

March 15, 2021

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

EXECUTIVE SUMMARY

ALL COUNTY LETTER NO. 21-31

The purpose of this All-County Letter (ACL) is to provide information to counties regarding the implementation of a new COVID Medical Accompaniment special transaction, which provides payment to In-Home Supportive Services (IHSS) providers for accompanying recipients to COVID-19 vaccine appointments.



KIM JOHNSON
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
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GOVERNOR

March 15, 2021

ALL COUNTY LETTER NO. 21-31

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

SUBJECT: IMPLEMENTATION OF NEW IHSS MEDICAL ACCOMPANIMENT
SPECIAL TRANSACTION RELATED TO COVID-19 PANDEMIC

The purpose of this All-County Letter (ACL) is to provide information to counties regarding the implementation of a new COVID Medical Accompaniment special transaction, which provides payment to In-Home Supportive Services (IHSS) providers for accompanying recipients to receive their COVID-19 vaccines.

BACKGROUND

As part of the changes made to California's COVID-19 vaccine plan, a new high risk medical/disabled group is being added to receive vaccinations beginning March 15, 2021. IHSS recipients aged 16 to 64 are considered eligible to receive COVID-19 vaccine under this criteria. Those over 65 years of age and older are already eligible to be vaccinated.

IMPLEMENTATION OF COVID MEDICAL ACCOMPANIMENT

IHSS recipients who need assistance from their providers to obtain a vaccination and currently have authorized time for Medical Accompaniment can use those service hours for this purpose. For recipients who need additional hours for this purpose, or for recipients who do not have authorized time for accompaniment to medical appointments, but require this IHSS service to get their vaccine, CDSS created a new COVID Medical Accompaniment special transaction to allow a one-time payment to the providers for up to four hours (two hours per vaccine appointment) per recipient.

CDSS is sending notices informing IHSS recipients about the changes made to California's vaccination plan. IHSS recipients aged 16 to 64 will receive a letter which they can use to verify they are an IHSS recipient if needed and a copy of the attached Vaccine Medical Accompaniment Claim Form. Recipients aged 65 and older will receive a copy of the Claim Form only.

To request this payment, providers would complete and have the recipient sign the Claim Form which would then be submitted to the county IHSS office. Note, under this process, the state statutory maximum number of hours of 195 or 283 still applies. Any hours claimed through this process that would increase the recipient hours above the applicable statutory maximum will not be eligible for payment.

COUNTY RESPONSIBILITIES

When the county IHSS office receives the Claim Form, county staff shall determine if a previous claim(s) has been paid and if there are remaining hours available as well as if any of the claimed hours are eligible for payment based on applicable statutory maximum hours. County staff will also need to verify the enrollment status of the provider, determine if he/she is active on the named recipient's case and eligible to receive the payment. No adjustment is needed to the existing service hours before processing the claim, and the hours will not be counted toward the provider's weekly working hours. Claims received requesting payments for the COVID Medical Accompaniment can be paid retroactively back to January 1, 2021. The county must document the claim outcome details in recipient's Case Note in CMIPS.

To assist counties with the denial process, a letter template will be posted on [CommsHub](#). Counties can customize the template and use it to inform the recipients of the claim denial/partial denial.

ISSUE PAYMENT FOR COVID MEDICAL ACCOMPAINMENT

The following information will be needed to create the COVID Medical Accompaniment special transaction in CMIPS.

- From/To Date: The pay period associated with the vaccination date(s) on the form
- Payee Name: Select the name of the provider claiming the hours
- Program: Select "IHSS"
- Type: Select "COVID Medical Accompaniment"
- Hours: Up to four hours (two hours per vaccine appointment)

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The “COVID Medical Accompaniment” special transaction, like all special transactions, requires a second level of approval. Once the transaction is saved, it will be routed for approval before a warrant is issued. Upon final approval, the request will be in pending payroll status and a payment will be sent to the provider by their preference payroll method as indicated in CMIPS. Please refer to [CMIPS User's Manual](#) for additional information on how to create special transactions.

Questions regarding the information transmitted in this ACL may be directed to the Adult Programs Division, CMIPS and Systems Enhancements Branch, at the following email address: CMIPSI-Requests@dss.ca.gov.

Sincerely,

Original Document Signed By

DEBBI THOMSON
Deputy Director
Adult Programs Division

Attachment

c: CWDA

Dear IHSS Recipient,

Your provider can be paid to accompany you to receive your COVID-19 vaccine if you have authorized hours for Accompaniment to Medical Appointments. These hours can be claimed on your provider's existing timesheet.

If you are not authorized for Accompaniment to Medical Appointments but require(d) this IHSS service to get your vaccine, or you need additional hours for this purpose, you can fill out the form below and sign, under penalty of perjury, that your provider had to accompany you to get your vaccine and they were not able to claim the time on their timesheet. This allows your provider to be paid up to 4 hours (2 hours per vaccine appointment). This form must be submitted to your county IHSS office to be processed.

Provider Information

Provider Name (Print):		
Street Address:		
City:	State:	Zip Code:

Provider Number (9 Digits):

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Recipient Information

Recipient Name:

Recipient Case Number (7 Digits):

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Recipient Vaccination Dates:

First Vaccine: _____

Second Vaccine: _____

Under the penalty of perjury, I hereby acknowledge that the information provided above is true and correct.

Recipient's Signature: _____

Date: _____

Provider's Signature: _____

Date: _____