

March 24, 2020

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

EXECUTIVE SUMMARY

ALL COUNTY LETTER NO. 19-100E

This Erratum corrects language in All County Letter 19-100 to allow an individual to request the Exemption from Workweek Limits for Extraordinary Circumstances (Exemption 2) State Administrative Review Request (ESAR) when an Exemption 2 is terminated. This erratum also transmits revised forms SOC 2312, SOC 2312A and SOC 2313 to reflect this correction.



STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • www.cdss.ca.gov



March 24, 2020

ERRATA

ALL COUNTY LETTER (ACL) NO. 19-100E

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

SUBJECT: CORRECTION TO ACL NO. 19-100

REFERENCE: [ACL 18-31](#); [ACL 18-54](#); [ACL 18-58](#); [SENATE BILL \(SB\) 89 \(CHAPTER 24, STATUTES OF 2017\)](#); [WELFARE AND INSTITUTIONS CODE \(WIC\) SECTION 12300.4](#)

The purpose of this erratum is to correct information contained in ACL No. 19-100, released on October 29, 2019. This erratum will correct language in ACL 19-100, which previously did not allow individuals the opportunity to request an Exemption from Workweek Limits for Extraordinary Circumstances (Exemption 2) State Administrative Review Request (ESAR) when an Exemption 2 is terminated. This correction will allow those individuals the opportunity to request an ESAR. Furthermore, this erratum corrects the language on forms released with the ACL 19-100 and as such, transmits revised forms In-Home Supportive Services (IHSS) Program Notice to Provider of Termination of Exemption from Workweek Limits for Extraordinary Circumstances (Exemption 2) Due to A Change in Eligibility (SOC 2312), In-Home Supportive Services (IHSS) Program Notice to Recipient of Termination of Exemption from Workweek Limits for Extraordinary Circumstances (Exemption 2) Due to a Change in Eligibility (SOC 2312A) and In-Home Supportive Services (IHSS) Program Exemption from Workweek Limits for Extraordinary Circumstances (Exemption 2) State Administrative Review Request Form (SOC 2313).

On page six of ACL No. 19-100, under the “Change in Exemption Eligibility” section, paragraph three currently states:

It should be noted that county staff should not send the Exemption from Workweek

Limits for Extraordinary Circumstances (Exemption 2) State Administrative Review Request Form (SOC 2313) with the SOC 2312 and SOC 2312A as an individual whose Exemption 2 is terminated due to a change in eligibility for the exemption is not entitled to request an ESAR. The individual may reapply for the Exemption 2 at any time.

The language is being corrected to state:

It should be noted that county staff should send the Exemption from Workweek Limits for Extraordinary Circumstances (Exemption 2) State Administrative Review Request Form (SOC 2313) with the SOC 2312 and SOC 2312A **as an individual whose Exemption 2 is terminated, regardless of the reason, is entitled to request an ESAR. Additionally, if the individual's circumstances under which they were originally approved have changed**, the individual may reapply for the Exemption 2 at any time.

This correction allows an individual to request an ESAR in circumstances when the county has determined that the individual is no longer allowed an Exemption 2 either prior to the end of the previously approved Exemption 2 or at the time of renewal.

Any questions regarding the information provided in this Erratum of ACL 19-100 may be directed to the Appeals, Administrative Review and Reimbursement Bureau at (916) 651-3488.

Sincerely,

Original Document Signed By:

DEBBI THOMSON
Deputy Director
Adult Program Division

Attachments

**IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
NOTICE TO PROVIDER OF TERMINATION OF EXEMPTION FROM
WORKWEEK LIMITS FOR EXTRAORDINARY CIRCUMSTANCES
(EXEMPTION 2) DUE TO A CHANGE IN ELIGIBILITY**

(ADDRESSEE)

County of: _____

┌ _____ ┐

Notice Date: _____

IHSS Office Address: _____

└ _____ ┘

IHSS Office Telephone: _____

Provider Name: _____

Provider Number: _____

At the end of service month _____, the Exemption 2 you were granted for the IHSS recipients listed below will be terminated because there has been a change in your eligibility for the exemption:

Recipient Name: _____ Case Number: _____

Recipient Name: _____ Case Number: _____

Recipient Name: _____ Case Number: _____

Recipient Name: _____ Case Number: _____

You are no longer eligible for an Exemption 2 because:

- ☐ You are no longer providing services for one or more of the recipients.
- ☐ You no longer live in the same home with one or more of the recipients.
- ☐ One or more of the recipients has had a reduction in authorized IHSS hours so you are now able to work within the workweek limits.
- ☐ One or more of the recipients no longer meets the Exemption 2 eligibility criteria.
- ☐ One or more of the recipients have hired an additional provider(s) and therefore, you are able to work within the workweek limits.
- ☐ You did not submit a signed copy of the Exemption from Workweek Limits for Extraordinary Circumstances Approved Exemption Provider Agreement (SOC 2308) to the county as required.

☐ OTHER REASON:

The termination of your Exemption 2 means you must adhere to the standard IHSS workweek limits. Therefore, the maximum combined number of hours you may work for two or more recipients is 66 hours per workweek. Once you work the maximum weekly hours, your recipients must hire another IHSS provider to work their remaining authorized IHSS hours.

If you submit timesheets that report working hours that exceed the 66-hour workweek limits for service periods after the exemption end date, you will receive a violation.

In the future, if there are any changes in the recipients' circumstances that may affect your eligibility for an exemption, you can request to be re-evaluated for an Exemption 2 at that time.

If you disagree with the county's determination that you are ineligible for an exemption, you can request a state administrative review of the ineligibility determination. See the attached Exemption 2 State Administrative Review Request Form (SOC 2313) for information about the state administrative review process and instructions on how to request one.

If you have questions about this notice, call your recipient's IHSS social worker at the telephone number shown above.

**IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
NOTICE TO RECIPIENT OF TERMINATION OF EXEMPTION FROM
WORKWEEK LIMITS FOR EXTRAORDINARY CIRCUMSTANCES
(EXEMPTION 2) DUE TO A CHANGE IN ELIGIBILITY**

(ADDRESSEE)

County of: _____

┌ _____ ┐

Notice Date: _____

IHSS Office Address: _____

└ _____ ┘

IHSS Office Telephone: _____

Provider Name: _____

Provider Number: _____

At the end of service month _____, your provider's Exemption 2 will be terminated because of the following change(s) in his or her eligibility for the exemption:

- ☐ Your provider is no longer providing services for you or one of the other recipients he or she was previously working for.
- ☐ Your provider no longer lives in the same home with you or one of his or her other recipients.
- ☐ You or one of your provider's other recipients has had a reduction in authorized IHSS hours so your provider is now able to work within the workweek limits.
- ☐ You or one of your provider's other recipients no longer meets the Exemption 2 eligibility criteria.
- ☐ You or one of your provider's other recipients has hired an additional provider(s) and therefore, your provider is able to work within the workweek limits.
- ☐ Your provider did not submit a signed copy of the Exemption from Workweek Limits for Extraordinary Circumstances Approved Exemption Provider Agreement (SOC 2308) to the county as required.

☐ OTHER REASON:

Because the Exemption 2 is being terminated, your provider will have to work within the standard IHSS workweek limits. This means that the maximum combined number of hours that your provider may work for you and any other recipients is 66 hours per workweek. If your provider works more than the 66-hour per workweek limit, he or she will receive a violation.

Either you or one of your provider's other recipients will need to hire another provider(s) to work any remaining authorized IHSS hours above the 66 hour per workweek limit. You should discuss this information with your provider and make arrangements to ensure that he or she does not work more than the workweek limits.

In the future, if there are any changes in your circumstances that may affect your provider's eligibility for an exemption, your provider can request to be re-evaluated for an Exemption 2 at that time.

If you disagree with the county's determination that you are ineligible for an exemption, you can request a state administrative review of the ineligibility determination. See the attached Exemption 2 State Administrative Review Request Form (SOC 2313) for information about the state administrative review process and instructions on how to request one.

If you have any questions about this notice, you may call your IHSS social worker at the telephone number shown above.

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM EXEMPTION FROM WORKWEEK LIMITS FOR EXTRAORDINARY CIRCUMSTANCES (EXEMPTION 2) STATE ADMINISTRATIVE REVIEW REQUEST FORM

IMPORTANT INFORMATION ABOUT THE EXEMPTION 2 STATE ADMINISTRATIVE REVIEW PROCESS

PLEASE READ CAREFULLY

You received this form (SOC 2313) because you requested an Exemption from the Workweek Limits for Extraordinary Circumstances (Exemption 2) and the county determined you were ineligible for the exemption or the exemption was terminated.

You can request an Exemption 2 State Administrative Review (ESAR) of the county's ineligibility determination by completing, signing and mailing this form to the California Department of Social Services (CDSS) at the address shown on page 3.

You must submit the form within 45 calendar days of the date of the Notice to Provider of Ineligibility for Exemption from the In-Home Supportive Services Program Workweek Limits for Extraordinary Circumstances (SOC 2310) and Notice to Recipient of Ineligibility for Exemption from the In-Home Supportive Services Program Workweek Limits for Extraordinary Circumstances (SOC 2310A) or the In-Home Supportive Services (IHSS) Program Notice to Provider of Termination of Exemption from the Workweek Limits for Extraordinary Circumstances (Exemption 2) Due to a Change in Eligibility (SOC 2312) and Notice To Recipients of Termination of Exemption from Workweek Limits for Extraordinary Circumstances (Exemption 2) Due to a Change in Eligibility (SOC 2312A) you received from the county.

NOTE: You must submit a copy of the SOC 2310 and SOC 2310A or the SOC 2312 and SOC 2312A that you received from the county to CDSS along with this form completed and signed by the provider and all recipients.

If the form is submitted (postmarked) more than 45 days from the date of the SOC 2310 and SOC 2310A, or the SOC 2312 and SOC 2312A it will be considered late and it will not be accepted for review. You will be sent a notice informing you that the county's ineligibility determination will stand.

If the form is submitted (postmarked) on time, it will be accepted for review. During the review period, you will not incur violations for working over the workweek limits.

Once your request has been accepted, you will be sent a notice informing you that a telephone conference has been scheduled so you can present information about why

you believe the county's ineligibility determination was not correct. The notice will show when the telephone conference will take place.

During the telephone conference, you will be able to explain why you believe you qualify for an Exemption 2. You can also request to submit additional written information to support why you believe you qualify for the exemption.

The information you provide on this form, including any supporting information/ documentation, and the information you provide in your telephone conference will all be considered in the review process. The information the county entered in your case record will also be reviewed. After considering all the information, a decision will be rendered regarding the county's ineligibility determination and if it was made in accordance with state requirements. The final decision will either uphold or overturn the county's ineligibility determination.

You will be sent a letter informing you of a final decision within 20 business days of the date of the telephone conference. If you asked to submit additional written information during the telephone conference, the decision may take longer than 20 business days.

INSTRUCTIONS

- Use black or blue ink to fill out. Print information clearly.
- Complete all parts of this form. If you need more space to answer any of the questions, you can attach an additional page(s).
- Make sure the provider and all recipients included in the Exemption 2 request (or their authorized representative(s)) sign on the last page.
- Mail the completed and signed form to the address shown below within 45 calendar days of the date of SOC 2310 and SOC 2310A or SOC 2312 and SOC 2312A you received from the county. **Forms submitted (postmarked) late will NOT be accepted for review.**
- **INCLUDE A COPY OF THE SOC 2310 AND SOC 2310A OR SOC 2312 AND SOC 2312A YOU RECEIVED FROM THE COUNTY ALONG WITH THIS FORM COMPLETED AND SIGNED BY THE PROVIDER AND ALL RECIPIENTS.**
- Include any supporting documentation. This may include, but is not limited to, letters from health care providers, family members, friends or others who have observed past incidents that resulted in negative effects on the recipients from being introduced to or having their services provided by a new provider.
- Keep a copy of the completed form and supporting documentation for your records.
- Mail the completed form to the following address:
**California Department of Social Services
Appeals, Administrative Review and Reimbursement Bureau
Attention: Appeals and Administrative Review Unit
744 P Street, M.S. 9-11-04
Sacramento, CA 95814**
- It is recommended that you ask for a receipt of mailing from the Post Office and keep it for your records.
- If you have any questions, call the Appeals and Administrative Review Unit at (916) 651-3488.

| | | | |
|-----------------------|--|--------------------|--|
| County Name: | | | |
| Provider Name: | | Provider #: | |

| | | | |
|---|--|----------------|--|
| Recipient #1 Name: | | Case #: | |
| This Recipient Meets the Following Criteria: (Check all that apply) | | | |
| <input type="checkbox"/> A- Has Complex Medical/Behavioral Needs Requiring Provider Who Lives in Same Home | | | |
| <input type="checkbox"/> B- Lives in Rural/Remote Location Where Available Providers Are Limited | | | |
| <input type="checkbox"/> C- Is Unable to Hire Provider Who Speaks Same Language Which Prevents Recipient From Directing Own Care | | | |

How does this recipient meet the criteria for an Exemption 2?

| | | | |
|---|--|----------------|--|
| Recipient #2 Name: | | Case #: | |
| This Recipient Meets the Following Criteria: (Check all that apply) | | | |
| <input type="checkbox"/> A- Has Complex Medical/Behavioral Needs Requiring Provider Who Lives in Same Home | | | |
| <input type="checkbox"/> B- Lives in Rural/Remote Location Where Available Providers Are Limited | | | |
| <input type="checkbox"/> C- Is Unable to Hire Provider Who Speaks Same Language Which Prevents Recipient From Directing Own Care | | | |

How does this recipient meet the criteria for an Exemption 2?

| | | | |
|---|--|----------------|--|
| Recipient #3 Name: | | Case #: | |
| This Recipient Meets the Following Criteria: (Check all that apply) | | | |
| <input type="checkbox"/> A- Has Complex Medical/Behavioral Needs Requiring Provider Who Lives in Same Home <input type="checkbox"/> B- Lives in Rural/Remote Location Where Available Providers Are Limited <input type="checkbox"/> C- Is Unable to Hire Provider Who Speaks Same Language Which Prevents Recipient From Directing Own Care | | | |

How does this recipient meet the criteria for an Exemption 2?

1. Have the recipients (or their authorized representatives) tried to hire an additional provider(s)? If not, why not? If so, why have these attempts not been successful? (Note: Examples of attempts to hire another provider(s) could include, but are not limited to, outreach to relatives, friends and neighbors, or individuals on the provider registry maintained by the Public Authority. Past incidents when having another provider has resulted in negative impacts to the recipients' health and/or safety should be noted and will be considered as sufficient confirmation.)

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

2. For recipients applying under Criteria A, explain why services must be provided by a provider who lives in the same home as the recipient. How has this been determined and confirmed? (Note: Do not simply list the recipient's medical/behavioral conditions. Describe the negative impact that having another provider would have on their health and/or safety and indicate how this has been confirmed.)

For recipients applying under Criteria B or C, explain how the recipient's rural location or language needs affect his/her ability to find another provider. How has this been determined and confirmed?

Recipient #1:

Recipient #2:

Recipient #3:

3. Why do you believe the county was incorrect in determining you were not eligible for an Exemption 2?

I agree with the above information and believe it to be true and correct.

| PROVIDER | | | |
|---|--|-------|------------|
| Do you need the state to provide you with an interpreter (at no cost to you) for the telephone conference? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| If YES, language or dialect: _____ | | | |
| Signature: | | Date: | Telephone: |

| RECIPIENT #1 | | | |
|---|--|-------|------------|
| Do you have additional information to present during a telephone conference? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| If YES, do you need the state to provide you with an interpreter (at no cost to you) for the telephone conference? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| If YES, language or dialect: _____ | | | |
| Signature: | | Date: | Telephone: |

| RECIPIENT #2 | | | |
|---|--|-------|------------|
| Do you have additional information to present during a telephone conference? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| If YES, do you need the state to provide you with an interpreter (at no cost to you) for the telephone conference? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| If YES, language or dialect: _____ | | | |
| Signature: | | Date: | Telephone: |

| RECIPIENT #3 | | | |
|---|--|-------|------------|
| Do you have additional information to present during a telephone conference? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| If YES, do you need the state to provide you with an interpreter (at no cost to you) for the telephone conference? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| If YES, language or dialect: _____ | | | |
| Signature: | | Date: | Telephone: |