforesources/IHSS-Providers/Resources/Timesheet-Information) (<http://www.cdss.ca.gov/inforesources/IHSS-Providers/Resources/Timesheet-Information>)

BVI recipients can access the ETS through a computer with a screen reader (i.e., a software program that allows BVI users to read text that is displayed on the computer screen with a speech synthesizer or Braille display). Also, an ETS Provider Help Line has been established to resolve issues and answer questions related to the ETS.

Finally, CMIPS has been modified to generate the SOC 2301 (IHSS or WPCS Recipient Confirmation of Enrollment in the ETS or the TTS) when a recipient is initially enrolled to approve electronic timesheets through the ETS or the TTS. The SOC 2301 informs the recipient of their enrollment and advises them to contact their county or WPCS if they did not enroll in the ETS or the TTS. The SOC 2301 will be produced in English, Armenian, Chinese (Mandarin), or Spanish based on the recipient's written language as indicated in CMIPS. The SOC 2301 will also be generated in the BVI formats of Braille, audio CD, data CD, or 18-point font based on the recipient's preference entered in CMIPS.

BVI FORMS AND NOTICES UPDATE

In addition to the IHSS forms and notices available in alternative formats as described in ACL 15-60, CDSS has expanded upon the list of such forms and notices. Please refer to the attached tables to identify the forms and notices now available in alternative formats. Please note that except for the SOC 295 (Application for IHSS), the content of these forms and notices has not changed. As a reminder, the SOC 295 was modified to include new sections to document reasonable accommodation preferences. CDSS recently updated the SOC 295 to clearly indicate that all BVI applicants have the option to select the TTS or the ETS.

All forms and notices listed in the first table attached to this ACL, "IHSS FORMS AND NOTICES IN ALTERNATIVE FORMATS RELEASED WITH ACL NO. 15-60," are now available in Braille, audio CD, data CD, and 18-point font including translations into the three threshold languages: Armenian, Chinese (Mandarin), and Spanish.

The forms and notices listed in the second attached table, "IHSS FORMS AND NOTICES AVAILABLE IN 18-POINT FONT," are now available in 18-point font including translations into the three threshold languages.

The forms and notices listed in the third attached table, "IHSS FORMS AND NOTICES AVAILABLE IN BRAILLE, AUDIO CD, AND DATA CD," are now available in Braille, audio CD, and data CD.

CAMERA READY COPIES AND TRANSLATIONS

For camera-ready copies in English, contact the Forms Management Unit at fmudss@dss.ca.gov. If your office has internet access you may obtain this form from the CDSS webpage at: <http://www.cdss.ca.gov/inforesources/Forms-Brochures>.

When translations are completed per MPP Section 21-115.2, including Spanish form, they are posted on our website. Copies of the translated forms can be obtained at: <http://www.cdss.ca.gov/inforesources/Translated-Forms-and-Publications>.

For questions on translated materials, please contact Language Services at (916) 651-8876. Until translations are available, recipients who have elected to receive materials in languages other than English should be sent the English version of the form or notice along with the *GEN 1365-Notice of Language Services* and a local contact.

The CWDs shall ensure that effective bilingual services are provided. This requirement may be met through utilization of paid interpreters, qualified bilingual employees, and qualified employees of other agencies or community resources. These services shall be provided free of charge to the applicant/recipient.

In the event that CDSS does not provide translations of a form, it is the county's responsibility to provide the translation if an applicant or recipient requests it. More information regarding translations can be found in MPP Section 21-115.

BVI OUTREACH

Since the release of ACL 15-60, counties have been working with BVI applicants and recipients to identify and apply reasonable accommodation format preferences. The following table displays statewide outreach results of the format preferences selected by each respondent BVI recipient as of April 2, 2019:

Statewide Outreach Results of Format Preferences

Document Type	BVI Reasonable Accommodation Format Option	Number of Recipient Selections
IHSS Required Forms	18-Point Font Documents	28,743
	Audio CD	491
	Braille Documents	216
	County Support	967
	Data CD	45
	No Accommodation is Needed	83,072
Notices of Action	18-Point Font Documents	40,984
	Audio CD	599
	Braille Documents	237
	County Support	179
	Data CD	53
	No Accommodation is Needed	71,482
Timesheets	18-Point Font Documents	17,693
	County Support	236
	Electronic Timesheet System	33,072
	Telephone Timesheet System	705
	No Accommodation is Needed	61,828

As of April 2, 2019, a total of 113,534 BVI recipients responded to the format outreach. The following number of BVI recipients are opting for a reasonable accommodation associated with the specified document types:

- 30,462 for IHSS Required Forms
- 42,052 for Notices of Action
- 51,706 for Timesheets

CDSS continues to work with counties to ensure that each applicant's and recipient's format preferences are identified and documented.

CDSS will create a report of all IHSS applicants and recipients who are identified as blind or visually impaired and who do not yet have format preferences documented in CMIPS. The CMIPS and System Enhancements Branch, Systems Operations and Data Analysis Bureau will release a forthcoming informational notice informing the counties of when the report will be available on Secure Automated File Exchange (SAFE). Once the report has been released, county IHSS offices must contact each of those applicants and recipients to determine their format preferences, which are to be documented in CMIPS. Such county contact may occur by telephone or in-person during a standard assessment. This will be the most effective way of ensuring that

contact has been made with each BVI applicant and recipient and that each of their format preferences have been identified and documented. IHSS county offices should complete such outreach as soon as administratively feasible, but no later than the following reassessment.

COUNTY RESPONSIBILITIES

County IHSS offices are reminded that at the time of application, during the initial assessment and reassessments, and as each applicant's and recipient's circumstance change, each applicant and recipient who identifies as blind or visually impaired must be offered reasonable accommodation format options as well as the ability to update their format preferences. County representatives should proactively offer reasonable accommodations to each applicant and recipient who exhibits or mentions having functional difficulties with reading or seeing. County IHSS offices are also responsible for documenting whether each applicant and recipient is blind or visually impaired and indicating their format preferences in CMIPS. If no accommodation is needed, that information should be documented in CMIPS.

If you have any questions about this ACL, please contact the Adult Programs Policy and Quality Assurance Branch, Policy and Operations Bureau at (916) 651-5350.

Sincerely,

Original Document Signed By:

DEBBI THOMSON
Deputy Director
Adult Programs Division
c: CWDA

Attachments

**IHSS FORMS AND NOTICES IN ALTERNATIVE FORMATS
RELEASED WITH ACL NO. 15-60**

Available in:

- **18-point font (designated by an L; e.g., NA 1250L), including translations in Armenian, Chinese (Mandarin), and Spanish**
- **Braille**
- **Audio CD**
- **Data CD**

FORM/NOTICE NUMBER	FORM/NOTICE NAME
NA 1250	Approval
NA 1251	Approval (Continued)
NA 1252	Denial
NA 1253	Change
NA 1254	Change (Continued)
NA 1255	Termination
NA 1256	Share of Cost
NA 1257	Multipurpose
NA BACK 9	Your Hearing Rights
NA Description of Services	Description of Services
SOC 295	Application for IHSS

Forms and notices are available at the following link: [Forms/Brochures](http://www.cdss.ca.gov/inforesources/Forms-Brochures)
(<http://www.cdss.ca.gov/inforesources/Forms-Brochures>)

Translated forms and notices are available at the following link: [Translated Forms and Publications](http://www.cdss.ca.gov/inforesources/Translated-Forms-and-Publications)
(<http://www.cdss.ca.gov/inforesources/Translated-Forms-and-Publications>)

**IHSS FORMS AND NOTICES AVAILABLE IN 18-POINT FONT
(designated by an L; e.g., SOC 332L)**

18-point font formats are available in Armenian, Chinese (Mandarin), and Spanish

FORM/ NOTICE NUMBER	FORM/NOTICE NAME
SOC 332	Recipient/Employer Responsibility Checklist
SOC 854	Notice to Recipient of Provider Eligibility
SOC 855	Notice to Recipient of Provider Ineligibility - Incomplete Provider Process
SOC 855A	Notice to Recipient of Provider Ineligibility - Tier 1 Crimes
SOC 855B	Notice to Recipient of Provider Ineligibility - Tier 2 Crimes
SOC 856	To Request Appeal of Provider Enrollment Denial
SOC 857	Notice to Recipient of Provider Eligibility - Acknowledgement of Receipt of Waiver
SOC 857A	Notice to Recipient of Provider Ineligibility - Acknowledgement of Receipt of Invalid Request for Provider Waiver
SOC 859A	Notice to Recipient of Provider Ineligibility - Tier 1 Crimes Ineligibility - Subsequent Conviction
SOC 859B	Notice to Recipient of Provider Ineligibility - Tier 2 Crimes Ineligibility - Subsequent Conviction
SOC 862	Recipient Request for Provider Waiver
SOC 865	Request for Applicant Provider Reference
SOC 873	Health Care Certification Form
SOC 874	Notice to Applicant of Health Care Certification Requirement
SOC 875	Notice to Recipient of Health Care Certification Requirement
SOC 876	Notice of Provisional Approval - Health Care Certification Exception Granted
SOC 2243	Recipients Notice of New Timesheets

Forms and notices are available at the following link: [Forms/Brochures](http://www.cdss.ca.gov/inforesources/Forms-Brochures)
(<http://www.cdss.ca.gov/inforesources/Forms-Brochures>)

Translated forms and notices are available at the following link: [Translated Forms and Publications](http://www.cdss.ca.gov/inforesources/Translated-Forms-and-Publications)
(<http://www.cdss.ca.gov/inforesources/Translated-Forms-and-Publications>)

IHSS FORMS AND NOTICES AVAILABLE IN BRAILLE, AUDIO CD, AND DATA CD

FORM/ NOTICE NUMBER	FORM/NOTICE NAME
SOC 2257A	Notice to Recipient of Provider's Violation for Exceeding Workweek and/or Travel Time Limits
SOC 2264	Notice to Recipient Rescinding Provider Violation
SOC 2266	Notice to Recipient Approval of Exception to Exceed Weekly Hours
SOC 2267	Notice to Recipient Denial of Exception to Exceed Weekly Hours
SOC 2268	Notice to Recipient Approval for Provider to Work Alternate Schedule Due to Recurring Event
SOC 2269	Notice to Recipient Cancellation of Alternate Schedule Due to Recurring Event
SOC 2271A	Recipient Notice of Maximum Weekly Hours
SOC 2281	Notice to Recipient Upholding Provider's First or Second Violation for Exceeding Workweek and/or Travel Time Limits
SOC 2283	Notice to Recipient Upholding Provider's Third Violation (90-Day Suspension of Eligibility) for Exceeding Workweek and/or Travel Time Limits
SOC 2285	Notice to Recipient Upholding Provider's Fourth Violation (One-Year Period of Ineligibility) for Exceeding Workweek and/or Travel Time Limits
SOC 2287	State Administrative Review Response Letter to Recipient Upholding Provider's Third Violation (90-Day Suspension of Eligibility) for Exceeding Workweek and/or Travel Time Limits
SOC 2289	State Administrative Review Response Letter to Recipient Rescinding Provider's Third or Fourth Violation for Exceeding Workweek and/or Travel Time Limits
SOC 2291	State Administrative Review Response Letter to Recipient Upholding Provider's Fourth Violation (One-Year Period of Ineligibility)

IN-HOME SUPPORTIVE SERVICES RECIPIENT/EMPLOYER RESPONSIBILITY CHECKLIST

I, _____, HAVE BEEN INFORMED BY MY SOCIAL WORKER THAT AS A RECIPIENT/EMPLOYER, I AM RESPONSIBLE FOR THE ACTIVITIES LISTED BELOW.

1. Provide required documentation to my Social Worker to determine continued eligibility and need for services. Information to report includes, but is not limited to, changes to my income, household composition, marital status, property ownership, phone number, and time I am away from my home.
2. Find, hire, train, supervise, and fire the provider I employ.
3. Comply with laws and regulations relating to wages/hours/working conditions and hiring of persons under age 18.

NOTE: Refer to Industrial Welfare Commission (IWC) Order Number 15 regarding wages/hours/working conditions obtainable from the State Department of Industrial Relations, Division of Labor Standards and Enforcement listed in the telephone book. Additional information regarding the hiring of minors may be obtained by contacting your local school district.

4. Verify that my provider legally resides in the United States. My provider and I will complete Form I-9. I will retain the I-9 for at least three (3) years or one (1) year after employment ends, which ever is longer. I will protect the provider's confidential information, such as his/her social security number, address, and phone number.

5. Ensure standards of compensation, work scheduling, and working conditions for my provider.
6. Inform my Social Worker of any future change in my provider(s), including:
 - ___ Name
 - ___ Address
 - ___ Telephone Number
 - ___ Relationship to me, if any
 - ___ Hours to be worked and services to be performed by each provider
7. Inform my provider that the gross hourly rate of pay is \$_____, and that Social Security and State Disability Insurance taxes are deducted from the provider's wages.
8. Inform my provider that he/she may request that Federal and/or State income taxes be deducted from his/her wages. Instruct the provider to submit Form W-4 (for federal income tax withholding) and/or Form DE 4 (for state income tax withholding).
9. Inform my provider that he/she is covered by Workers' Compensation, State Unemployment Insurance benefits, and State Disability Insurance benefits.
10. Inform my provider that he/she will receive an information sheet that will state my authorized services and the authorized time given to perform those services. Payment will not be made for any services not authorized.

11. Pay my share of cost, if any.
12. Ensure the total hours reported by each provider for services provided to me while working for the IHSS program does not exceed more than my total weekly authorized hours in one workweek, unless I receive county approval for the increase.
13. Verify and sign my provider's timesheet for each pay period, showing the correct day(s) and the total number of hours worked. I understand I can be prosecuted under Federal and State laws for reporting false information or concealing information.
14. Ensure my provider signed his/her timesheet.
15. Advise my provider to mail his/her signed timesheet to the appropriate address at the end of each pay period.

Recipient' Signature

Date

Printed Name

INSTRUCTIONS FOR USE OF THE RECIPIENT/EMPLOYER RESPONSIBILITY CHECKLIST

1. This form is used for review with recipients receiving service from Individual Providers **only**.
2. Counties shall use this form to assure that recipients have been advised of and understand their basic responsibilities as employers of IHSS providers.
3. Review each item with the recipient and explain how the recipient can comply with each requirement.
4. Leave a copy of the form with the recipient.

**IN-HOME SUPPORTIVE SERVICES PROGRAM
NOTICE TO RECIPIENT OF PROVIDER ELIGIBILITY**

(ADDRESSEE)**COUNTY OF:** _____

┌ _____ ┐

Notice Date: _____

Provider Name: _____

└ _____ ┘ Recipient Name: _____

Recipient Case Number: _____

IHSS Office Address: _____

IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Recipient

As of the date of this notice, _____,
has been officially enrolled as a provider. He/she can now begin
providing services for you.

If you have any questions, call _____.

(ADDRESSEE)	COUNTY OF:
	Notice Date:
	Applicant
	Provider Name:
	Recipient Name:
	Recipient Case Number:
	IHSS Office Address:
	IHSS Office Telephone Number:

To: In-Home Supportive Services (IHSS) Recipient

Due to a criminal conviction, the person you have chosen to employ to provide IHSS services for you, _____, has been denied eligibility. He/she cannot receive payment from the IHSS program for providing services to you or to any other person.

As part of the provider enrollment process, this person submitted fingerprints for a California Department of Justice criminal background check. This background check or a court document showed that he/she had been convicted of a crime(s) that makes him/her ineligible to be an IHSS provider and to receive payment from the IHSS Program for providing services based on Welfare

and Institutions Code, Section 12305.81. The crime(s) which disqualified him/her is/are one or more of the crimes listed below:

- Abuse of an elder or dependent adult; and/or
- Specified abuse of a child; and/or
- Fraud against a government health care or supportive services program.

This information regarding the applicant provider's convictions is highly sensitive and must be kept strictly confidential. You are prohibited by law from sharing any part of this information with any other individual or entity.

Because this applicant provider has been determined to be ineligible to provide services through the IHSS program, you must choose a different person to provide services. If you choose to continue receiving services from this person, you will be responsible for paying him/her with your own money for any services provided.

If you need help finding a different provider, call _____.

(ADDRESSEE)		COUNTY OF: _____
┌		
		Notice Date: _____
		Applicant
└	┌	Provider Name: _____
		Recipient Name: _____
		Recipient Case Number: _____
		IHSS Office Address: _____

		IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Recipient

Due to a criminal felony conviction, the person you have chosen to employ to provide IHSS services to you, _____, has been denied eligibility to receive payment from the IHSS program for providing services to you or to any other person.

As part of the provider enrollment process, this person submitted fingerprints for a California Department of Justice criminal background check. The background check showed that he/she had been convicted of a crime(s) that makes him/her ineligible to be an IHSS provider and to receive payment from the IHSS program for providing services based on Welfare and Institutions Code, Section 12305.87. The crime(s) which disqualified him/her

is/are listed below:

This information regarding the applicant provider's convictions is highly sensitive and must be kept strictly confidential. You are prohibited by law from sharing any part of this information with any other individual or entity.

Despite this individual's felony conviction, you may submit a signed waiver that would allow this person to work as your IHSS provider. If you agree to a waiver, you are accepting the responsibility for this decision and the risk of any potential actions that may occur as a result of this decision. You must complete, date, and sign the enclosed SOC 862 form, "IHSS Recipient Request for Provider Waiver," and submit it to the county/Public Authority/Non-Profit Consortium IHSS office.

The waiver will allow this person to serve as an IHSS provider for you only and only in the county in which the waiver is filed, and he/she will receive payment from the IHSS program for providing services to you. This waiver will only apply to the disqualifying crimes listed on this page. If the provider is convicted of any subsequent disqualifying crime(s), another SOC 862 form must be completed and submitted for that subsequent disqualifying crime.

If this person wishes to provide services for multiple recipients, each recipient must submit a separate signed SOC 862 form or this person must seek a general exception by completing an SOC 863 form, "IHSS Applicant Provider Request for General Exception," and submit it with the requested documentation to the California Department of Social Services.

Without this waiver or general exception, you must choose a different person to provide services. Otherwise, you will be responsible for paying him/her with your own money for any services provided.

Please do not contact the county/Public Authority/Non-Profit Consortium or the California Department of Social Services for any additional information regarding any of the crimes or convictions listed on Page 2. Each of these agencies is prohibited under Penal Code Sections 11105 and 13300 from providing any detail regarding any of these crimes or convictions beyond that listed in this notice.

If you need help finding a different provider, call the IHSS office at the telephone number listed at the top of Page 1.

**IN-HOME SUPPORTIVE SERVICES PROGRAM
NOTICE TO RECIPIENT OF PROVIDER INELIGIBILITY
INCOMPLETE PROVIDER PROCESS**

(ADDRESSEE) _____ COUNTY OF: _____

Notice Date: _____
Applicant _____

Provider Name: _____
Recipient Name: _____
Recipient Case Number: _____
IHSS Office Address: _____

IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Recipient

The person you have chosen to employ to provide IHSS services to you, _____, is not eligible to receive payment from the IHSS program for providing services to you or to any other person. Here's why:

He/she did not complete one or more of the required steps of the provider enrollment process listed below within 90 days of starting the provider enrollment process.

- ☐ He/she did not complete, sign and return the IHSS Provider Enrollment Form (SOC 426) to the county; and/or
- ☐ He/she did not attend an IHSS Provider Orientation; and/or
- ☐ He/she did not sign an IHSS Provider Enrollment Agreement (SOC 846); and/or
- ☐ He/she did not complete a California Department of Justice criminal background check.

Because this individual has been deemed ineligible as an IHSS provider, you must choose a different person to provide services. If you choose to continue receiving services from this individual, you will be responsible for paying him/her with your own money for any services provided.

If you need help finding a different provider, call the IHSS Office at the telephone number listed at the top of Page 1.

TO REQUEST APPEAL OF PROVIDER ENROLLMENT DENIAL:

- This request for appeal must be received within sixty (60) calendar days of the date of the notice informing you that the county has denied your eligibility to serve as an IHSS provider.
- Fill out and sign the third and fourth pages of this form.
- Provide a copy of your notice from the county denying your eligibility.
- Provide any supporting documentation for your appeal request. You may provide, for example, certified court documents.
- Make a copy of this form for your records.
- Send this form to:

California Department of Social Services
Fiscal, Appeals and Benefits Program Branch
Appeals, Administrative Review and Reimbursement Bureau
Attn: AARU, MS 9-11-04
PO Box 944243
Sacramento, CA 94244-2430

- The California Department of Social Services (CDSS), IHSS Appeals and Administrative Review Unit (AARU), will review the information contained with this request (including both information you provided and all information provided by the county/Public Authority/Non-Profit Consortium) to make

the decision regarding your eligibility. Upon completion of this review of all materials, the AARU will make a determination of eligibility.

- If you have any questions, call the CDSS AARU at (916) 651-3488.

I want to appeal the determination of _____
_____ County about my ineligibility to be
a provider of In-Home Supportive Services. I believe that the
County's decision is not correct. Here's why:

Page 3 of 4

Print Name:

Street Address:

City:**State:****Zip Code:**

Telephone Number:**Date of Birth:**

Signature of Applicant Provider:**Date:**

**IN-HOME SUPPORTIVE SERVICES PROGRAM
NOTICE TO RECIPIENT OF PROVIDER INELIGIBILITY
ACKNOWLEDGMENT OF RECEIPT OF INVALID
REQUEST FOR PROVIDER WAIVER**

(ADDRESSEE)

COUNTY OF: _____

Notice Date: _____

Provider Name: _____

IHSS Office

Address: _____

IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Recipient

On _____, you were notified that, based on state law*,
(DATE)

_____, the person you chose to
(PROVIDER NAME)

be your IHSS provider, was ineligible because he/she had been convicted of a disqualifying crime in the last 10 years. The notice explained that if you wanted him/her to be your provider, even though he/she had been convicted of a disqualifying crime, you could submit a signed request for a provider waiver to the county/ Public Authority (PA)/Non-Profit Consortium (NPC) IHSS office.

On _____, the county/PA/NPC IHSS program office
(DATE)

received an invalid request for a provider waiver.

The waiver request is invalid because it was signed by _____ as your authorized representative.
(PROVIDER NAME)

State law* does not allow your authorized representative to sign the waiver request to be your provider unless he/she is:

- Your parent, guardian or person having legal custody (if you are a minor), or
- Your conservator, spouse or registered domestic partner (if you are an adult).

County/PA/NPC records show that _____
(PROVIDER NAME)

is NOT your parent, guardian or a person having legal custody (if you are a minor), or your conservator, spouse or registered domestic partner (if you are an adult). If he/she IS your parent, guardian or a person having legal custody (if you are a minor), or if he/she is your conservator, spouse or registered domestic partner (if you are an adult), call your IHSS worker at the number shown at the top of the first page of this notice.

If you still want _____ to be your provider,
(PROVIDER NAME)

you can either:

- Sign the attached waiver request yourself if you are able, or
- Name another person to be your authorized representative, who will not be your provider, and ask him/her to sign the Recipient Request for Provider Waiver (form SOC 862).

Once the waiver request has been signed, you must return it to the county/PA/NPC IHSS program office, either in person or by mail.

If this person provides services for you without a valid waiver request, you will be responsible for paying him/her with your own money for any services he/she provides.

As an alternative, you may choose someone else to be your provider. If you need help finding a provider, call _____.

If you have any questions about this notice, call your IHSS worker at the number listed at the top of the first page of this notice.

***Welfare and Institutions Code Section 12305.87**

**IN-HOME SUPPORTIVE SERVICES PROGRAM
NOTICE TO RECIPIENT OF PROVIDER ELIGIBILITY
ACKNOWLEDGMENT OF RECEIPT OF WAIVER**

(ADDRESSEE)

COUNTY OF: _____

Notice Date: _____

Applicant

Provider Name: _____

Recipient Name: _____

Recipient Case Number: _____

IHSS Office Address: _____

IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Recipient

On _____, you were informed that, based on Welfare
MM/DD/YYYY

and Institutions Code, Section 12305.87, _____
was denied eligibility to work as an IHSS provider because he/she
had been convicted of a felony crime.

On _____, the IHSS office received your signed
waiver request. By signing the waiver, you confirmed that you
understand that you are employing the above-named individual to
work for you as an IHSS provider with the knowledge of
his/her criminal conviction(s) and that the State of California and
the County of _____ are not liable for the actions of
this individual while in your employ as an IHSS provider.

He/she may begin work as an IHSS provider for you as of the date of this notice. If this individual has already begun providing IHSS services to you, he/she may be eligible to receive retroactive payments for any authorized services he/she provided up to 90 days prior to the date of this notice.

If you move to a different county and wish to retain the above-named individual as your provider, he/she must go through another criminal background check through the California Department of Justice to be your provider in that county and you must complete and submit another IHSS Recipient Request for Provider Waiver (SOC 862) to that county.

If you have any questions about this notice, call the IHSS office at the telephone number listed at the top of Page 1.

**IN-HOME SUPPORTIVE SERVICES PROGRAM
NOTICE TO RECIPIENT OF PROVIDER INELIGIBILITY
TIER I CRIMES INELIGIBILITY - SUBSEQUENT CONVICTION
[WELFARE AND INSTITUTIONS CODE SECTION 12305.81]**

(ADDRESSEE) **COUNTY OF:** _____

Notice Date: _____

Provider Name: _____

_____ _____ Recipient Name: _____

Recipient Case Number: _____

IHSS Office Address: _____

IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Recipient

Effective twenty (20) days from the date of this notice, the person you have chosen to provide IHSS services to you, _____, is not eligible to receive payment from the IHSS program for providing services to you or to any other person. If this person has been providing services for you, he/she can only be paid for services he/she provides for you through _____.

Since this person's initial enrollment, the county/Public Authority/ Non-Profit Consortium has learned through certified court documents or through a criminal background check that he/she has been convicted of a crime(s) that makes him/her ineligible to serve as an IHSS provider or to receive payments from the IHSS program for providing services based on Welfare and Institutions

Code, Section 12305.81. The crime(s) which disqualified him/her is/are one or more of the crimes listed below:

- Abuse of an elder or dependent adult; and/or
- Specified abuse of a child; and/or
- Fraud against a government health care or supportive services program.

The information regarding the provider's criminal convictions is highly sensitive and must be kept strictly confidential. You are prohibited by law from sharing any part of this information with any other individual or entity.

Because this provider has been determined to be ineligible to provide services through the IHSS program, you must choose a different individual to act as your IHSS provider. If you choose to continue receiving services from this individual, you will be responsible for paying him/her with your own money for any services provided.

If you have any questions about this notice or need help finding a different provider, you may call _____ .

**IN-HOME SUPPORTIVE SERVICES PROGRAM
NOTICE TO RECIPIENT OF PROVIDER INELIGIBILITY
TIER 2 CRIMES INELIGIBILITY—SUBSEQUENT
CONVICTION
[WELFARE AND INSTITUTIONS CODE SECTION 12305.87]**

(ADDRESSEE) **COUNTY OF:** _____

Notice Date: _____

Provider Name: _____

_____ _____ Recipient Name: _____

Recipient Case Number: _____

IHSS Office Address: _____

IHSS Office Telephone Number: _____

To: In-Home Supportive Services (IHSS) Recipient

Effective twenty (20) days from the date of this notice, the person you have chosen to provide IHSS services to you, _____, is not eligible to receive payment from the IHSS program for providing services to you or to any other person. If this person has been providing services for you, he/she can only be paid for services he/she provides for you through _____.

Since this person's initial enrollment, the county/Public Authority/Non-Profit Consortium has learned through a criminal background check that he/she has been convicted of a crime(s) that makes him/her ineligible to serve as an IHSS provider or to receive payments from the IHSS program for providing services based on

Welfare and Institutions Code, Section 12305.87. The crime(s) which disqualified him/her is/are one or more of the crimes listed below:

The information regarding the provider's criminal convictions is highly sensitive and must be kept strictly confidential. You are prohibited by law from sharing any part of this information with any other individual or entity.

Despite this individual's felony conviction, you may submit a signed waiver that would allow this individual to continue working as your IHSS provider. If you agree to a waiver, you are accepting all responsibility for this decision and the risk of any potential actions that may occur as a result of this decision. You must complete, date, and sign the enclosed SOC 862 form, "IHSS Recipient Request for Individual Provider Waiver," and submit it to the county/Public Authority/Non-Profit Consortium IHSS office.

This waiver will allow this individual to continue to serve as an IHSS provider for you only and only in the county in which the waiver is filed, and he/she will receive payment from the IHSS program for providing services to you. This waiver only applies to the disqualifying crimes listed on this page. If the person is convicted of any subsequent disqualifying crime(s), another SOC 862 form must be completed and submitted for that subsequent disqualifying crime.

Because this provider has been determined to be ineligible to provide services through the IHSS program, if you choose not to submit a signed waiver, you must choose a different individual to act as your IHSS provider. If you choose to continue receiving services from this individual without submitting a waiver, you will be responsible for paying him/her with your own money for any services provided.

If you have any questions about this letter or need help finding a different provider, you may call the IHSS office at the telephone number listed at the top of Page 1.

**IN-HOME SUPPORTIVE SERVICES PROGRAM
RECIPIENT REQUEST FOR PROVIDER WAIVER**

(ADDRESSEE)**COUNTY OF:** _____☐ _____

Notice Date: _____

Applicant

☐ _____

Provider Name: _____

Recipient Name: _____

Recipient Case Number: _____

IHSS Office Address: _____

IHSS Office Telephone Number: _____

I, _____, am submitting this waiver
request to the _____

COUNTY/PUBLIC AUTHORITY/NON-PROFIT CONSORTIUM

in order to hire the person named below to be my In-Home
Supportive Services (IHSS) provider. I understand he/she has
been denied eligibility to be paid from the IHSS program, due to a
felony criminal conviction(s). Despite this information, I accept the
responsibility for my decision, and the possible risks involved, in
allowing this person to work in my home as an IHSS provider.

I have chosen to hire _____ to be my
IHSS provider and acknowledge that he/she has been convicted of
the following crime(s):

Date of Conviction	Penal Code Section	Felony Conviction Description
1.		
2.		
3.		
4.		
5.		

IN-HOME SUPPORTIVE SERVICES (IHSS) RECIPIENT REQUEST FOR PROVIDER WAIVER

AS THE IHSS RECIPIENT WHO WILL HIRE THIS PERSON TO PROVIDE IN-HOME SUPPORTIVE SERVICES, I UNDERSTAND AND AGREE TO THE FOLLOWING STATEMENTS AND ACTIVITIES LISTED BELOW

- I am hiring a person who has been convicted of the felony crime(s) listed on this form.
- I am required to keep this person's criminal conviction information confidential, and I am prohibited, by law, from sharing any part of it with any other individual or entity.
- I am completing this waiver request form, which applies only to the crime(s) listed on this form.
- This waiver only applies in the county to which I am sending it. If I move to a new county, the person I am hiring as my provider will have to go through another criminal background check and I will have to complete and submit another waiver request form in the new county before he/she can work and be paid for providing services to me as my provider.
- If the county notifies me that this person is convicted of an additional disqualifying felony crime(s) in the future, I will be required to complete and submit another waiver if I wish to continue receiving services from this person.
- A notice will be sent to me when the county has accepted this waiver.
- The county will send a timesheet to the provider I have chosen to hire only after this waiver has been accepted.

By signing this form, I accept the responsibility for hiring the person named on this form to work in my home. I understand the County and the State of California are immune from any liability, due to the risk of any actions that may occur, because of my decision to hire him/her as my IHSS provider.

This document may only be signed by the recipient or by an authorized representative who is not the provider named on this form.

SIGNATURE OF RECIPIENT OR RECIPIENT'S AUTHORIZED REPRESENTATIVE

PRINT NAME

DATE

Without an approved waiver to hire the person named on this form, you will be responsible for paying him/her with your own money for any services provided.

Submit this form within ten (10) calendar days from the "Notice Date" listed on the upper right corner of Page 1. You may submit this form by mail or in person to your IHSS county, Public Authority, or Non-Profit Consortium at the following address:

By mail:

In person:

IN-HOME SUPPORTIVE SERVICES (IHSS) REQUEST FOR APPLICANT PROVIDER REFERENCE

Applicant Provider: You must enter your full name in the space below and at the top of each page BEFORE you give this form to your reference for completion.

REFERENCE REQUEST FOR: _____

Person Submitting Reference: In-Home Supportive Services (IHSS) providers are caregivers for elderly, blind, and/or disabled individuals in their own homes. The above-named person has requested to be an IHSS provider but he/she was found ineligible because he/she has been convicted of a felony criminal conviction(s). He/she is requesting a general exception, which, if granted, would allow him/her to be an IHSS provider despite his/her felony criminal conviction(s). The information you provide will help us evaluate whether this person should be granted a general exception and allowed to be an IHSS provider.

Please complete the information below.

Your Name:		Date Completed:
Street Address:		
City:	State:	Zip Code:
Daytime Telephone Number: ()		

REFERENCE REQUEST FOR: _____

Please answer all questions on this form to the best of your ability.

1. How long have you known the person you are writing this reference for? _____

2. How do you know this person? _____

3. Please give your opinion of this person's character. _____

REFERENCE REQUEST FOR: _____

4. Please describe any interaction you have observed between this person and elderly, blind, or disabled individuals. _____

5. Please add any comments you feel are relevant about this person and his/her ability to work as an IHSS provider. _____

Name Of Person Submitting Reference: *(Please Print)*

Your Signature:

Date:

**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, _____, authorize the release of health care
(PRINT NAME)

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.*

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(s) 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 on page 5 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 on page 5 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.

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM NOTICE TO APPLICANT OF HEALTH CARE CERTIFICATION REQUIREMENT

State Law (Welfare and Institutions Code section 12309.1) requires that each person applying for IHSS provide a health care certification from a licensed health care professional (LHCP) before they can get IHSS.

The certification must be completed by a LHCP, such as a physician (doctor), physician assistant, regional center clinician or clinician supervisor, occupational therapist, physical therapist, psychiatrist, psychologist, optometrist, ophthalmologist, public health nurse, etc.

The certification must state that you are not able to do some activities of daily living (ADLs) on your own and that without help to do these activities you would be at risk of placement in out-of-home care.

Basic ADLs are: eating, bathing, dressing, using the toilet, walking, and getting out of bed or a chair. Other ADLs are: housekeeping, preparing meals, shopping for food or other necessities, taking medication, etc.

Attached is a blank copy of the Health Care Certification Form (SOC 873) that you can give to your LHCP to complete. If you want, the county can send it to the LHCP for you but you will have to give the county the LHCP's name and address.

The county may accept alternative documentation in place of the SOC 873 as long as it meets all of the following requirements:

1. Indicates that you are not able to do one or more ADLs on your own, and without services, you are at risk of placement in out-of-home care,
2. Describes the medical or other condition that makes you unable to do ADLs on your own and causes you to need IHSS, and
3. Has been signed by a LHCP within the last 60 days.

Whether you give the SOC 873 to the LHCP yourself or the county sends it for you, you are responsible for making sure it is completed and returned to the county within **45 days** from the date the county worker requested it.

If you do not provide the SOC 873 or alternative documentation to the county within 45 days, your application for IHSS will be denied. As with any county action taken on your case, you may request a state hearing if you do not agree with the county's decision.

Under certain limited circumstances, such as when services are requested because you are being discharged from a hospital or nursing facility and you need services to return safely to your home, or the county determines that you are at risk of placement in out-of-home care, the county may grant an exception that would allow you to get IHSS on a temporary basis before the county receives the completed SOC 873 or alternative documentation. However, even if an exception is granted, you will still be required

to provide one of these documents for the county within the 45-day timeframe to determine if you can continue getting IHSS. If you have been granted an exception but you are not able to get the SOC 873 from your LHCP within 45 days, call your social worker **before the due date** to tell him/her why you are not able to meet the due date and ask if the county can grant you more time.

If you have questions about the health care certification requirement, ask the social worker who has been assigned to your case.

DUE BY: ____/____/____

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM NOTICE TO RECIPIENT OF HEALTH CARE CERTIFICATION REQUIREMENT

(ADDRESSEE)**COUNTY OF:** _____

| |

Notice Date: _____

IHSS Office

| | Address: _____

IHSS Office Telephone Number: _____

Social Worker Name: _____

To: In-Home Supportive Services (IHSS) Recipient _____

There has been a change in state law (Welfare and Institutions Code section 12309.1) that requires each person getting IHSS to provide a health care certification from a licensed health care professional (LHCP) to continue to get IHSS.

The certification must be completed by a LHCP, such as a physician (doctor), physician assistant, regional center clinician or clinician supervisor, occupational therapist, physical therapist, psychiatrist, psychologist, optometrist, ophthalmologist, public health nurse, etc.

The certification must state that you are not able to do some activities of daily living (ADLs) on your own and that without help to do these activities you would be at risk of placement in out-of-home care.

Basic ADLs are: eating, bathing, dressing, using the toilet, walking, and getting out of bed or a chair. Other ADLs are: housekeeping, preparing meals, shopping for food or other necessities, taking medication, etc.

Attached is a blank copy of the Health Care Certification Form (SOC 873) that you can give to your LHCP to complete. If you want, the county can send it to the LHCP for you but you will have to give the county the LHCP's name and address.

The county may accept alternative documentation in place of the SOC 873 as long as it meets all of the following requirements:

1. Indicates that you are not able to do one or more ADLs on your own,
2. Describes the medical or other condition that makes you unable to do ADLs on your own and causes you to need IHSS, and
3. Has been signed by a LHCP within the last 60 days.

Whether you give the SOC 873 to the LHCP yourself or the county sends it for you, you are responsible for making sure it is completed and returned to the county within **45 days** following your reassessment.

If the county does not receive the completed SOC 873 or alternative documentation within 45 days following your reassessment, your IHSS may stop. As with any county action taken on your case, you may request a state hearing if you do not agree with the county's decision.

If you are not able to get the SOC 873 from your LHCP within 45 days, call your social worker at the number listed above **before the due date** to tell him/her why you are not able to meet the due date and ask if the county can grant you more time.

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM

NOTICE OF PROVISIONAL APPROVAL HEALTH CARE CERTIFICATION

EXCEPTION GRANTED

TO:**COUNTY OF:** _____

Notice Date: _____

Case Number: _____

IHSS Office Address: _____

IHSS Office Telephone Number: _____

The county has provisionally approved your application for In-Home Supportive Services (IHSS). Here's what that means:

State law requires that before you can get IHSS, you have to provide the county with a health care certification, or alternative documentation, completed and signed by a licensed health care professional, and you have to have an assessment of your needs completed in your own home.

The county has granted an exception so that you can get IHSS on a temporary basis **before** you meet these requirements, but you still have to provide the county with the

health care certification, or alternative documentation (if you have not already provided it). You will temporarily get the services/hours shown below once you return to your own home. These services/hours are based on a preliminary assessment of your needs done while you were in a medical facility.

When you provide the county with the health care certification, or alternative documentation, the county will determine your eligibility to continue getting IHSS. If you are determined eligible, the county will do an in-home assessment to complete the determination of your services/hours.

The county asked you to provide the health care certification, or alternative documentation, by _____.
DATE

If you do not provide the county with a health care certification, or alternative documentation, by this date, the IHSS you have been getting on a temporary basis will stop. If you cannot provide the health care certification, or alternative documentation, by this date, contact your social worker before the due date to explain why and ask if the county can grant you more time.

If you have questions about the information in this notice, call your social worker.

Services	TOTAL AMOUNT OF THE SERVICE NEEDED	ADJUSTMENTS FOR OTHERS WHO SHARE THE HOME	AMOUNT OF THE SERVICE YOU NEED	SERVICES YOU REFUSED OR GET FROM OTHERS	AUTHORIZED AMOUNT OF SERVICE YOU CAN GET
	HRS:MINS	(PRORATION)	HRS:MINS		HRS:MINS
DOMESTIC SERVICES (per MONTH)					
RELATED SERVICES (per WEEK)					
Prepare Meals					
Meal Clean-up					
Routine Laundry					
Shopping for Food					
Other Shopping/ Errands					

Services	TOTAL AMOUNT OF THE SERVICE NEEDED	ADJUSTMENTS FOR OTHERS WHO SHARE THE HOME	AMOUNT OF THE SERVICE YOU NEED	SERVICES YOU REFUSED OR GET FROM OTHERS	AUTHORIZED AMOUNT OF SERVICE YOU CAN GET
	HRS:MINS	(PRORATION)	HRS:MINS		HRS:MINS
NON-MEDICAL PERSONAL SERVICES (per WEEK)					
Respiration Assistance (Help with Breathing)					
Bowel, Bladder Care					
Feeding					
Routine Bed Baths					
Dressing					
Menstrual Care					

Services	TOTAL AMOUNT OF THE SERVICE NEEDED	ADJUSTMENTS FOR OTHERS WHO SHARE THE HOME	AMOUNT OF THE SERVICE YOU NEED	SERVICES YOU REFUSED OR GET FROM OTHERS	AUTHORIZED AMOUNT OF SERVICE YOU CAN GET
	HRS:MINS	(PRORATION)	HRS:MINS		HRS:MINS

NON-MEDICAL PERSONAL SERVICES (per WEEK)

Ambulation (Help w/ Walking, including Getting In/Out of Vehicles)					
Transferring (Help Moving In/Out of Bed, On/Off Seats, etc.)					
Bathing, Oral Hygiene, Grooming					

Services	TOTAL AMOUNT OF THE SERVICE NEEDED	ADJUSTMENTS FOR OTHERS WHO SHARE THE HOME	AMOUNT OF THE SERVICE YOU NEED	SERVICES YOU REFUSED OR GET FROM OTHERS	AUTHORIZED AMOUNT OF SERVICE YOU CAN GET
	HRS:MINS	(PRORATION)	HRS:MINS		HRS:MINS
NON-MEDICAL PERSONAL SERVICES (per WEEK)					
Rubbing Skin, Repositioning					
Help with Prosthesis (Artificial Limb, Visual/ Hearing Aid) and/or Setting up Medications					

Services	TOTAL AMOUNT OF THE SERVICE NEEDED	ADJUSTMENTS FOR OTHERS WHO SHARE THE HOME	AMOUNT OF THE SERVICE YOU NEED	SERVICES YOU REFUSED OR GET FROM OTHERS	AUTHORIZED AMOUNT OF SERVICE YOU CAN GET
	HRS:MINS	(PRORATION)	HRS:MINS		HRS:MINS

ACCOMPANIMENT (per WEEK)

To/From Medical Appointments					
To/From Places You Get Services in Place of IHSS					
PROTEC- TIVE SU- PERVISION (per WEEK)					

Services	TOTAL AMOUNT OF THE SERVICE NEEDED	ADJUSTMENTS FOR OTHERS WHO SHARE THE HOME	AMOUNT OF THE SERVICE YOU NEED	SERVICES YOU REFUSED OR GET FROM OTHERS	AUTHORIZED AMOUNT OF SERVICE YOU CAN GET
	HRS:MINS	(PRORATION)	HRS:MINS		HRS:MINS
PARAMED- ICAL SER- VICES (per WEEK)					
TOTAL WEEKLY HRS:MINS OF SERVICE YOU CAN GET:					
MULTIPLY BY 4.33 (average # of weeks per month) TO CONVERT TO MONTHLY HRS:MINS:					x 4.33 =
SUBTOTAL MONTHLY HRS:MINS OF SERVICE YOU CAN GET:					
ADD MONTHLY DOMESTIC HRS:MINS OF SERVICE YOU CAN GET (from above):					
TOTAL HRS:MINS OF SERVICE YOU CAN GET PER MONTH:					

Services	TOTAL AMOUNT OF THE SERVICE NEEDED	ADJUSTMENTS FOR OTHERS WHO SHARE THE HOME	AMOUNT OF THE SERVICE YOU NEED	SERVICES YOU REFUSED OR GET FROM OTHERS	AUTHORIZED AMOUNT OF SERVICE YOU CAN GET
	HRS:MINS	(PRORATION)	HRS:MINS		HRS:MINS

TIME LIMITED SERVICES

Heavy Cleaning					
Yard Hazard Abatement					
Remove Ice, Snow					
Teaching and Demonstra- tion					
TOTAL HRS:MINS OF TIME LIMITED SERVICES YOU CAN GET PER MONTH:					

IHSS RECIPIENTS NOTICE OF NEW TIMESHEETS PLEASE KEEP FOR FUTURE USE

As of _____ the IHSS program in your county will be
MM/YY

getting a new payroll system that will use a New IHSS Timesheet. Your provider will be receiving the New IHSS Timesheet with their paycheck (a sample of the New Timesheet is enclosed). This notice gives you information about the New Timesheet. It is important that the timesheet be completed correctly so that your provider is paid correctly and on time. Please read and follow the instructions in this notice.

Where New Timesheets are Processed for Payment: New Timesheets will be processed at a Timesheet Processing Facility (TPF) in Chico, California. **They will NOT be processed at the county IHSS office. Your provider MUST mail all New Timesheets to the Chico facility.**

The envelope your provider receives with the New Timesheet will have the TPF address printed on it. The TPF address is also on the back of the New Timesheet if the envelope is lost. Your provider **MUST NOT** mail or drop the New Timesheet at any county IHSS office. This will cause a **DELAY** in receiving their paycheck. Old-style timesheets should still be sent to the county IHSS payroll office.

What to Send to the Timesheet Processing Facility (TPF):

Send **ONLY** the timesheet to the TPF. **Do not send any other documents to the TPF.** The TPF will **NOT** process any other information. If you or your provider sends other information it will **DELAY** your county receiving this information. If you have other information to report to the IHSS program, send it to your county IHSS office – **Do not mail it to the TPF.**

When to Send Timesheets: Timesheets should be sent to the TPF promptly at the end of each pay period. There are two pay periods each month.

- The first pay period ends on the 15th of the month and the second pay period ends on the last day of the month. If your provider sends their timesheet in early it will either be rejected for payment or held until the end of the pay period.
- If time is claimed after the date the timesheet is received, it will be rejected for payment. For example, if the timesheet is received at the TPF on the 10th of the month and hours are entered on the timesheet for the 14th of the month, it will be rejected for payment. Your provider will have to get another timesheet from the county IHSS payroll office, fill it out and have it signed and then send it to the TPF.
- If time is not claimed after the date the timesheet is received it will be held until the end of the pay period to be processed. For example, if the timesheet is received at the TPF on the 10th of the month but no hours are entered on the timesheet after the 10th of the month, the timesheet will be held until the end of the pay period to be processed.

- If your provider stops working for you, the county IHSS office **MUST immediately** be notified of the provider's work end date. Their timesheet may then be submitted on the last day they work and it will be processed as soon as it is received.

How Your Provider(s) Claims Time Worked: On the New Timesheet, your provider writes the time they worked in **hours and minutes** each day. Your provider no longer needs to change minutes to decimals. For example, if they work 4 hours and 45 minutes they would enter 4 in the "Hours" boxes and 45 in the "Minutes" boxes (see example on enclosed sample Pay Stub).

What Time Your Provider(s) can Claim: You are authorized hours for specific domestic and related and personal care services. The IHSS program only pays for authorized hours and services. Your provider(s) can only be paid for time spent performing authorized services. You or your representative is responsible for scheduling these services to ensure your needs are met throughout the month. The total hours claimed each month for all your providers cannot be more than your total monthly authorized hours. If you have multiple providers you will have to set a schedule for each so that the total of all their hours does not exceed your monthly authorized hours.

If too many of your authorized hours are used during the first pay period, your needs may not be met during the rest of the month. Provider timesheets claiming too many of your hours in the first pay period will be reviewed and you or your provider may be contacted to discuss the hours being claimed. This may **DELAY** your provider's paycheck.

Completing the New Timesheet: Your provider **MUST** use black ink to complete the timesheet; **MUST NOT** use pencil; **MUST NOT** fold the timesheet; and **MUST NOT** write anything on the timesheet except time worked (hours and minutes), signature and date.

Signing and Dating New Timesheet: You or your representative are responsible for reviewing your provider's timesheet before you sign it to ensure it is claiming the correct hours. **DO NOT** sign an incorrect or blank timesheet. The new timesheets must be signed and dated on the back side by both you and your provider. Timesheets submitted without both signatures will be rejected for payment. Another timesheet will have to be completed. This will create a **DELAY** for your provider receiving their paycheck.

How to Report a Provider's Change of Address: If your provider moves, they **MUST immediately** complete a change of address form that they can get from and return to the county IHSS payroll office. IHSS paychecks will **not** be forwarded by the post office. If the payroll system does not have the provider's correct address, their paycheck will be returned to the State Controller's Office as undeliverable.

**KEEP THIS NOTICE FOR USE IN COMPLETING THE NEW
TIMESHEET.**

**CONTACT THE COUNTY IHSS PAYROLL OFFICE IF YOU
HAVE QUESTIONS OR NEED ASSISTANCE COMPLETING
THE NEW TIMESHEET.**